No. 21-5261

In The Supreme Court of the United States

SHAKEEL KAHN,

Petitioner,

vs.

UNITED STATES,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

JOINT APPENDIX

VOLUME I

BEAU B. BRINDLEY*
BLAIR WESTOVER
LAW OFFICES OF
BEAU B. BRINDLEY
53 W. Jackson Blvd.
Ste. 1410
Chicago, Illinois 60604
(312) 765-8878
bbbrindley@gmail.com

Counsel for Petitioner

ELIZABETH PRELOGAR*
KENNETH A. POLITE, JR.
DAVID M. LIEBERMAN
DEPARTMENT OF JUSTICE
950 Pennsylvania Ave., N.W.
Rm. 5616
Washington, D.C. 20530
(202) 514-2217
SupremeCtBriefs@usdoj.gov

Counsel for Respondent

**Counsel of Record*

Petition For Certiorari Filed July 26, 2021
Certiorari Granted November 5, 2021

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

TABLE OF CONTENTS

Page

VOLUME I

Relevant Docket Entries, United States District Court for the District of Wyoming 1

Relevant Docket Entries, United States Court of Appeals for the Tenth Circuit 39

Third Superseding Indictment, March 15, 2018 41

Excerpts of Government's Proposed Jury Instructions, April 16, 2019 79

Defendant Shakeel Kahn's Objections to Government's Proposed Jury Instructions and His Proposed Instructions, April 25, 2019 86

Excerpts of Transcript of Trial Proceedings, April 29, 2019 103

Excerpts of Transcript of Trial Proceedings, April 30, 2019 130

Excerpts of Transcript of Trial Proceedings, May 1, 2019 154

VOLUME II

Excerpts of Transcript of Trial Proceedings, May 7, 2019 384

Excerpts of Transcript of Trial Proceedings, May 9, 2019 408

Excerpts of Transcript of Trial Proceedings, May 10, 2019 417

TABLE OF CONTENTS – Continued

Page

Excerpts of Transcript of Trial Proceedings, May 13, 2019 429

Excerpts of Transcript of Trial Proceedings, May 17, 2019 434

Excerpts of Transcript of Trial Proceedings, May 20, 2019 450

Excerpts of Transcript of Trial Proceedings, May 21, 2019 477

District Court Order Denying Shakeel A. Kahn's Motion for New Trial, August 9, 2019 489

District Court Amended Judgment in a Criminal Case, August 19, 2019....................496

Circuit Court Opinion, February 25, 2021....................509

U.S. District Court
District of Wyoming (Cheyenne)
CRIMINAL DOCKET EXCERPT FOR CASE #:
2:17–cr–00029–ABJ–1

Date Filed	#	Docket Text
11/30/2016	1	COMPLAINT as to Shakeel A Kahn (1), Lyn Kahn (2). (Court Staff, ssw) [2:16–mj–00100–ABJ] (Entered: 11/30/2016)
01/12/2017	52	INDICTMENT as to Shakeel A Kahn (1) count(s) 1, 2, 3, 4–5, 6, 7–8, 9, 10–11, 12, 14, 15–16, 17, 18, 19, 20–21, Lyn Kahn (2) count(s) 1, 6, 10–11, 12, 13, 16, 17, Paul Edward Beland (3) count(s) 1, 3, 7–8, 13, 15. (Court Staff, szf) (Entered: 01/13/2017)
04/18/2017	133	MOTION for Leave to *File an Interlocutory Appeal* by Shakeel A Kahn as to Defendant(s) Shakeel A Kahn, Lyn Kahn, Paul Edward Beland. (Attachments: # 1 Proposed Order)(Fleener, Thomas) Modified on 4/20/2017 (Court Staff, sth). (Entered: 04/18/2017)
04/24/2017	143	NOTICE OF INTERLOCUTORY APPEAL by defendant Shakeel A Kahn re 129 Order on Motion for Order, Order on Motion for Release of Funds,. (Attachments: # 1 Exhibit, # 2 Exhibit) (Harris, Terry) (Entered: 04/24/2017)

05/19/2017	154	SUPERSEDING INDICTMENT as to Shakeel A Kahn (1) count(s) 1s, 2s, 4s, 5s, 6s–7s, 8s, 9s–10s, 1 1s, 12s–13s, 14s, 16s, 17s–18s, 19s, 20s, 21s, 22s–23s, Lyn Kahn (2) count(s) 1s, 8s, 12s–13s, 14s, 15s, 18s, 19s, Paul Edward Beland (3) count(s) 1s, 5s, 9s–10s, 15s, 17s, Nabeel Aziz Khan (4) count(s) 1, 3. (Court Staff, szf) Modified docket text and counts (Count 20s for Lyn Kahn deleted as it was added in error) on 6/22/2017 (Court Staff, szf). (Entered: 05/23/2017)
08/04/2017	267	NOTICE OF INTENT TO OFFER EXPERT TESTIMONY by USA as to defendant Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan. (Attachments: # 1 Dr. Poffenbarger CV, # 2 Dr. Shay CV, # 3 Amber Peterson CV, # 4 Ryan Cox CV, # 5 Robert Churchwell CV, # 6 Chris Reed CV, # 7 Paul Short CV)(Sprecher, Stephanie) (Entered: 08/04/2017)
10/02/2017	298	MOTION to Dismiss Count Eleven(11) of the Superseding Indictment by Defendant(s) Shakeel A Kahn. (Attachments: # 1 cover letter)(Court Staff, sth) (Entered: 10/02/2017)
10/17/2017	302	RESPONSE to 298 Motion to Dismiss Count 11 of the Superseding Indictment by USA as to Shakeel A

		Kahn. (Sprecher, Stephanie) Link added on 10/18/2017 (Court Staff, ssw). (Entered: 10/17/2017)
11/16/2017	305	ORDER denying 298 Motion to Vacate or otherwise modify Order Prohibiting Contact as to Shakeel A Kahn (1) by the Honorable Alan B Johnson. (Copy mailed to defendant Shakeel Kahn)(Court Staff, ssw) (Entered: 11/16/2017)
11/16/2017	308	SECOND SUPERSEDING INDICTMENT as to Shakeel A Kahn (1) count(s) 1ss, 2ss, 4ss, 5ss, 6ss, 7ss, 8ss, 9ss–10ss, 1 1ss, 12ss, 13ss, 14ss, 16ss, 17ss–18ss, 19ss, 20ss, 21ss, 22ss–23ss, Lyn Kahn (2) count(s) 1ss, 8ss, 12ss, 13ss, 14ss, 15ss, 18ss, 19ss, Paul Edward Beland (3) count(s) 1ss, 5ss, 9ss–10ss, 15ss, 17ss, Nabeel Aziz Khan (4) count(s) 1s, 3s, Shawnna Christine Thacker (5) count(s) 1. (Court Staff, stbd) (Additional attachment(s) added on 11/21/2017: # 1 Amended Penalty Summaries) (Court Staff, ssw). Modified text on 11/28/2017 (Court Staff, szf). (Entered: 11/17/2017)
03/15/2018	356	THIRD SUPERSEDING INDICTMENT as to Shakeel A Kahn (1) count(s) 1sss, 2sss, 4sss, 5sss, 6sss–7sss, 8sss, 9sss–10sss, 1 1sss, 12sss–13sss, 14sss, 16sss, 17sss–18sss, 19sss, 20sss, 21sss, 22sss, 23sss, Lyn Kahn (2) count(s)

		1sss, 8sss, 12sss–13sss, 14sss, 15sss, 18sss, 19sss, Paul Edward Beland (3) count(s) 1sss, 5sss, 9sss–10sss, 15sss, 17sss, Nabeel Aziz Khan (4) count(s) 1ss, 3ss, Shawnna Christine Thacker (5) count(s) 1s. (Court Staff, stbd) Count 6sss deleted for Paul Beland on 3/19/2018 (Court Staff, ssw). (Entered: 03/15/2018)
03/22/2018	369	Minute Entry: Initial Appearance/Arraignment as to Shakeel A Kahn (1) Count 1sss, 2sss, 4sss–14sss, and 16sss–23sss held on 3/22/2018. Defendant pled not guilty, detained. Proceedings held before Honorable Kelly H. Rankin. (Tape #FTR Touch Courtroom No. 3.) (Court Staff, szf) (Entered: 03/22/2018)
06/08/2018	406	MANDATE of USCA as to Shakeel A Kahn REVERSED AND REMANDED re 143 Notice of Appeal – Interlocutory filed by Shakeel A Kahn. (Attachments: # 1 Opinion, # 2 Judgment) (Court Staff, ssw) (Entered: 06/08/2018)
01/25/2019	504	NOTICE OF INTENT TO OFFER EXPERT TESTIMONY by USA as to defendant Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan, Shawnna Christine Thacker. (Sprecher, Stephanie) (Entered: 01/25/2019)

03/04/2019	559	NOTICE OF INTENT TO OFFER EXPERT TESTIMONY by defendant Shakeel A Kahn. (Attachments: # 1 Exhibit)(Reese, Michael) (Entered: 03/04/2019)
03/08/2019	570	NOTICE OF INTENT TO OFFER EXPERT TESTIMONY by defendant Shakeel A Kahn. (Attachments: # 1 Exhibit)(Reese, Michael) (Entered: 03/08/2019)
04/09/2019	641	Supplemental NOTICE OF INTENT TO OFFER EXPERT TESTIMONY re 267 Notice, 504 Notice by USA as to defendant Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan, Shawnna Christine Thacker (Sprecher, Stephanie) Modified text and created links on 4/9/2019 (Court Staff, sbh). (Entered: 04/09/2019)
04/16/2019	668	Proposed Jury Instructions (cited) by USA as to defendant Shakeel A Kahn, Lyn Kahn, Nabeel Aziz Khan (Sprecher, Stephanie) (Entered: 04/16/2019)
04/16/2019	669	Proposed Jury Instructions (uncited) by USA as to defendant Shakeel A Kahn, Lyn Kahn, Nabeel Aziz Khan (Sprecher, Stephanie) (Entered: 04/16/2019)
04/16/2019	670	Proposed Verdict Form by Plaintiff USA (Sprecher, Stephanie) (Entered: 04/16/2019)

04/24/2019	690	TRIAL BRIEF by Plaintiff USA (Sprecher, Stephanie) Text Modified on 4/25/2019 (Court Staff, ssw). (Entered: 04/24/2019)
04/25/2019	693	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – WITNESS LIST by defendant Shakeel A Kahn (Brindley, Beau) (Entered: 04/25/2019)
04/25/2019	694	OBJECTIONS to Government's 668 Proposed Jury Instructions and 670 Proposed Verdict form, with Proposed Alternative Jury Instructions (cited) by defendant Shakeel A Kahn (Brindley, Beau) Text Modified on 4/26/2019 (Court Staff, ssw). (Entered: 04/25/2019)
04/25/2019	698	MINUTES: Jury Selection as to Shakeel A Kahn, Nabeel Aziz Khan held on 4/25/2019. Proceedings held before Honorable Alan B. Johnson. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 04/26/2019)
04/25/2019	699	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – Peremptory Challenges as to Shakeel A Kahn, Nabeel Aziz Khan (Court Staff, sbh) (Entered: 04/26/2019)

04/29/2019	701	JOINT STIPULATION to U.S. Income Tax Records by USA as to Defendants Shakeel A. Kahn and Nabeel A. Khan. (Court Staff, scat) Text Modified on 4/29/2019 (Court Staff, ssw). (Entered: 04/29/2019)
04/29/2019	703	MINUTES – Jury Trial commenced to a Jury of 15 on 4/29/2019 as to Shakeel A Kahn, Nabeel Aziz Khan. Proceedings held before Honorable Alan B. Johnson. Witnesses: Ryan Cox, Gina Moore. (Court Reporter: Monique Gentry) (Court Staff, sbh) Modified text on 4/30/2019 (Court Staff, sbh). (Entered: 04/30/2019)
04/30/2019	704	MINUTES – Jury Trial Day 3 as to Shakeel A Kahn, Nabeel Aziz Khan held on 4/30/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Gina Moore, Monica Carter, Robert Churchwell. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/01/2019)
05/01/2019	707	MINUTES – Jury Trial Day 4 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/1/2019. Proceedings held before Honorable Alan B. Johnson. Witness: Jed Shay (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/01/2019)
05/02/2019	708	MINUTES – Jury Trial Day 5 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/2/2019. Proceedings held

		before Honorable Alan B. Johnson. Witnesses: Pam Godinez, Debbie Thorpe, Irene Riveness, Robert Churchwell, Paul Beland. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/02/2019)
05/06/2019	712	MINUTES – Jury Trial Day 6 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/6/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Paul Beland, Dawn St. George, Jessica Rodriguez. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/06/2019)
05/07/2019	715	MINUTES – Jury Trial Day 7 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/7/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Chris Muehlhausen, Jed Shay, Shawnna Thacker. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/07/2019)
05/08/2019	716	MINUTES – Jury Trial Day 8 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/8/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: David Drndarski, Brett Patterson, Stacy Drndarski, Erinn Downey. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/08/2019)
05/09/2019	717	MINUTES – Jury Trial Day 9 as to Shakeel A Kahn, Nabeel Aziz Khan

		held on 5/9/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Erinn Downey, Lynn Hamar, Blake Hamar, Randy Moody, Cori Morgan, Bruce Berg, Ryan Hieb. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/09/2019)
05/10/2019	720	MINUTES – Jury Trial Day 10 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/10/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Ryan Hieb, Stacey Hail, Jennifer Robinson. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/10/2019)
05/10/2019	722	EX–PARTE DOCUMENT – ORDER re 719 Motion for Guidance as to Shakeel A Kahn (1), Lyn Kahn (2) by the Honorable Alan B. Johnson (Court Staff, sbh) (Entered: 05/10/2019)
05/13/2019	723	Joint STIPULATION to Interstate Commerce by USA, defendants Shakeel A Kahn, Nabeel Aziz Khan (Court Staff, sbh) (Entered: 05/13/2019)
05/13/2019	724	MINUTES – Jury Trial Day 11 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/13/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Deni Antelope, Shaina Voss, Jake Rice. (Court Reporter:

		Monique Gentry) (Court Staff, sbh) (Entered: 05/13/2019)
05/14/2019	725	MINUTES – Jury Trial Day 12 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/14/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Lyn Kahn, Anthony Vargas. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/14/2019)
05/15/2019	727	MINUTES – Jury Trial Day 13 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/15/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Anthony Vargas, Anita Sposato, Robert Churchwell. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/15/2019)
05/16/2019	728	MINUTES – Jury Trial Day 14 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/16/2019. Proceedings held before Honorable Alan B. Johnson. Witnesses: Robert Churchwell, Katherine Raven. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/16/2019)
05/17/2019	729	Proposed Jury Instructions (cited) by defendant Shakeel A Kahn (Brindley, Beau) (Entered: 05/17/2019)
05/17/2019	730	MINUTES – Jury Trial Day 15 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/17/2019. Proceedings held

		before Honorable Alan B. Johnson. Witnesses: Katherine Raven, Shakeel Kahn. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/17/2019)
05/19/2019	731	Objections to Court's Proposed Jury Instructions and Proposed Jury Instructions (cited) by Nabeel Aziz Khan as to defendant Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan, Shawnna Christine Thacker (Bowen, Stephanie) Text Modified on 5/20/2019 (Court Staff, ssw). (Entered: 05/19/2019)
05/20/2019	732	MINUTES – Jury Trial Day 16 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/20/2019. Proceedings held before Honorable Alan B. Johnson. Witness: Shakeel Kahn. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Main Document 732 replaced on 5/21/2019) (Court Staff, sbh). (Entered: 05/20/2019)
05/21/2019	733	MINUTES – Jury Trial Day 17 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/21/2019. Proceedings held before Honorable Alan B. Johnson. (Court Reporter: Monique Gentry) (Court Staff, sbh) (Entered: 05/22/2019)
05/22/2019	736	MINUTES – Jury Trial day 18 as to Shakeel A Kahn, Nabeel Aziz Khan

		held on 5/22/2019 Proceedings held before Honorable Alan B Johnson. (Court Reporter Monique Gentry.) (Court Staff, scat) (Entered: 05/23/2019)
05/22/2019	737	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – Jury Note/Question1 (Court Staff, scat) Modified text on 5/23/2019 (Court Staff, scat). (Entered: 05/23/2019)
05/22/2019	738	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – Jury Note/Question 2 (Court Staff, scat) (Entered: 05/23/2019)
05/22/2019	739	JERS ADMITTED EXHIBIT LIST by defendant Shakeel A Kahn, Nabeel Aziz Khan (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	740	Proposed Jury Instructions given by the court as to Shakeel A Kahn, Nabeel Aziz Khan (Attachments: # 1 Verdict Form) (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	741	Final Jury Instructions given by the court as to Shakeel A Kahn, Nabeel Aziz Khan (Attachments: # 1 Verdict Form) (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	742	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference

		Policy on Privacy and Public Access – Jury Note/Question 3 (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	743	Supplemental Jury Instruction A given by the court as to Shakeel A Kahn, Nabeel Aziz Khan (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	744	Supplemental Jury Instruction B given by the court as to Shakeel A Kahn, Nabeel Aziz Khan (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	746	Supplemental Jury Instruction C given by the court as to Shakeel A Kahn, Nabeel Aziz Khan (Court Staff, scat) (Entered: 05/23/2019)
05/23/2019	747	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – Jury Note/Question 4 (Court Staff, scat) (Entered: 05/24/2019)
05/23/2019	748	MINUTES – Jury Trial day 19 as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/23/2019 Proceedings held before Honorable Alan B Johnson. (Court Reporter Monique Gentry.) (Court Staff, scat) (Entered: 05/24/2019)
05/24/2019	749	MINUTES – Jury Trial as to Shakeel A Kahn, Nabeel Aziz Khan completed on 5/24/2019 Proceedings held before Honorable Alan B Johnson. (Court Reporter Monique

		Gentry.) (Court Staff, scat) (Entered: 05/24/2019)
05/24/2019	750	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – Jury Note/Question 5 (Court Staff, scat) (Entered: 05/24/2019)
05/24/2019	751	NON–PUBLIC DOCUMENT pursuant to the Judicial Conference Policy on Privacy and Public Access – JURY VERDICT as to Shakeel A Kahn (1) Guilty on Count 1sss,2sss,3, 4sss,5sss,6sss–7sss,8sss,9sss–10sss, 11sss,12sss–13sss,14sss,16sss,17sss –18sss,19sss,20sss,21sss,23sss and Nabeel Aziz Khan (4) Guilty on Count 1ss,3ss. (Court Staff, scat) (Entered: 05/24/2019)
07/02/2019	792	PRELIMINARY FORFEITURE ORDER by the Honorable Alan B Johnson granting 790 Motion for Order as to Shakeel A Kahn (1), Lyn Kahn (2).(Court Staff, ssw) 4 certified Copies sent to AUSA on 7/8/2019 (Court Staff, ssw). (Entered: 07/02/2019)
07/15/2019	803	EX–PARTE DOCUMENT – OBJECTIONS/RESPONSES TO PRESENTENCE INVESTIGATION REPORT as to defendant Shakeel A Kahn. (Sprecher, Stephanie) (Entered: 07/15/2019)

07/16/2019	806	EX–PARTE DOCUMENT – OBJECTIONS/RESPONSES TO PRESENTENCE INVESTIGATION REPORT as to defendant Shakeel A Kahn. NO OBJECTIONS SUBMITTED. (Brindley, Beau) (Entered: 07/16/2019)
07/19/2019	808	MOTION for New Trial by Defendant(s) Shakeel A Kahn. (Brindley, Beau) (Entered: 07/19/2019)
07/20/2019	809	SUPPLEMENT to 808 MOTION for New Trial by defendant Shakeel A Kahn (Brindley, Beau) (Entered: 07/20/2019)
07/25/2019	814	SEALED DOCUMENT – ADDENDUM TO PRESENTENCE REPORT as to Shakeel A Kahn Access granted to: Stephanie Sprecher, Stephanie Hambrick, Michael H Reese, Beau B Brindley, Michael J Thompson, Blair T Westover. (scanada,) (Entered: 07/25/2019)
07/25/2019	815	SEALED DOCUMENT – REVISED PRESENTENCE REPORT as to Shakeel A Kahn Access granted to: Stephanie Sprecher, Stephanie Hambrick, Michael H Reese, Beau B Brindley, Michael J Thompson, Blair T Westover. (scanada,) (Entered: 07/25/2019)
08/02/2019	838	RESPONSE to 808 MOTION for New Trial by USA as to Shakeel A Kahn. (Sprecher, Stephanie) (Entered: 08/02/2019)

08/09/2019	844	ORDER denying 808 Motion for New Trial and 809 Supplemental Motion for New Trial as to Shakeel A Kahn (1) by the Honorable Alan B Johnson. (Court Staff, ssw) (Entered: 08/09/2019)
08/12/2019	848	Minute Entry: Sentencing held on 8/12/2019 for Shakeel A Kahn (1), Defendant sentenced to 240 months incarceration as to Counts 1, 4, 5, 6, 7, 9, 10, 11, 14, 16, 19, 20, and 21; 48 months as to Counts 8, 12, 13, 17 and 18; 120 months as to Counts 22 and 23, all to be served concurrently; and 5 years as to Count 2, consecutive to all other counts; 5 years of supervised release as to Counts 1, 2, 4, 5, 6, 7, 9, 10, 11, 14, 16, 19, 20 and 21; 3 years as to Counts 22 and 23; and 1 year as to Counts 8, 12, 13, 17 and 18, all to be served concurrently; $5,000 in restitution; no fine; and a special assessment of $100 per count for a total of $2,100. Proceedings held before Honorable Alan B Johnson. (Court Reporter Monique Gentry.) (Court Staff, ssw) (Main Document 848 replaced on 8/15/2019) (Court Staff, ssw). (Entered: 08/13/2019)
08/14/2019	851	JUDGMENT and COMMITMENT as to Shakeel A Kahn (1), Defendant sentenced to 240 months incarceration as to Counts 1, 4, 5, 6, 7, 9,

		10, 11, 14, 16, 19, 20, and 21; 48 months as to Counts 8, 12, 13, 17 and 18; 120 months as to Counts 22 and 23, all to be served concurrently; and 5 years as to Count 2, consecutive to all other counts; 5 years of supervised release as to Counts 1, 2, 4, 5, 6, 7, 9, 10, 11, 14, 16, 19, 20 and 21; 3 years of supervised release as to Counts 22 and 23; and 1 year of supervised release as to Counts 8, 12, 13, 17 and 18, all to be served concurrently; $5,000 in restitution; no fine; and a special assessment of $100 per count for a total of $2,100 by the Honorable Alan B Johnson.(Court Staff, ssw) (Entered: 08/14/2019)
08/14/2019	852	ADDENDUM to 851 Judgment as to Shakeel A Kahn, by the Honorable Alan B Johnson.(Court Staff, ssw) (Entered: 08/14/2019)
08/19/2019	856	AMENDED JUDGMENT as to Shakeel A Kahn (1) by the Honorable Alan B Johnson. Count(s) 10sss, 11sss, 12sss, 13sss, 14sss, 16sss, 17sss, 18sss, 19sss, 1sss, 20sss, 21sss, 22sss, 23sss, 2sss, 4sss, 5sss, 6sss, 7ss, 7sss, 8sss, 9sss, Defendant sentenced to 240 months incarceration as to Counts 1, 4, 5, 6, 7, 9, 10, 11, 14, 16, 19, 20, and 21; 48 months as to Counts 8, 12, 13, 17 and 18; 120 months as to Counts 22 and 23, all to be served concurrently; and 5

		years as to Count 2, consecutive to all other counts; 5 years of supervised release as to Counts 1, 2, 4, 5, 6, 7, 9, 10, 11, 14, 16, 19, 20 and 21; 3 years of supervised release as to Counts 22 and 23; and 1 year of supervised release as to Counts 8, 12, 13, 17 and 18, all to be served concurrently; $5,000 in restitution; no fine; and a special assessment of $100 per count for a total of $2,100. (Court Staff, sbh) (Entered: 08/19/2019)
08/28/2019	862	NOTICE OF APPEAL by defendant Shakeel A Kahn re 856 Amended Judgment; Filing fee $ 505, receipt number 1089–1645875. (Brindley, Beau) Modified on 8/28/2019 (Court Staff, ssw). (Entered: 08/28/2019)
08/28/2019	863	Preliminary Record of appeal sent to USCA and counsel as to Shakeel A Kahn re 862 Notice of Appeal **The procedures and appeals packet may be obtained from our website at www.wyd.uscourts.gov** (Attachments: # 1 Preliminary Record on Appeal Including Notice of Appeal) (Court Staff, ssw) (Entered: 08/28/2019)
08/28/2019	864	APPEAL NUMBER **19–8054** received from USCA as to Shakeel A Kahn for 862 Notice of Appeal filed by Shakeel A Kahn. Criminal case docketed. Preliminary record filed. DATE RECEIVED: 08/28/2019.

		Docketing statement due 09/11/2019 for Shakeel Kahn. Notice of appearance due on 09/11/2019 for Shakeel Kahn and United States of America. Transcript order form due 09/11/2019 for Shakeel Kahn. [19–8054] (Court Staff, ssw) (Entered: 08/28/2019)
10/27/2019	906	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume I of XX, Trial Proceedings, Jury Selection as to Nabeel Aziz Khan held on 4/25/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) Modified on 10/28/2019 (Court Staff, stbd). (Main Document 906 replaced on

		11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	907	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Motion Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 4/26/19 before Judge Alan B. Johnson re 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 907 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	908	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume II of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 4/29/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of

		this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 908 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	909	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume III of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 4/30/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made

		available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 909 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	910	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume IV of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/1/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 910

		replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	911	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume V of XX as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/2/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 911 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	912	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume VI of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/6/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice

		of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 912 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	913	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume VII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/7/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript

		attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 913 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	914	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume VIII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/8/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 914

		replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	915	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume IX of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/9/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 915 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	916	DISREGARD. Refiled at 919 . ~~NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume IX of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/10/19 before Judge Alan B.~~

		~~Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique)~~ Modified on 10/28/2019 (Court Staff, sbh). (Entered: 10/27/2019)
10/27/2019	917	SEALED DOCUMENT – NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Motions Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/10/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. (Gentry, Monique) (Main Document 917 replaced on 11/7/2019)

		(Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	918	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XI of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/13/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 918 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	919	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume X of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 05/10/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862

		Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 919 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	920	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/14/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript

		attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 920 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	921	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XIII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/15/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 921

		replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	922	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XIV of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/16/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 922 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	923	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XV of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/17/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862

		Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 923 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	924	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XVI of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/20/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this

		entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 924 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	925	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XVII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/21/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 925 replaced on

		11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	926	DUPLICATE ENTRY ~~NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XVII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/21/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique)~~ Modified on 10/28/2019 (Court Staff, stbd). (Entered: 10/27/2019)
10/27/2019	927	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XVIII of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/22/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862

		Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 927 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	928	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XIX of XX, Trial Proceedings as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/23/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this

		entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 928 replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
10/27/2019	929	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Volume XX of XX, Trial Proceedings, Verdict as to Shakeel A Kahn, Nabeel Aziz Khan held on 5/24/19 before Judge Alan B. Johnson re 858 Notice of Appeal, 862 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 11/4/2019. Notice of Redaction Request due 11/18/2019. Redacted Transcript Deadline set for 11/27/2019. Release of Transcript Restriction set for 1/27/2020. (Gentry, Monique) (Main Document 929

		replaced on 11/7/2019) (Court Staff, ssw). (Entered: 10/27/2019)
12/18/2019	970	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Trial Proceedings Opening Statements Vol XV–A of XX as to Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan, Shawnna Christine Thacker held on 5/17/2019 before Judge Alan B. Johnson re 858 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 12/26/2019. Notice of Redaction Request due 1/8/2020. Redacted Transcript Deadline set for 1/21/2020. Release of Transcript Restriction set for 3/17/2020. (Gentry, Monique) (Entered: 12/18/2019)
12/18/2019	971	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Trial Proceedings Opening Statements Vol II–A of XX as to Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan, Shawnna Christine Thacker

		held on 04/29/19 before Judge Alan B. Johnson re 858 Notice of Appeal. To purchase a copy of this transcript, please contact Court Reporter Monique Gentry, phone (307) 274–4661 or email mkg.gentry@gmail.com. A party must file a Notice of Intent to Request Redaction within 7 calendar days. If a party fails to request redaction, the unredacted transcript attached to this entry will be made available electronically without redaction. Notice of Intent to Redact due 12/26/2019. Notice of Redaction Request due 1/8/2020. Redacted Transcript Deadline set for 1/21/2020. Release of Transcript Restriction set for 3/17/2020. (Gentry, Monique) (Entered: 12/18/2019)
02/26/2020	993	FINAL ORDER OF FORFEITURE by the Honorable Alan B. Johnson as to Shakeel A Kahn, Lyn Kahn, Paul Edward Beland, Nabeel Aziz Khan, Shawnna Christine Thacker (Court Staff, sbh) (Entered: 02/26/2020)
07/16/2020	1015	Amended FINAL ORDER of Forfeiture pursuant to FRCP 32.2(c)(2) re 1014 Motion for Final Order of Forfeiture as to Shakeel A Kahn (1), Lyn Kahn (2) by the Honorable Alan B. Johnson (Court Staff, sbh) (Entered: 07/16/2020)

Tenth Circuit Court Of Appeals Docket #: 19-8054 Excerpts *United States v. Kahn*

- 08/28/2019: [10674289] Criminal case docketed. Preliminary record filed. DATE RECEIVED: 08/28/2019. Docketing statement due 09/11/2019 for Shakeel Kahn. Notice of appearance due on 09/11/2019 for Shakeel Kahn and United States of America. Transcript order form due 09/11/2019 for Shakeel Kahn. [19-8054] [Entered: 08/28/2019 02:58 PM]

- 03/23/2020: [10727606] Appellant/Petitioner's brief filed by Shakeel Kahn. Served on 03/23/2020 by email. Oral argument requested? Yes. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [19-8054] BBB [Entered: 03/23/2020 07:22 PM]

- 03/24/2020: [10727827] Appellant's appendix filed by Shakeel Kahn. Total number of volumes filed: 2. Served on 03/24/2020. Manner of Service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [19-8054] BBB [Entered: 03/24/2020 12:33 PM]

- 07/22/2020: [10757314] Appellee/Respondent's brief filed by United States of America. Served on: 07/22/2020. Manner of service: email. Oral argument requested? Yes. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [19-8054] SIS [Entered: 07/22/2020 02:56 PM]

- 08/26/2020: [10765801] Appellant/Petitioner's reply brief filed by Shakeel Kahn. Served on 08/26/2020. Manner of Service: email. This

pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [19-8054] BBB [Entered: 08/26/2020 03:24 PM]

- 01/11/2021: [10798845] Case argued and submitted to Judges Briscoe, Matheson and Carson. Beau Brindley argued for the Appellant. Stephanie Sprecher argued for the Appellee. [19-8054] [Entered: 01/11/2021 10:07 AM]

- 02/25/2021: [10810471] Affirmed; Terminated on the merits after oral hearing; Written, signed, published; Judges Briscoe, authoring, Matheson and Carson. Mandate to issue. [19-8051, 19-8054] [Entered: 02/25/2021 11:51 AM]

- 02/25/2021: [10810472] Judgment for opinion filed. [19-8051, 19-8054] [Entered: 02/25/2021 11:55 AM]

- 03/19/2021: [10816345] Mandate issued. [19-8054] [Entered: 03/19/2021 07:21 AM]

- 07/30/3021: [10847307] Petition for writ of certiorari filed by Shakeel Kahn on 07/26/2021. Supreme Court Number 21-5261. [19-8054] [Entered: 07/30/2021 03:15 PM]

- 11/08/2021: [10870783] Supreme court order dated 11/05/2021 granting certiorari and leave to proceed in forma pauperis filed. [19-8054] [Entered: 11/08/2021 03:42 PM]

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

(Filed Mar. 15, 2018)

UNITED STATES OF AMERICA,

Plaintiff,

v.

SHAKEEL A. KAHN, (Counts 1, 2, 4-14, and 16-23)

LYN KAHN, a/k/a Lyn Voss, (Counts 1, 8, 12-15, 18, and 19)

NABEEL AZIZ "SONNY" KHAN a/k/a Nabeel Aziz "Sonny" Kahn, (Counts 1 and 3)

PAUL EDWARD BELAND, (Counts 1, 5, 9, 10, 15, and 17)

and

SHAWNNA CHRISTINE THACKER, (Count 1)

Defendants.

Criminal No. 17-CR-29-J

Count 1:
21 U.S.C. §§ 846, 841(a)(1), (b)(1)(C) and (b)(2)
Conspiracy to Dispense and Distribute Oxycodone, Alprazolam, Hydromorphone, and Carisoprodol Resulting in Death

Count 2:
18 U.S.C. § 924(c)(1)
Possession of Firearms in Furtherance of a Federal Drug Trafficking Crime

Count 3:
18 U.S.C. § 924(c)(1)
Use, Carry and Brandish Firearms During and in Relation to a Federal Drug Trafficking Crime; and Possession of Firearms in Furtherance of a Federal Drug Trafficking Crime

Counts 4, 6, 7, 16, and 20:
21 U.S.C. §§ 841(a)(1) and (b)(1)(C)
Dispensing of Oxycodone

Counts 5, 9, and 10:
21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. §2
Possession with Intent to Distribute Oxycodone and Aid and Abet

Counts 8, 12, 13, 15, 17, and 18:
21 U.S.C. § 843(b)
Unlawful Use of a Communication Facility

Counts 11, 14, and 19:
21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. §2
Dispensing of Oxycodone and Aid and Abet

Count 21:
21 U.S.C. § 848(a), (b) and (c)
Continuing Criminal Enterprise

Counts 22 and 23:
18 U.S.C. § 1957
Engaging in Monetary Transactions Derived from Specified Unlawful Activity

CRIMINAL FORFEITURE

THIRD SUPERSEDING INDICTMENT

THE GRAND JURY CHARGES THAT:

GENERAL ALLEGATIONS

At all times relevant to this indictment:

1. Defendant **Shakeel A. Kahn ("S. KAHN")** was a medical doctor licensed by the Arizona Medical Board to practice medicine in the State of Arizona from approximately March 2008 to August 5, 2016.

2. Defendant **S. KAHN** maintained a Drug Enforcement Administration (DEA) registration number in Arizona that allowed him to order, dispense, and prescribe controlled substances from February 22, 2007, to December 13, 2016.

3. Defendant **S. KAHN** was also licensed by the Wyoming Board of Medicine to practice medicine in the State of Wyoming from October 2015 to November 29, 2016.

4. Defendant **S. KAHN** maintained a DEA registration number in Wyoming that allowed him to order, dispense, and prescribe controlled substances beginning September 25, 2015.

5. Defendant **S. KAHN** operated a medical office in Fort Mohave, Arizona, beginning in about March 2008. He did business under the name of Medicorp, Inc. From his Fort Mohave office, he issued prescriptions for controlled

substances outside the usual course of professional practice and to persons who did not possess a legitimate medical need for those prescriptions.

6. Defendant **S. KAHN** operated a medical office in Casper, Wyoming, beginning in about October 2015. He also did business in that office under the name of Medicorp, Inc. From his Casper office, he issued prescriptions for controlled substances outside the usual course of professional practice and to persons who did not possess a legitimate medical need for those prescriptions.

COUNT ONE

From January 2011, through and including on or about November 30, 2016, in the District of Wyoming and elsewhere, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally and unlawfully combine, conspire, confederate, and agree together with **LYN KAHN, a/k/a Lyn Voss ("L. KAHN"); NABEEL AZIZ "Sonny" KHAN, a/k/a Nabeel Aziz "Sonny" Kahn ("N. KAHN"); SHAWNNA CHRISTINE THACKER** and **PAUL EDWARD BELAND**, and with other persons known and unknown to the grand jury, to dispense and distribute mixtures or substances containing detectable amounts of Oxycodone, a Schedule II controlled substance, Hydromorphone, a

Schedule II controlled substance, Carisoprodol, a Schedule IV controlled substance and Alprazolam, a Schedule IV controlled substance, the use of which resulted in the death of Jessica Burch.

In violation of 21 U.S.C. § 841(a)(1), (b)(1)(C) and (b)(2).

MANNER AND MEANS

1. It was a part of the conspiracy that **S. KAHN** would use his Wyoming and Arizona DEA registrations to prescribe large amounts of Oxycodone and other controlled substances to his customers outside of the usual course of professional practice and to customers without a legitimate medical need.

2. It was a further part of the conspiracy that from January 2011, to on or about August 5, 2016, **S. KAHN** used his Arizona DEA registration number to issue approximately 22,338 prescriptions for pills containing Oxycodone and other Schedule II and Schedule IV controlled substances.

3. It was a further part of the conspiracy that beginning in October 2015, **S. KAHN** used his Wyoming DEA registration number to issue approximately 1,617 prescriptions for pills containing Oxycodone and other Schedule II and Schedule IV controlled substances.

4. It was a further part of the conspiracy that before issuing his customers a prescription, **S. KAHN** would require his customers to sign a

"Drug Addiction Statement" that stated, in part, "Dr. Shakeel A. Kahn is not now and has never been a 'drug dealer.' Any statement to that effect made by me or by others known to me in the past, present or in the future are complete falsehoods and actionable as slander. I unequivocally deny any such statements made to that effect and they should be considered to be lies." The Statement also provided, in part, "Finally, by signing this release I agree to pay Shakeel A. Kahn, its officers and agents $100,000.00 USD for each and every action, investigation, complaint, or other legal or administrative proceeding whether civil or criminal however commenced against any of Shakeel A. Kahn, its officers or agents by or at the behest or as a direct and/or indirect result of any action attributable in any manner whatsoever to me."

5. It was a further part of the conspiracy that **S. KAHN**'s medical practice was primarily a cash only business. **S. KAHN**, **L. KAHN** and N. KAHN would separately charge **S. KAHN**'s customers for each prescription authorized for them. **S. KAHN**, **L. KAHN**, and **N. KAHN** would require an upfront, cash payment for most prescriptions. The cost of the prescriptions were directly related to the amount of medication prescribed. If a customer was unable to pay for a "full" prescription, **S. KAHN** reduced the amount of medication authorized commensurate with the amount of money the customer could pay **S. KAHN**.

6. It was further part of the conspiracy that **S. KAHN** and **N. KAHN** possessed, carried, and brandished firearms at the medical office, during medical office hours and other times.

7. It was a further part of the conspiracy that **S. KAHN** failed to conduct any legitimate medical examinations of his customers prior to prescribing for them Oxycodone and other controlled substances.

8. It was a further part of the conspiracy that **S. KAHN** would prescribe large amounts of Oxycodone and other controlled substances to customers who resided both inside and outside the States of Wyoming and Arizona, including Kentucky, Massachusetts, Oregon and Washington, on a regular monthly basis. These prescriptions were issued by **S. KAHN** outside the usual course of professional practice and were not for legitimate medical needs.

9. It was a further part of the conspiracy that individuals who resided inside and outside the States of Wyoming and Arizona, including Kentucky, Massachusetts, Oregon and Washington, would unlawfully redistribute the controlled substances unlawfully prescribed by **S. KAHN**.

10. It was a further part of the conspiracy that **S. KAHN** would use his Wyoming and Arizona DEA registrations to issue some of his customers Oxycodone prescriptions in both Arizona and Wyoming during the same month, thus doubling the amount of Oxycodone such

customers would have been able to receive had their prescriptions been written in only one of those states.

11. It was a further part of the conspiracy that **S. KAHN** would sometimes issue early prescription refills to his customers for Oxycodone and other controlled substances.

12. It was a further part of the conspiracy that **S. KAHN** and **L. KAHN** would receive wire transfers from customers for the purpose of paying for and obtaining prescriptions for Oxycodone and other controlled substances from **S. KAHN**. **L. KAHN** and **S. KAHN** would also direct customers to wire money to **KAHN**s' designees rather than directly to the **KAHN**s.

13. It was a further part of the conspiracy that **S. KAHN**, **L. KAHN** and **N. KAHN** would use communication facilities, including cellular telephones and mail and wire communication services, to arrange for the dispensing of Oxycodone and other controlled substances, as well as to effect payment for those prescriptions.

14. It was a further part of the conspiracy that **SHAWNNA CHRISTINE THACKER ("THACKER")** and others known to the grand jury would use such communication facilities to arrange for the distribution of and payment for **S. KAHN**'s prescriptions of Oxycodone and other controlled substances.

15. It was a further part of the conspiracy that **THACKER** would obtain prescriptions for controlled substances from **S. KAHN** in Arizona. **THACKER** would also travel from Arizona to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN** and would fill those prescriptions at pharmacies in Casper, Wyoming, and elsewhere.

16. It was a further part of the conspiracy that **S. KAHN** would issue prescriptions to Jessica Burch and a person known to the grand jury for controlled substances including Oxycodone, Carisoprodol, and Alprazolam in Arizona. The issuance of these prescriptions to Jessica Burch and to the person known to the grand jury was known by and reasonably foreseeable to **N. KHAN**.

17. It was a further part of the conspiracy that on March 17, 2015, Jessica Burch caused to be filled prescriptions issued by **S. KAHN** for controlled substances including Oxycodone, Carisoprodol and Alprazolam. Jessica Burch used the controlled substances obtained via these prescriptions, the issuance of which was known by and reasonably foreseeable to **N. KHAN**, which resulted in her death on March 19, 2015.

18. It was further part of the conspiracy that sometime after March 19, 2015, **L. KAHN** altered **S. KAHN**'s medical records belonging to individuals known to the grand jury

including the individual referenced in paragraphs 16 and 17 of this document.

19. It was a further part of the conspiracy that **PAUL EDWARD BELAND ("BELAND")** and others known to the grand jury would use such communication facilities to arrange for the distribution of and payment for **S. KAHN**'s prescriptions of Oxycodone and other controlled substances.

20. It was a further part of the conspiracy that **BELAND** would travel from Massachusetts to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN**, and would fill those prescriptions at pharmacies in Casper, Wyoming, and elsewhere.

21. It was a further part of the conspiracy that during parts of the conspiracy, a person known to the grand jury lived in Arizona and was a customer of **S. KAHN**. Said person moved to Kentucky during parts of this conspiracy. Because Kentucky pharmacies refused to fill **S. KAHN**'s out of state prescriptions, **S. KAHN** wrote prescriptions for said person which were filled in Arizona by a person other than said person. On one occasion, said person traveled from Kentucky to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN**, and filled those prescriptions at pharmacies in Casper, Wyoming. Said person paid **S. KAHN** for his/her prescriptions via wire transfer service.

22. It was a further part of the conspiracy that a person known to the grand jury resided in Washington during parts of this conspiracy and was a customer of **S. KAHN**. Said person would travel from the State of Washington to Arizona and to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN**, and would fill those prescriptions at pharmacies in Arizona and Casper, Wyoming.

23. It was a further part of the conspiracy that a person known to the grand jury resided in Arizona for parts of this conspiracy and was a customer of **S. KAHN**. At some time during the conspiracy, said person relocated to Oregon. Said person would thereafter travel from Oregon to Arizona and to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN**, and would fill those prescriptions at pharmacies in Arizona and Casper, Wyoming.

24. It was a further part of the conspiracy that persons known to the grand jury would travel from Arizona to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN**, and would fill those prescriptions at pharmacies in Casper, Wyoming. During the same thirty-day period when they had travelled to Wyoming to obtain prescriptions from **S. KAHN**, said persons would also obtain prescriptions for Oxycodone and other controlled substances from **S. KAHN**, which were written on **S. KAHN**'s Arizona DEA

registration and would be filled at pharmacies in Arizona.

25. It was a further part of the conspiracy that **BELAND** would recruit "clients" for **S. KAHN**, including persons known to the grand jury, who would travel with **BELAND** from Massachusetts to Casper, Wyoming, to obtain prescriptions for controlled substances from **S. KAHN**, and would fill those prescriptions at pharmacies in Casper, Wyoming and elsewhere in Wyoming.

26. It was a further part of the conspiracy that **S. KAHN**, **L. KAHN** and **N. KAHN** would, by issuing said prescriptions, cause the dispensing and distributing of mixtures and substances containing detectable amounts of Oxycodone and Alprazolam in violation of 21 U.S.C. § 841(a)(1), (b)(1)(C) and (b)(2), to **BELAND** and to others known and unknown to the grand jury, which prescriptions were issued outside the usual course of professional practice and without a legitimate medical need, and with reasonable cause to believe that the Oxycodone and Alprazolam authorized by such prescriptions was being unlawfully redistributed by these individuals and others.

27. It was a further part of the conspiracy that **BELAND** and others known to the grand jury unlawfully possessed with intent to distribute and did distribute mixtures and substances containing detectable amounts of Oxycodone

and Alprazolam, in violation of 21 U.S.C. §841(a)(1), (b)(1)(C) and (b)(2).

All in violation of 21 U.S.C. § 846.

COUNT TWO

From January 2011, through and including on or about November 30, 2016, in the District of Wyoming and elsewhere, the Defendant, **SHAKEEL A. KAHN**, did knowingly possess firearms in furtherance of a federal drug trafficking crime, namely, conspiracy to dispense and distribute mixtures or substances containing detectable amounts of Oxycodone, a Schedule II controlled substance, and Alprazolam, a Schedule IV controlled substance, in violation of 21 U.S.C. §§ 846 and 841(a)(1), (b)(1)(C) and (b)(2), as more fully alleged in Count One of this Superseding Indictment.

In violation of 18 U.S.C. § 924(c)(1).

COUNT THREE

From January 2011, through and including on or about November 30, 2016, in the District of Wyoming and elsewhere, the Defendant, **NABEEL AZIZ "Sonny" KHAN a/k/a Nabeel Aziz "Sonny" Kahn**, did knowingly use, carry and brandish firearms during and in relation to a federal drug trafficking crime and possess firearms in furtherance of a federal drug trafficking crime, namely, conspiracy to dispense and distribute mixtures or substances containing

detectable amounts of Oxycodone, a Schedule II controlled substance, and Alprazolam, a Schedule IV controlled substance, in violation of 21 U.S.C. §§ 846 and 841(a)(1), (b)(1)(C) and (b)(2), as more fully alleged in Count One of this Superseding Indictment.

In violation of 18 U.S.C. § 924(c)(1).

COUNT FOUR

On or about September 2, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to persons known to the grand jury.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C).

COUNT FIVE

On or about September 2, 2016, in the District of Wyoming, the Defendant, **PAUL EDWARD BELAND**, did knowingly, intentionally, and unlawfully possess with intent to distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, and the Defendant **SHAKEEL A. KAHN** did knowingly aid and abet Defendant

PAUL EDWARD BELAND in the commission of said offense.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2.

COUNT SIX

On or about September 30, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to an undercover agent.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C).

COUNT SEVEN

On or about October 1, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II

controlled substance, to a person known to the grand jury.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C).

COUNT EIGHT

On or about October 1, 2016, in the District of Wyoming and elsewhere, the Defendants, **SHAKEEL A. KAHN** and **LYN KAHN, a/k/a Lyn Voss**, did knowingly use a communication facility, to wit, a telephone, in causing and facilitating the commission of acts constituting a felony under the federal Controlled Substance Act, to wit: unlawfully dispensing and distributing a mixture and substance containing a detectable amount of Oxycodone, a Schedule H controlled substance, in violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C), as more fully alleged in Count Seven of this indictment.

In violation of 21 U.S.C. § 843(b).

COUNT NINE

On or about October 1, 2016, in the District of Wyoming, the Defendant, **PAUL EDWARD BELAND**, did knowingly, intentionally, and unlawfully possess with intent to distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, and the Defendant **SHAKEEL A. KAHN** did knowingly aid and abet Defendant **PAUL EDWARD BELAND** in the commission of said offense.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2.

COUNT TEN

On or about October 2, 2016, in the District of Wyoming, the Defendant, **PAUL EDWARD BELAND**, did knowingly, intentionally, and unlawfully possess with intent to distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, and the Defendant **SHAKEEL A. KAHN** did knowingly aid and abet Defendant **PAUL EDWARD BELAND** in the commission of said offense.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2.

COUNT ELEVEN

On or about October 7, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to a person known to the grand jury.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2.

COUNT TWELVE

On or about October 3, 2016, in the District of Wyoming and elsewhere, the Defendants, **SHAKEEL A. KAHN** and **LYN KAHN, a/k/a Lyn Voss**, did knowingly use a communication facility, to wit, a telephone, in causing and facilitating the commission of acts constituting a felony under the federal Controlled Substance Act, to wit: unlawfully dispensing and distributing a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, in violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C), as more fully alleged in Count Eleven of this indictment.

In violation of 21 U.S.C. § 843(b).

COUNT THIRTEEN

On or about October 7, 2016, in the District of Wyoming and elsewhere, the Defendants, **SHAKEEL A. KAHN** and **LYN KAHN, a/k/a Lyn Voss**, did knowingly, intentionally and unlawfully use a communication facility, to wit, a telephone, in causing and facilitating the commission of acts constituting a felony under the federal Controlled Substance Act, to wit: unlawfully dispensing and distributing a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, in

violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C), as more fully alleged in Count Eleven of this indictment.

In violation of 21 U.S.C. § 843(b).

COUNT FOURTEEN

Between on or about November 5, 2016, and on or about November 9, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to persons known to the grand jury, and the Defendant **LYN KAHN** did knowingly aid and abet Defendant **SHAKEEL A. KAHN** in the commission of said offense.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2.

COUNT FIFTEEN

On or about October 22, 2016, in the District of Wyoming and elsewhere, the Defendants, **LYN KAHN, a/k/a Lyn Voss**, and **PAUL EDWARD BELAND**, did knowingly use a communication facility, to wit, a telephone, in causing and facilitating the commission of acts constituting a felony under the federal

Controlled Substance Act, to wit: unlawfully dispensing and distributing a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, in violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C), as more fully alleged in Count Fourteen of this indictment.

In violation of 21 U.S.C. § 843(b).

COUNT SIXTEEN

On or about October 28, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to an undercover agent.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C).

COUNT SEVENTEEN

On or about October 31, 2016, in the District of Wyoming and elsewhere, the Defendants, **SHAKEEL A. KAHN** and **PAUL EDWARD BELAND**, did knowingly use a communication facility, to wit, a telephone, in causing and facilitating the commission of acts constituting a felony under the federal Controlled Substance Act, to wit: conspiracy to unlawfully

dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, in violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 846, as more fully alleged in Count One of this indictment.

In violation of 21 U.S.C. § 843(b).

COUNT EIGHTEEN

On or about November 14, 2016, in the District of Wyoming and elsewhere, the Defendants, **SHAKEEL A. KAHN** and **LYN KAHN, a/k/a Lyn Voss**, did knowingly use a communication facility, to wit, a telephone, in causing and facilitating the commission of acts constituting a felony under the federal Controlled Substances Act, to wit: conspiracy to unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, in violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 846, as alleged more fully in Count One of this indictment.

In violation of 21 U.S.C. § 843(b).

COUNT NINETEEN

On or about November 11, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional

practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to persons known to the grand jury, and the Defendant **LYN KAHN** did knowingly aid and abet Defendant **SHAKEEL A. KAHN** in the commission of said offense.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2.

COUNT TWENTY

From on or about June 7, 2016, through and including on or about June 9, 2016, in the District of Wyoming, the Defendant, **SHAKEEL A. KAHN**, then a physician licensed to practice medicine in the States of Wyoming and Arizona, and while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose, did knowingly, intentionally, and unlawfully dispense and distribute a mixture and substance containing a detectable amount of Oxycodone, a Schedule II controlled substance, to persons known to the grand jury.

In violation of 21 U.S.C. §§ 841(a)(1) and (b)(1)(C).

COUNT TWENTY-ONE

From January 2011, and continuing through on or about November 30, 2016, in the District of Wyoming and elsewhere, the Defendant, **SHAKEEL A. KAHN**, did knowingly, intentionally, and unlawfully engage in a continuing criminal enterprise, that is, the Defendant, **SHAKEEL A. KAHN**, knowingly and intentionally violated Title 21, United States Code, Chapter 13, including but not limited to violations of 21 U.S.C. §§ 841(a)(1), (b)(1)(C), 843(b), and 846, which violations, including those set forth in Counts One through Twenty of this indictment, were part of a continuing series of felony violations of Title 21, United States Code, and were undertaken by **SHAKEEL A. KAHN** in concert with at least five other persons with respect to whom **SHAKEEL A. KAHN** occupied a position of organizer, supervisor or manager, and from which continuing series of violations the Defendant, **SHAKEEL A. KAHN**, obtained substantial income and resources.

In violation of 21 U.S.C. § 848(a), (b) and (c).

COUNT TWENTY-TWO

On or about June 9, 2014, in the District of Wyoming and elsewhere, the Defendant, **SHAKEEL A. KAHN**, did knowingly engage in a monetary transaction, by, through, or to a financial institution affecting interstate commerce, in criminally derived property of a value greater than $10,000, that is the wire transfer of approximately $140,849.43 in the form

of a monetary instrument from Horizon Community Bank, in Arizona to the First American Title Insurance Company in Casper, Wyoming, said property having been derived from specified unlawful activities as alleged in Counts One, Four through Seven, Nine through Eleven, Fourteen, Sixteen, Nineteen and Twenty of this indictment.

In violation of 18 U.S.C. § 1957.

COUNT TWENTY-THREE

On or about November 29, 2016, in the District of Wyoming and elsewhere, the Defendant, **SHAKEEL A. KAHN**, did knowingly engage in a monetary transaction, by, through or to a financial institution affecting interstate commerce, in criminally derived property of a value greater than $10,000, that is the deposit or transfer of approximately $13,215.00 into Wells Fargo Bank, such property having been derived from specified unlawful activities as alleged in Counts One, Four through Seven, Nine through Eleven, Fourteen, Sixteen, Nineteen and Twenty of this indictment.

In violation of 18 U.S.C. § 1957.

FORFEITURE

Upon the conviction of one or more of the controlled substance offenses alleged in Counts One through Nineteen of this indictment, the Defendants, **SHAKEEL A. KAHN**, **LYN KAHN a/k/a Lyn Voss**,

NABEEL AZIZ "Sonny" KHAN a/k/a Nabeel Aziz "Sonny" Kahn, and **PAUL EDWARD BELAND** shall forfeit to the United States pursuant to 21 U.S.C. § 853 any property constituting or derived from proceeds obtained, directly or indirectly, as a result of the said violations and any property used, or intended to be used, in any manner or part, to commit, or to facilitate the commission of, the said violations, including, but not limited to the following:

Money Judgment

A sum of money equal to $2,898,614.42 in United States currency, representing the amount of proceeds obtained as a result of the offense alleged in the control substance counts enumerated herein.

Bank Accounts

Wells Fargo Bank Account #xxxxxx0091 – $50,040.60

JP Morgan Chase Bank Account # xxxxxx0906 – $15,036.89

Wells Fargo Bank Account # xxxxxx1789 – $6,531.15

Wells Fargo Bank Account # xxxxxx4357 – $2,323.73

Wells Fargo Bank Account # xxxxxx8531 – $5,272.46

Wells Fargo Bank Account # xxxxxx9001 – $14,466.10

Wells Fargo Bank Account # xxxxxx9019 – $16,903.87

Wells Fargo Bank Account # xxxxxx1039 – $4,579.59

Vehicles

2016 Chevrolet Corvette, VIN: 1G1YU2D60G5603506

2014 Ford Mustang, VIN: 1ZVBP8JZOE5208001

2014 Dodge Ram Pickup, VIN: 1C6RR7PT8ES447667

Real Property

2001 Primavera Lane, Fort Mohave, Mohave County, Arizona

2314 Primavera Loop, Fort Mohave, Mohave County, Arizona

2141 Thorndike Avenue, Casper, Natrona County, Wyoming

Currency

$1,048,450.00 in US currency

$3,000.00 in US currency

$6,450.00 in US currency

Substitute Assets

If any of the property described above, as a result of any act or omission of the Defendants:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third party;

c. has been placed beyond the jurisdiction of the court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be divided without difficulty,

the United States shall be entitled to forfeiture of substitute property pursuant to Title 21, United States Code, Section 853(p).

A TRUE BILL:

Ink Simnature on File in Clerk's Office
FOREPERSON

/s/ Mark A. Klaassen
MARK A. KLAASSEN
United States Attorney

Criminal No. 17-CR-29-J

PENALTY SUMMARY

DEFENDANT NAME: **SHAKEEL A. KAHN**

DATE: March 13, 2018

INTERPRETER NEEDED: No

PLACE OF TRIAL:

The government, pursuant to Rule 18, F.R.Cr.P., with due regard for the convenience of the Defendant, any victim and witnesses, and the prompt administration of justice, requests trial be held in: **Casper**

VICTIM(S): No

OFFENSE/PENALTIES:

Count 1:

21 U.S.C. §§ 846, 841(a)(1), (b)(1)(C) and (b)(2)
Conspiracy to Dispense and Distribute Oxycodone, Alprazolam, Hydromorphone, and Carisoprodol Resulting in Death

20 Years to Life Imprisonment
Up to $10,000,000 Fine
5 Years to Life Supervised Release
$100 Special Assessment

Count 2:

18 U.S.C. § 924(c)(1)
Possession of Firearms in Furtherance of a Federal Drug Trafficking Crime

not less than 5 years imprisonment consecutive
$250,000 Fine
3 Years Supervised Release
$100 Special Assessment

Counts 4, 6, 7, 16, 20:

21 U.S.C. §§ 841(a)(1) and (b)(1)(C)

Dispensing of Oxycodone

0-20 Years Imprisonment
Up to $1,000,000 Fine
Nlt 3 Years to Life Supervised Release
$100 Special Assessment

Counts 5, 9, 10:

21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2

Possession with Intent to Distribute
Oxycodone and Aid and Abet

0-20 Years Imprisonment
Up to $1,000,000 Fine
Nlt 3 Years to Life Supervised Release
$100 Special Assessment

Counts 8, 12, 13, 17, 18:

21 U.S.C. §§ 843(b)
Unlawful Use of a Communication Facility

0-4 Years Imprisonment
$250,000 Fine
0-1 Year Supervised Release
$100 Special Assessment

Count 11, 14, 19:

21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2
Dispensing of Oxycodone and Aid and Abet

0-20 Years Imprisonment
Up to $1,000,000 Fine
Nlt 3 Years to Life Supervised Release
$100 Special Assessment

Count 21:

21 U.S.C. §§ 848(a), (b) and (c)
Continuing Criminal Enterprise

20 Years to Life Imprisonment
$2,000,000 Fine
0-5 Years Supervised Release
$100 Special Assessment

Counts 22, 23:

18 U.S.C. § 1957
Engaging in Monetary Transactions Derived from Specified Unlawful Activity

0-10 Years Imprisonment
$250,000 Fine
0-3 Years Supervised Release
$100 Special Assessment

TOTALS: 45 Years to Life Imprisonment
$25,000,000 Fine
Years to Life Supervised Release
2,100 Special Assessment

AGENT: Dan Fox, DCI

AUSA: Stephanie I. Sprecher
Assistant United States Attorney

ESTIMATED TIME OF TRIAL:

More than 5 days

WILL THE GOVERNMENT SEEK DETENTION IN THIS CASE:

Yes

ARE THERE DETAINERS FROM OTHER JURISDICTIONS:

No

Criminal No. 17-CR-29-J

PENALTY SUMMARY

DEFENDANT NAME: LYN KAHN a/lc/a Lyn Voss

DATE: March 13, 2018

INTERPRETER NEEDED: No

PLACE OF TRIAL:

The government, pursuant to Rule 18, F.R.Cr.P., with due regard for the convenience of the Defendant, any victim and witnesses, and the prompt administration of justice, requests trial be held in: **Casper**

VICTIM(S): No

OFFENSE/PENALTIES:

Count 1:

21 U.S.C. §§ 846, 841(a)(1), (b)(1)(C) and (b)(2)
Conspiracy to Dispense and Distribute Oxycodone, Alprazolam, Hydromorphone, and Carisoprodol

0-20 Years Imprisonment
Up to $1,000,000 Fine
3 Years to Life Supervised Release
$100 Special Assessment

Counts 8, 12, 13, 15, 18:

21 U.S.C. §§ 843(b)
Unlawful Use of a Communication Facility

0-4 Years Imprisonment
$250,000 Fine
0-1 Year Supervised Release
$100 Special Assessment

Count 14, 19:

21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2
Dispensing of Oxycodone and Aid and Abet

0-20 Years Imprisonment
Up to $1,000,000 Fine
Nlt 3 Years to Life Supervised Release
$100 Special Assessment

TOTALS: 0-20 Years Imprisonment
$4,250,000 Fine
3 Years to Life Supervised Release
$800 Special Assessment

AGENT: Dan Fox, DCI

AUSA: Stephanie I. Sprecher
Assistant United States Attorney

ESTIMATED TIME OF TRIAL:

More than 5 days

WILL THE GOVERNMENT SEEK DETENTION IN THIS CASE:

Yes

ARE THERE DETAINERS FROM OTHER JURISDICTIONS:

No

Criminal No. 17-CR-29-J

PENALTY SUMMARY

DEFENDANT NAME: **NABEEL AZIZ "SONNY" KHAN a/k/a Nabeel Aziz "Sonny" Kahn**

DATE: March 13, 2018

INTERPRETER NEEDED: No

PLACE OF TRIAL:

The government, pursuant to Rule 18, F.R.Cr.P., with due regard for the convenience of the Defendant, any victim and witnesses, and the prompt administration of justice, requests trial be held in: **Casper**

VICTIM(S): No

OFFENSE/PENALTIES:

Count 1:

21 U.S.C. §§ 846, 841(a)(1), (b)(1)(C) and (b)(2)
Conspiracy to Dispense and Distribute Oxycodone, Alprazolam, Hydromorphone, and Carisoprodol Resulting in Death

0-20 Years Imprisonment
Up to $10,000,000 Fine
5 Years to Life Supervised Release
$100 Special Assessment

Count 3:

18 U.S.C. § 924(c)(1)
Use, Carry and Brandish Firearms During

and in Relation to a Federal Drug Trafficking Crime

not less than 7 years imprisonment consecutive
$250,000 Fine
3 Years Supervised Release
$100 Special Assessment

TOTALS: 27 Years to Life Imprisonment
$10,250,000 Fine
5 Years to Life Supervised Release
$200 Special Assessment

AGENT: Dan Fox, DCI

AUSA: Stephanie I. Sprecher
Assistant United States Attorney

ESTIMATED TIME OF TRIAL:

More than 5 days

WILL THE GOVERNMENT SEEK DETENTION IN THIS CASE:

Yes

ARE THERE DETAINERS FROM OTHER JURISDICTIONS:

No

Criminal No. 17-CR-29-J

PENALTY SUMMARY

DEFENDANT NAME: **PAUL EDWARD BELAND**

DATE: March 13, 2018

INTERPRETER NEEDED: No

PLACE OF TRIAL:

The government, pursuant to Rule 18, F.R.Cr.P., with due regard for the convenience of the Defendant, any victim and witnesses, and the prompt administration of justice, requests trial be held in: **Casper**

VICTIM(S): No

OFFENSE/PENALTIES:

Count 1:

21 U.S.C. §§ 846, 841(a)(1), (b)(1)(C) and (b)(2)
Conspiracy to Dispense and Distribute Oxycodone, Alprazolam, Hydromorphone, and Carisoprodol

0-20 Years Imprisonment
Up to $1,000,000 Fine
3 Years to Life Supervised Release
$100 Special Assessment

Counts 5, 9, 10:

21 U.S.C. §§ 841(a)(1) and (b)(1)(C) and 18 U.S.C. § 2
Possession with Intent to Distribute Oxycodone and Aid and Abet

0-20 Years Imprisonment
Up to $1,000,000 Fine
Nlt 3 Years to Life Supervised Release
$100 Special Assessment

Count 15, 17:

21 U.S.C. §§ 843(b)
Unlawful Use of a Communication Facility

0-4 Years Imprisonment
$250,000 Fine
0-1 Year Supervised Release
$100 Special Assessment

TOTALS: 0-20 Years Imprisonment
$4,500,000 Fine
3Years to Life Supervised Release
$600 Special Assessment

AGENT: Dan Fox, DCI

AUSA: Stephanie I. Sprecher
Assistant United States Attorney

ESTIMATED TIME OF TRIAL:

More than 5 days

WILL THE GOVERNMENT SEEK DETENTION IN THIS CASE:

Yes

ARE THERE DETAINERS FROM OTHER JURISDICTIONS:

No

Criminal No. 17-CR-29-J

PENALTY SUMMARY

DEFENDANT NAME: **SHAWNA CHRISTINE THACKER**

DATE: March 13, 2018

INTERPRETER NEEDED: No

PLACE OF TRIAL:

The government, pursuant to Rule 18, F.R.Cr.P., with due regard for the convenience of the Defendant, any victim and witnesses, and the prompt administration of justice, requests trial be held in: **Casper**

VICTIM(S): No

OFFENSE/PENALTIES:

Count 1:

21 U.S.C. §§ 846, 841(a)(1), (b)(1)(C) and (b)(2)
Conspiracy to Dispense and Distribute Oxycodone, Alprazolam, Hydromorphone, and Carisoprodol

0-20 Years Imprisonment
Up to $1,000,000 Fine
3 Years to Life Supervised Release
$100 Special Assessment

AGENT: Dan Fox, DCI

AUSA: Stephanie I. Sprecher
Assistant United States Attorney

ESTIMATED TIME OF TRIAL:

More than 5 days

WILL THE GOVERNMENT SEEK DETENTION IN THIS CASE:

Yes

ARE THERE DETAINERS FROM OTHER JURISDICTIONS:

No

UNITED STATES DISTRICT COURT
DISTRICT OF WYOMING

UNITED STATES OF AMERICA	)	
vs.	)	No 17 CR 29
	)	
SHAKEEL KAHN	)	

EXCERPTS OF GOVERNMENT'S PROPOSED JURY INSTRUCTIONS

(Filed Apr. 16, 2019)

* * *

JURY INSTRUCTION NO. ____

The term "knowingly," as used in these instructions to describe the alleged state of mind of the defendants, means that he or she was conscious and aware of his or her actions, realized what he or she was doing or what was happening around him or her, and did not act because of mistake or accident.

JURY INSTRUCTION NO. ____

The intent of a person or the knowledge that a person possesses at any given time may not ordinarily be proved directly because there is no way of directly scrutinizing the workings of the human mind. In determining the issue of what a person knew or what a person intended at a particular time, you may consider any statements made or acts done or acts omitted by that person and all other facts and circumstances received

in evidence which may aid in your determination of that person's knowledge or intent.

You may infer, but you are certainly not required to infer, that a person intends the natural and probable consequences of acts knowingly done or knowingly omitted. It is entirely up to you, however, to decide what facts to find from the evidence received during this trial.

JURY INSTRUCTION NO. ____

The charge contained in Count One of the Third Superseding Indictment is based upon a statute which is federal law, Title 21 United States Code, Section 846, which reads in pertinent part as follows:

> Any person who attempts or conspires to commit any offense defined in this subchapter . . .

is guilty of an offense against the United States.

The "subchapter" referred to above includes Section 841(a)(1) of Title 21 of the United States Code, which provides in pertinent part:

> it shall be unlawful for any person knowingly or intentionally to . . . distribute, or dispense, . . . a controlled substance.

Title 21, United States Code, Section 841(a)(1) makes it a crime for anyone to knowingly or intentionally distribute, possess with the intent to distribute, or dispense a controlled substance. However, federal regulations provide an exception for controlled substance

prescriptions that are issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. To be lawful and effective, a prescription must meet the requirements of Section 1306.04 of Title 21 of the Code of Federal Regulations. That section states, in pertinent part:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner. . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of . . . the Act . . . and the person knowingly issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

To qualify for this exception, a practitioner must have provided the prescription both for a legitimate medical purpose and while acting in the usual course of his profession. Without both, the practitioner is subject to prosecution. In other words, if the government proves beyond a reasonable doubt that a prescription was written (1) not for a legitimate medical purpose, or (2) outside the usual course of professional practice, then the exception to the Controlled Substances Act does not apply.

The term "practitioner" means a physician or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he or she practices to dispense a controlled substance in the usual course of professional practice.

The term "dispense" includes the prescribing or administering by a practitioner of a controlled substance.

A practitioner violates Section 841 if the practitioner dispenses a controlled substance without a legitimate medical purpose or outside the usual course of professional practice.

A person who is not a registered practitioner may violate Section 841(a)(1) by distributing or possessing with the intent to distribute or dispensing a controlled substance. That person may also violate Sections 841 and 846 by conspiring with or aiding and abetting a registered practitioner to distribute or possess with the intent to distribute or dispense a controlled substance not for a legitimate medical purpose or outside the usual course of professional practice.

You are instructed that a "registered practitioner" is a practitioner who has a valid DEA Registration Number.

*   *   *

JURY INSTRUCTION NO. ____

The Defendants are charged in Count One of the Third Superseding Indictment with a violation of 21 U.S.C. § 846.

This law makes it a crime for anyone to conspire with someone else to violate federal laws pertaining to controlled substances. In this case, the Defendants are charged with conspiracy to dispense and distribute mixtures or substances containing detectable amounts of Oxycodone, Hydromorphone, Carisoprodol, and Alprazolam, and the use of which resulted in the death of Jessica Burch.

To find the Defendants guilty of this crime, you must be convinced that the government has proved each of the following elements beyond a reasonable doubt:

First: The Defendants agreed with at least one other person to distribute or dispense Oxycodone, Hydromorphone, Carisoprodol, and/or Alprazolam;

Second: The Defendants knew the essential objective of the conspiracy;

Third: The Defendants knowingly and voluntarily joined the conspiracy;

Fourth: There was interdependence among the members of the conspiracy; that is, the members, in some way or manner, intended to act together for their shared mutual benefit within the scope of the conspiracy charged; and

Fifth: Jessica Burch's use of controlled substances distributed and dispensed to her in connection with the conspiracy was a "but for" cause of her death.

* * *

JURY INSTRUCTION NO. ____

As to Counts Four, Six, Seven, Eleven, Fourteen, Sixteen, Nineteen and Twenty of the Third Superseding Indictment, 21 U.S.C. § 841(a)(1) provides, in pertinent part, as follows:

> it shall be unlawful for any person knowingly or intentionally to . . . distribute, or dispense, . . . a controlled substance.

Title 21, United States Code, Section 841(a)(1) makes it a crime for anyone to knowingly or intentionally distribute, possess with the intent to distribute, or dispense a controlled substance. However, federal regulations provide an exception for controlled substance prescriptions that are issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. To be lawful and effective, a prescription must meet the requirements of Section 1306.04 of Title 21 of the Code of Federal Regulations. That section states, in pertinent part:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper

> prescribing and dispensing of controlled substances is upon the prescribing practitioner. . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of . . . the Act . . . and the person knowingly issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

*   *   *

JURY INSTRUCTION NO. ____

In order to prove that Defendant **Shakeel Kahn** is guilty of a violation of 21 U.S.C § 841(a)(1), as charged in Counts Four, Six, Seven, Eleven, Fourteen, Sixteen, Nineteen and Twenty, the government must prove beyond a reasonable doubt each of the following elements:

First: That the Defendant **Shakeel Kahn** distributed or dispensed a mixture or substance containing a detectable amount of Oxycodone;

Second: That Defendant **Shakeel Kahn** acted knowingly and intentionally; and

Third: That Defendant **Shakeel Kahn's** actions were not for a legitimate medical purpose or the actions were outside the usual course of profession medical practice.

*   *   *

UNITED STATES DISTRICT COURT
DISTRICT OF WYOMING

UNITED STATES OF AMERICA	)	
vs.	))	No 17 CR 29
SHAKEEL KAHN	)	

DEFENDANT SHAKEEL KAHN'S OBJECTIONS TO GOVERNMENT'S PROPOSED JURY INSTRUCTIONS AND HIS PROPOSED INSTRUCTIONS

(Filed Apr. 25, 2019)

COMES NOW Defendant Dr. Shakeel A. Kahn, by and through his attorney, Beau B. Brindley and presents the following objections to the government's proposed jury instructions (Dkt. 668) and verdict forms (Dkt. 670), and submits the attached additional and alternative instructions:

1. Dr. Kahn objects to each of the government's proposed verdict forms. The proposals ask the jury, for each given count, whether they "unanimously find the Defendant, beyond a reasonable doubt" "guilty" or "not guilty." This is an unfair and inaccurate statement o the law. To find the defendant not guilty, the jury obviously need not do so beyond a reasonable doubt. The verdict forms as presented are highly misleading about this fact. The "beyond a reasonable doubt" clause must be omitted.

Dr. Kahn also submits that it would be preferable to phrase the verdict forms in the affirmative ("We the

jury find . . . ") instead of as interrogatives ("do you unanimously find . . . ").

2. Dr. Kahn objects to the instruction proposed at page 10 of the government's proposed jury instructions (Dkt. 668), dealing with the elements of Count One. The First Element must specify that the agreed distribution was "outside the usual course of professional practice or without a legitimate medical purpose." Omitting that requirement misleads the jury.

This same problem persists for the same reason in the elements listed in the instructions posed on pages 11 and 25.

3. Dr. Kahn objects to the instruction proposed on page 19 of the government's filing. The instruction should be wholly omitted. It unnecessarily highlights specific inferences that a juror can make, which are already permissible under the totality of the jury instructions. There is no need to highlight specific inferences that the government would like the jurors to make about the evidence. The instruction is more argument than information.

However, if the Court is inclined to give the instruction, Dr. Kahn proposes that it be given along with the context in which the cited statements were made in the cases cited by the government in support of the instruction. Contemporaneously with the instruction that an agreement can be inferred from circumstantial evidence like frequent contacts, the jury should be instructed that "It is not enough, however, for the government to show only 'mere association'

with conspirators known to be involved in crime, 'casual transactions' between the defendant and conspirators known to be involved in crime, or a buyer-seller relationship between the defendant and a member of the conspiracy," as stated in *United States v. Evans*, 970 F.2d 663, 669 (10th Cir. 1992) immediately after the statement proposed by the government.

4. Dr. Kahn objects to the instruction proposed by the government at page 49 of their filing, the elements of Count Four, Six, Seven, Eleven, Fourteen, Nineteen, and Twenty. The government's instruction improperly strips the mens rea requirement from the Third element, that Dr. Kahn acted without a legitimate medical purpose or outside the usual course of professional medical practice.

Dr. Kahn proposes that the Court instruct the jury as to these charges in accordance with the method used by Judge Marten of the District of Kansas in *United States v. Henson* (6:16 CR 10018), rearranging the elements proposed second and third by the government as follows:

> *Second:* That Defendant Shakeel Kahn's actions were not for a legitimate medical purpose or the actions were outside the usual course of professional practice; and
>
> *Third:* That as to the prior two elements, Defendant Shakeel Kahn acted knowingly and intentionally.

See United States v. Henson (District of Kansas, 6:16 CR 10018) Dkt 368 at 32.

5. Dr. Kahn objects to the instruction proposed at page 55 of the government's filing. The instruction indicates that the jury "must find beyond a reasonable doubt" that physician dispensed a controlled substance other than in good faith. As written, the instruction is misleading. Presumably, the government meant to convey, "In order to convict the defendant, you must find beyond a reasonable doubt . . . " that he dispensed the controlled substance other than in good faith. As written, it is an inaccurate statement of the law at best.

Moreover, the instruction as written seems to require that the controlled substance be prescribed for detoxification in order to be dispensed in good faith. This is inaccurate as well. This case does not concern prescriptions for detoxification, but rather for pain management.

6. Dr. Kahn objects to the "deliberate ignorance" or "willful blindness" instruction proposed by the government on page 97. The instruction is not at all supported by the evidence in this case. The government's theory of the case would not allow the jury to find that Dr. Kahn did not actually know the nature of his acts, but had a strong suspicion of their nature and took some deliberate step to avoid confirming it. The undersigned cannot understand what legitimate argument the government could make that would tend to suggest deliberate indifference.

In an unpublished opinion, the Tenth Circuit outlined four principles underlying the deliberate avoidance instruction:

> "These principles include: (1) the instruction should be rarely given, because the prosecution rarely can prove that the defendant deliberately avoided knowledge, (2) the evidence supporting a deliberate ignorance instruction must be independent from that supporting actual knowledge; the same fact or facts cannot be used to prove defendant's actual knowledge and deliberate ignorance, (3) any acts relied upon to prove deliberate ignorance "must be deliberate and not equivocal," and (4) suspicious circumstances, without a defendant's deliberate undertaking to avoid knowledge, do not warrant a deliberate ignorance instruction.

United States v. Galindo-Torres, 953 F.2d 1392, 1409-11 (10th Cir. 1992) (unpublished). The ostrich instruction cannot allow the government to convict on something less than actual knowledge. *Manriquez Arbizo*, 833 F.2d at 248 ("does not authorize conviction of one who in fact does not have guilty knowledge."). There is no doctrine of law that allows the government to substitute a recklessness mens rea for a knowledge or intent means rea. *United States v. de Francisco-Lopez*, 939 F.2d 1405, 1410 (10th Cir. 199 1) ("Conviction because the defendant ' should have known' is tantamount to conviction for negligence, contrary to section 841(a) which requires intentional misbehavior.").

The ostrich instruction can only be given if the government establishes sufficient facts to allow the jury to find beyond a reasonable doubt that "(1) the defendant . . . subjectively believes that there is a *high*

probability that a fact exists and (2) the defendant . . . took *deliberate* actions to avoid learning of that fact. *Glob.-Tech Appliances, Inc. v. SEB S.A.*, 563 U.S. 754, 769 (2011) (emphasis added); *Jewell*, 532 F.2d at 704 ("'A court can properly find willful blindness only where it can almost be said that the defendant actually knew.'" (citation omitted)). *Glob.-Tech Appliances, Inc. v. SEB S.A.*, 563 U.S. 754, 770 (2011);

The ostrich instruction cannot be wielded as a substitute for the *mens rea* requirement. Rather, it is another way of proving knowledge. "The purpose of such an instruction is to alert the jury to the fact that the act of avoidance of knowledge of particular facts may itself circumstantially show that the avoidance was motivated by sufficient guilty knowledge to satisfy the statute". *United States v. Ochoa-Fabian*, 935 F.2d 1139, 1141 (10th Cir. 1991). The jury must find actual knowledge.

Courts routinely caution against the issuance of the ostrich instruction because giving it without sufficient supporting evidence risks reducing the burden of proof. This is a due process problem of the highest order. *United States v. de Francisco-Lopez*, 939 F.2d 1405, 1410 (10th Cir. 1991) ("The danger in giving the instruction where there is evidence of direct knowledge but no evidence of avoidance of knowledge is that the jury could still convict a defendant who merely should have known about the criminal venture.") (*quoting*, *Manriquez Arbizo*, 833 F.2d at 249.

The danger in giving the instruction where there is evidence of direct knowledge but no evidence of avoidance of knowledge is that the jury could still convict a defendant who merely should have known about the criminal venture. *United States v. Manriquez Arbizo*, 833 F.2d 244, 249 (10th Cir. 1987); *United States v. Little*, 829 F.3d 1177, 1185 (10th Cir. 2016). "[A] deliberate ignorance instruction is proper *only* when evidence has been presented showing the defendant purposely contrived to avoid learning the truth." (emphasis in original) (quoting, *United States v. Bornfield*, 145 F.3d 1123, 1129 (10th Cir. 1998); *United States v. de Francisco-Lopez*, 939 F.2d 1405, 1409 (10th Cir. 1991) ("This instruction is rarely appropriate, however, because it is a rare occasion when the prosecution can present evidence that the defendant deliberately avoided knowledge.") "[C]ourts must studiously guard against the danger of shifting the burden to the defendant to prove his or her innocence." *United States v. de Francisco-Lopez*, 939 F.2d 1405, 1411 (10th Cir. 1991) (quoting *See Murrieta-Bejarano*, 552 F.2d at 1325: "The effect of a [deliberate ignorance] instruction in a case in which no facts point to deliberate ignorance may be to create a presumption of guilt.").

Where the facts at a trial present the jury with only a binary choice, the ostrich instruction should not be issued. *United States v. de Francisco-Lopez*, 939 F.2d 1405, 1410 (10th Cir. 199 1) ("deliberate ignorance instruction must not be tendered to the jury unless sufficient independent evidence of deliberate avoidance of knowledge has been admitted.") That is, if the facts at

trial only suggest either that a defendant actually knew of the offending facts, or that he did not know the offending facts, an ostrich instruction is not appropriate and only works to lessen the government's burden of proof. *Manriquez Arbizo* Id. at 248–49 ("[I]f the evidence against the defendant points solely to direct knowledge of the criminal venture, it would be error to give the instruction.").

The government is not entitled to an ostrich instruction if it merely presents evidence that the defendant should have known of the offending facts. *United States v. Little*, 829 F.3d 1177, 1185 (10th Cir. 2016) (for the proposition that a defendant should have known is not sufficient to justify issuance of willful blindness instruction). In *Little*, The Tenth Circuit found that evidence that a defendant *should* have known the offending facts is evidence of direct knowledge and not of willful blindness and that the instruction is inappropriate. *United States v. Little*, 829 F.3d 1177, 1185 (10th Cir. 2016) (quoting, *Manriquez Arbizo* Id. at 248–49 ("[I]f the evidence against the defendant points solely to direct knowledge of the criminal venture, it would be error to give the instruction.")); *United States v. de Francisco-Lopez*, 939 F.2d 1405, 1409 (10th Cir. 1991) ("The evidence must establish that the defendant had subjective knowledge of his criminal behavior. Such knowledge may not be evaluated under an objective, reasonable person test."); but see, *United States v. Ochoa-Fabian*, 935 F.2d 1139, 1141–42 (10th Cir. 1991) ("While a deliberate ignorance instruction is not appropriate when the evidence

points solely to direct knowledge, where, as here, the evidence supports both actual knowledge and deliberate ignorance, the instruction is properly given.")

Before even getting to the question of whether an act of avoidance has been taken, the government must establish that the defendant *actually* entertained a suspicion that the events occurred with a high degree of likelihood. *See*, *e.g*., *United States v. Little*, 829 F.3d 1177, 1185 (10th Cir. 2016) (finding issuance of the willful blindness instruct to be error where the Tenth Circuit was "not directed to any evidence in the record suggesting that [the defendant] deliberately avoided knowledge of the firearms.")

The instruction is simply inapplicable to the facts of this case and would only serve to confuse the jury. It should not be given.

7. Dr. Kahn objects to the instruction proposed on page 105 of the government's filing, concerning the word "and." This appears to be an inaccurate statement of the law as applied to this case.

8. Dr. Kahn objects to the good faith instructions proposed by the government at pages 53 and 56 of their filing. Instead, he offers the attached Dr. Kahn Instruction 1, which is in substance identical to the instruction given by Judge Marten in *Henson*. This more robust statement of the good faith standard provides the jury with a better understanding of the concept that is more in line with relevant law.

Additionally, Dr. Kahn objects to the language in the instruction on page 56 that seems to remove the mens rea requirement from acting "outside the usual course of professional practice." Dr. Kahn is not guilty of the relevant offenses unless he "knowingly or intentionally" acted outside the usual course of professional practice. Instructing the jury to insert some sort of "objective" standard or to ignore what Dr. Kahn viewed to be the normal course of "his" professional practice willfully obfuscates this requirement. The instruction is misleading and inaccurate.

9. Dr. Kahn also proposes the additional instructions attached hereto, each of which was given by Judge Marten in *Henson*.

Respectfully submitted,

Shakeel Kahn

By: s/Beau B. Brindley

LAW OFFICES OF BEAU B. BRINDLEY

53 West Jackson Blvd.
Suite 1410
Chicago, Illinois 60604
(312) 765-8878 (Phone)
(312) 276-8040 (Fax)

Certificate of Service

The undersigned, an attorney, certifies that he caused a true and correct copy of the attached instructions and objections to be served upon the government by electronically serving it through the CM/ECF system on April 25, 2019.

By: s/Beau B. Brindley

LAW OFFICES OF BEAU B. BRINDLEY

53 West Jackson Blvd.
Suite 1410
Chicago, Illinois 60604
(312) 765-8878 (Phone)
(312) 276-8040 (Fax)

SHAKEEL KAHN INSTRUCTION 1
Good Faith

The good faith of a defendant, whether or not objectively reasonable, is a complete defense to the crimes charged, because good faith on the part of a defendant is inconsistent with specific intent, which is an essential part of the charges.

A defendant who acts upon an opinion honestly held by him or her at the time of the alleged acts, or pursuant to a belief honestly entertained by him or her at the time of the alleged acts, cannot be found guilty even though his or her opinion is erroneous or his or her belief is mistaken or wrong.

A defendant's good faith must have existed at the time the alleged unlawful acts were committed. One cannot assert good faith as a defense if the opinions or beliefs advanced as justifications for the good faith defense were formulated after the commission of criminal acts. If you find that the defendant lied about some aspect of the charged conduct, you may consider that, in addition to other evidence presented, in determining whether the defendant acted in good faith.

While the term "good faith" has no precise definition, it means, among other things, a belief or opinion honestly held, an absence of malice or ill will, and an intention to avoid taking unfair advantage of another.

In the practice of medicine, good faith means the honest exercise of good professional judgment as to a patient's medical needs. Good faith connotes an honest effort to treat patients in compliance with generally recognized and accepted standards of medical practice.

The burden of proving good faith does not rest with a defendant because a defendant does not have any obligation to prove anything in this case. It is the government's burden to prove to you, beyond a reasonable doubt, that a defendant acted knowingly and intentionally.

In determining whether or not the government has proven that a defendant acted intentionally, you jury should consider all of the evidence in the case bearing on that defendant's state of mind.

United States v. Henson, 6:16 CR 10018, Dkt 368 at 51 (D.Kan, Oct. 24, 2018);
See, *also: United States v. Szyman*, 16CR00095, Dkt. 49 at 6-7 (E.D. Wi., Nov. 17, 2017); *United States v. Werther*, No. CRIM.A. 11-434, 2013 WL 5309451, at *8–9 (E.D. Pa. Sept. 23, 2013);
United States v. Solomon, 08 CR 26, Dkt. 356 (W. Dist. Mo., June 30, 2010) (different wording but similar concept).

SHAKEEL KAHN INSTRUCTION 2
Malpractice

You must remember this is not a medical malpractice case. It is not enough for the government to prove any degree of negligence, malpractice, carelessness or sloppiness on Dr. Kahn's part. You cannot convict the defendant if all the government proves is that he is an inferior doctor. This is a criminal case, and you must apply the instructions I am giving to you to determine whether Dr. Kahn unlawfully distributed or dispensed a controlled substance

United States v. Henson, 6:16 CR 10018, Dkt 368 at 61 (D.Kan, Oct. 24, 2018);
See, *also: United States v. Szyman*, 16CR00095, Dkt. 49 at 7-8 (E.D. Wi., Nov. 17, 2017); *United States v. Werther*, No. CRIM.A. 11-434, 2013 WL 5309451, at *9 (E.D. Pa. Sept. 23, 2013);
United States v. Michael Minas, 13 Cr. 109, D. Idaho. J. Edward J. Lodge. Dkt. 217 (April 28, 2016) (different wording but malpractice instruction given).

SHAKEEL KAHN INSTRUCTION 3
Addict Testimony

The testimony of a drug abuser must be examined and weighed by the jury with greater caution than the testimony of a witness who does not abuse drugs.

Several witnesses who testified may be considered either former or present abusers of drugs.

In this case, you have also heard testimony from witnesses who were using addictive drugs Ñ either prescribed by Defendant Shakeel Kahn or otherwise Ñ during the time period about which they testified. Such witnesses may have impaired memory of those events. While a witness of that kind may be entirely truthful when testifying, you should consider that testimony with more caution than the testimony of other witnesses. You must determine whether the testimony of each witness has been affected by the use of drugs or the need for drugs.

10th Circuit Criminal Pattern Jury Instruction 1.16 (Revised February, 2018) (modified)

SHAKEEL KAHN INSTRUCTION 4
Presumption of Innocence

The law presumes a defendant to be innocent of crime. This presumption remains with defendant throughout the trial. The law permits the jury to consider only admissible evidence and the reasonable inferences drawn from that evidence in support of any charge against the defendant. As a result, the

presumption of innocence alone is sufficient to support a verdict of not guilty.

United States v. Henson, 6:16 CR 10018, Dkt 368 at 19 (D.Kan, Oct. 24, 2018);
Taylor v. Kentucky, 436 U.S. 478, 481, (1978) (*citing* 1 E. Devitt & C. Blackmar, Federal Jury Practice and Instructions § 11. 14, p. 310 (3d ed. 1977))

SHAKEEL KAHN INSTRUCTION 5
Reasonable Doubt

An indictment is not evidence of guilt. As I just instructed you, a defendant is presumed by law to be innocent. The government has the burden of proving a defendant guilty beyond a reasonable doubt. The law does not require a defendant to prove his innocence or produce any evidence at all. If the government fails to prove the defendant guilty beyond a reasonable doubt, you must find the defendant not guilty.

Proof beyond a reasonable doubt is proof that leaves you firmly convinced of the defendant's guilt. There are few things in this world that we know with absolute certainty, and in criminal cases the law does not require proof that overcomes every possible doubt. It is only required that the government's proof exclude any "reasonable doubt" concerning the defendant's guilt.

A reasonable doubt is a doubt based on reason and common sense after careful and impartial consideration of all the evidence in the case. If, based on your consideration of the evidence, you are firmly convinced

that the defendant is guilty of a crime charged, you must find him guilty of that crime. If on the other hand, you think there is a real possibility that he is not guilty of that crime, you must give him the benefit of the doubt and find him not guilty of that crime.

United States v. Henson, 6:16 CR 10018, Dkt 368 at 20 (D.Kan, Oct. 24, 2018);
See 10th Circuit Criminal Pattern Jury Instruction 1.05 (Revised February, 2018) (modified)

SHAKEEL KAHN INSTRUCTION 6
Deliberation

Any verdict must represent the considered judgment of each juror. In order to return a verdict, each juror must agree to the verdict. In other words, your verdict must be unanimous.

As jurors, your duty is to consult with one another and to deliberate in an effort to reach agreement. Each of you ultimately must decide the case for yourself, but only after an impartial consideration of the evidence with your fellow jurors. In your deliberations, do not hesitate to reexamine your own views and change your opinion if you are convinced it is erroneous. But do not surrender your honest belief about the weight or effect of the evidence because of the opinion of your fellow jurors or simply to return a verdict.

You are not partisans. Your interest must be to seek the truth from the evidence in the case.

United States v. Henson, 6:16 CR 10018, Dkt 368 at 64 (D.Kan, Oct. 24, 2018);
See 10th Circuit Criminal Pattern Jury Instruction 1.42 (Revised February, 2018) (modified)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

UNITED STATES OF AMERICA, Plaintiff, vs. SHAKEEL KAHN, NABEEL AZIZ "SONNY" KHAN aka Nabeel Aziz "Sonny" Kahn, Defendants.	DOCKET NO. 17-CR-29-J Casper, Wyoming April 29, 2019 9:39 a.m. VOLUME II of XX (Pages 1 to 150)

TRANSCRIPT OF TRIAL PROCEEDINGS

BEFORE THE HONORABLE ALAN B. JOHNSON
UNITED STATES DISTRICT JUDGE
and a jury of twelve and three alternates

* * *

[93] of opioids?

A Yes. Absolutely. The ones we worry about most is the respiratory depression. So we will – I know we will talk about MMEs or morphine milligram equivalents in a little bit more detail, but if you exceed 200 MMEs, generally, one in about 32 patients will die after about a period of about three years if they are continued on those medications.

Q Are there certain people that metabolize opioids faster than others?

A Um, it is – it is controversial in the literature. About one percent have been described to be what we call "rapid metabolizer." There is an enzyme, the Cytochrome P450 system in our body that is responsible for metabolizing a lot of different drugs. One specific Cytochrome P450 enzyme is the CYP2D6 –

Q Stop one second. We have a record that we have to make, and Monique has to make the record. I didn't give her this particular term.

A Okay.

Q So could you say it slowly, and then there is an abbreviation for what you are saying, right?

A Yes. Sorry.

Q That's my fault.

A There the Cytochrome P450 system or enzymes in our body that are responsible for metabolizing many of the drugs that we [94] normally take. One specific enzyme is called the CYP2D6. That is primarily responsible for metabolizing many of the opioids, and oxycodone in particular. You could measure that and that is becoming more common that if you are really worried about somebody not responding or not having an effect that you would expect to a particular medication that you could measure that particular enzyme in the body.

Q So you could measure the CYP2D6?

A You could.

Q Is that through a blood test?

A Actually, we do it in our – we have a center for personalized medicine, and it just as easy as a cheek swab.

Q Okay. So not expensive? Relatively?

A $300, but many of the insurance companies are paying for it particularly for cancer drugs that you want to – that are thousands and thousands of dollars that you want to make sure that you are getting the right dose and the proper medication.

Q Okay. Is there any other consideration physical consideration that might effect how a person metabolizes their opioids, for example, gastric bypass surgery?

A Yeah, that is a really good question, since gastric bypasses are becoming more common. We do think a lot about medications, and how they are absorbed. So it is something that we think about in terms of opioids. It is hard to know. There is not a lot of good data available on that. There are [95] real different routes of administration for somebody needing pain management such as transdermal fentanyl patches that might be a better alternative if somebody – had recent bypass surgery and is not having an appropriate or at least expected effect to the medication.

Q So if I understand what you are saying, a person instead of taking a pill form of a pain killer, pain reliever, they could take a patch that goes on their skin?

A Correct. Yes.

Q You mentioned for 60 Minutes, you talked about – and maybe an article that appeared on there, has pain management changed in the last decade or two?

A It is probably more in the last two to three decades, that in the last – 30 years ago, frankly, when I went to pharmacy school what was common was that pain is something we should treat, and that it was one of the fifth vital signs if you will or one of the vital signs that was commonly assessed when admitted to hospitals. We probably had unrealistic expectations of pain management 20, 30 years ago where the expectation was that we should be pain-free. Now we know that pain is a normal physiological response usually to some underlying issue that the goal of therapy should always be improvement of functional status and not elimination of pain altogether.

Q I'm sorry. When you say "improvement of functional [96] status," what do you mean?

A Ah. So is the pain tolerable? Can the person continue to go to work? Can they continue their activities of daily living?

Q There has been talk of an opioid epidemic. Can you talk about what that means now?

A Sure.

MR. BRINDLEY: Objection, Your Honor; outside the scope of this witness' particular expertise as phrased.

THE COURT: I will sustain the objection.

BY MS. SPRECHER:

Q Is there any difference in teaching about how to use or administer opioids that has occurred recently as compared to 20, 30 years ago?

A Yeah. Absolutely. And I don't know if it is appropriate to show the slide at this time, but as a result of what we have seen the last – since the 1990s, and that really parallels when OxyContin was released on the market in the mid 90s. You can see what's happened in the United States in particular –

MR. BRINDLEY: Your Honor, I object. This subject area is outside the witness' particular area of expertise. This is talking about statistics and data regarding overdose. This is outside the witness' area of expertise.

THE COURT: I think she can if she lays a foundation.

* * *

[99] take or misuse it, they turn – as well as the rising cost of opioids, many of those individuals turned to heroin as a result of that, because it was more readily available and less expensive.

So you can see a spike in heroin use in 2010. The whole picture really paints the fact that all of those opioids in combination both the ones that are available by prescription as well as heroin causing a significant spike in overdose death rates in the last ten years.

Q That is represented by the green line?

A That's represented by the green line, yes.

Q Can you explain what "tolerance" is?

A Yes. So generally – I can't remember. Generally, if somebody is exposed to an opioid for a period of time – generally, it could be as little as five to 10 days that you will get what is called a tolerance to the medication, meaning that you will need higher doses to get the same amount of pain relief.

These particular slides what this is showing you is that – at on the left, after five days of an individual taking opioids – so if somebody is still on opioids at five days, like say, post-op, if they are still on it at one year, about 45 percent of the patients will continue to take opioids. So it really speaks to the importance of trying to limit the exposure to that, because of the tolerance that oftentimes [100] develops as well as addiction that I know we will talk about in a bit.

Tolerance is normal. Tolerance is excepted. Individuals that get opioids or pain medications for a period of time will develop what is called "tolerance." There is a lot of different theories underlying why that occurs in terms of some of the opioid receptors in the body, but it does occur. It is something that we expect.

Q So as you – as a person builds up tolerance, what do they – what happens? What do they need?

A Yeah. So they'll want – they'll need more higher doses of opioids in order to get the same amount of pain relief.

Q All right. What is your box on the right-hand side?

A Ah. So that is also speaking to opioid naive patients. What that means is generally somebody that hasn't taken opioids in the last 30 – or excuse me – three months is generally opioid naive. What this is showing is that if you get more than one prescription, so if you are getting two prescriptions for example, the one-year probability that an individual will continue to use opioids is approaching 90 percent.

Q I want to talk a little bit about what it is to be opioid naive. You described if a person hasn't been on it for three months, they would be considered to be opioid naive?

A Right.

Q What if a person has never been on an opioid?

[101] A That would be the same. So generally, opioid naive is somebody that hasn't taken opioids or hasn't taken opioids for a considerable period of time.

Q All right. Are there any dangers in prescribing, for example, the same regimen a person might have had three months ago, the same regimen that they

have after not having opioids for three months, meaning the same amount of drugs that are opioid?

A Yeah. Absolutely. And that is – so yes. Individuals that take opioids for long periods of time have an expectation of what dose it is going to take for them to get the same type of either pain relief or euphoric effect that they are looking for when taking an opioid.

It is a huge problem say within, for example, our jail system, that if somebody were admitted to jail, they were on opioid for a long period of time, they detox or essentially are forced to go through detox in a jail situation, and then are released from jail, let's say, three months later, go back. Get a hold of opioids again, and often times they are less tolerant. Oftentimes they haven't – their tolerance has waned over that period of time. They will take the same amount and unfortunately die.

That is a pretty common scenario of what happens. Similarly somebody that has gone to rehab for a period of time, that happens not infrequently, as well.

[102] Q All right. Is – so we talked about tolerance. As you build up tolerance, are you familiar with the term "dependence and addiction"?

A Yes.

Q Can you describe how dependence and addiction interact with each other and tolerance?

A Dependence is somewhat similar to the word tolerance, that you become dependent on the drug. So

if you were to take somebody off of an opioid that had been on it for a period of time, they will likely go through withdrawal, because they are dependent on the drug – they are very reliant upon those – the receptors and the effects that that provides you. If you were to go through withdrawal symptoms, it literally feels like you have the flu. Many times people experience extreme nausea and vomiting, and anxiety, irritability, shaking. It is hugely unpleasant. They are depressed. They lose some of the mental effects that they are looking for too. It is very painful and very hard to go through. And then – I'm sorry.

Q Go ahead. Can you – so when we are looking here at the addiction –

A Yeah.

Q – this multi-factorial, what do these rings represent?

A Yeah. So there is a difference, then, between addiction and dependence. Tolerance or dependence is expected. What we don't know is there is a certain subset of the population that [103] will go on to be addicted to the medication – to opioids. There is a variety of different factors that you can see here that have been at least proposed in terms of why some people become addicted on it. There is the drug itself, for example. And there is genetic factors, so if an individual had a family member that is addicted to opioids or other types of abuse or alcohol as an example, a family history of addiction, there is a greater likelihood that they're also going to suffer addiction. That is, for example, if

somebody is an alcoholic, you don't want a child to be exposed to alcohol until their brain is fully developed, because you don't want to expose them to a – predispose them to addiction. Similarly there is some psychological factors, so anxiety or depression. If child abuse – all of those are situations that may set somebody up for addiction.

Q Are there tools that are available to practitioners to use to assess these multi factors?

A Yes. There are forms and screening forms that are commonly used and should be used by practitioners when they are assessing patients for long-term therapy with opioids.

Q Okay. Are there also other factors to consider, other than what you have told us about?

A There's – you know, I think I have gone over them. I am not sure what the question is.

Q For example, you mentioned, like, the drug itself might

* * *

[108] talk about. So it could be side effects. It could be really troublesome constipation. It could be that oversedated. It could be that somebody is wanting excessive amounts of opioids that – if they are exhibiting drug seeking behavior, that there is always risk that you want to assess. What are the benefits a patient is getting as a result of the opioid therapy?

Q Okay. I interrupted you.

A Oh, no. That's okay.

Q You said when starting opioids, you should begin with the immediate release medications?

A Right. And you know, that is something that we in Colorado spend a good deal of time educating providers on in our state, because of some of the problem prescribing practices.

What is recommended by the CDC is prescribing the lowest effective dose. Their most recent recommendations, and these came out in 2016, was that we should avoid for chronic therapy greater than 90 MMEs; that for acute pain, that you should limit the duration of therapy, so three days or less. So gone are the days when somebody would go and get their wisdom teeth taken out and get 7-to-10 day supply of opioids; that if somebody is getting – if you are stating somebody on chronic opioids, that you should evaluate the need within one to four weeks.

Q Can I interrupt you for a second?

[109] A Of course.

Q What is chronic pain defined as? Is there a definition?

A Yeah. So there is not a consistent definition; however, majority of guidelines will say anywhere – something longer than three months or 90 days constitutes chronic pain.

Q All right. Thank you.

A Sure. On an ongoing basis, that we should always evaluate the other risk factors including contaminant benzodiazepines, they are taking benzodiazepines like Valium or alprazolam in combination, because of the risk of respiratory depression that we should monitor what is called the PDMP. I think we are going to talk about that in a little bit more detail.

Q What is it, though?

A It is the Prescription Drug Monitoring Program. So it is essentially a database that all states will have and pharmacies will upload their data, so all the dispensing data gets uploaded on a consistent basis to the state's PDMP so prescribers, pharmacists, law enforcement and patients can access or get access to the PDMP data to see the history of dispensing controlled substances to those individuals.

You want to look at that. You want to see if somebody is seeing multiple physicians or if they are what we call "doctor shopping" or if you are going to multiple pharmacies to get your prescriptions filled, or if you may be, for example, seeing a podiatrist for one type of pain medicine, [110] and you are seeing a psychiatrist that is prescribing a benzodiazepine, you want to be very careful that you are really making sure that you know exactly what that patient is taking.

Q And "you" being the pharmacist?

A Yeah. Absolutely. When I worked at Walgreens, we were required as our policy to check the PDMP before dispensing certain high risk medications. And

then, again, avoiding – you will see a lot of mention of avoiding opioids and benzodiazepines together whenever possible.

So that is generally the only exceptions I think that people will make is if somebody has – if somebody is on opioids, and they have severe anxiety with going on a plane flight, as an example, you might give them one or two doses. For the most part, you want to avoid chronic long-term use of those medications. For individuals with opioid use disorder meaning that they are actually addicted to opioids, you want to try whenever possible to arrange treatment for those patients.

Q You mentioned in the third point of that slide – no. Yes. You talked about risks versus benefits. In your training and experience, are opioids recommended as the primary drug for the long term treatment of chronic pain?

A No, that – you will see that on the first bullet point. All non-pharmacologic and non-opioid therapies are preferred. That generally if you give somebody an opioid for one or two months, they will think it is magical, and they will have a [111] very – they will usually respond quite positively, but then after about two months, you have got a big problem. One, it doesn't work anymore, and, two, they are going to be seeking and require higher dosages and become dependent on those drugs.

Q Okay. And the cost/benefits, the benefits I am understanding are to relieve pain? Improve your quality of life?

A Yes.

Q Is it a goal to alleviate all pain?

A No. No. That has been a misperception, I think, particularly in the U.S. that – rarely, unless it is end of life care or somebody is suffering in cancer that – that is not the goal of therapy. You want to try to improve their functional status, help them continue to be a functional citizen, but recognizing that elimination of pain is rarely ever the goal.

Q And you say it is a misperception of – of whom?

A In the U.S. just if you look at statistics of U.S. consumption of opioids, we use way more than any other developed nation.

Q All right. And would that presumption be for lay people or for people educated in pharmacy or medicine?

A Generally, it is the layperson that has that perception.

Q Okay. I understand that the CDC guideline is more recent. Is it –

[112] A 2016.

Q Was the thinking that is expressed in the CDC guideline similar or different back in 2001 through 2015 – excuse me – 2011 through 2015?

A Yeah. The only real change that we have seen in the CDC guidelines is a lowering of the MME

threshold. Many states, including Wyoming, Wyoming first released their pain guidelines that is a collaboration of all the different healthcare professions, including dentistry, medicine, veterinary medicine and pharmacy back in 2009.

Q Okay.

A And other states as well. There is all sorts of guidelines that date back to the mid 2000's.

Q Are most of those guidelines based on a certain study or article or literature that is put out by an organization?

A It is –

Q For example, the Federation of State Medical Board?

A Yes. So the Federation of State Medical Boards has been very active in trying to introduce policy for each of the state medical boards to adopt best practices for physicians and prescribers in prescribing opioids; that is one example that dates back in the mid 2000s, the VA pain guidelines and others have been out for quite some time.

Q Is there an understood best practice inside the medical profession for prescribing opioids?

[113] A In general, I think the CDC guidelines are really what most people will point to now. The CDC has put – given a lot of moneys and grants to the states and the state health departments –

MR. BRINDLEY: Your Honor, I would object to the witness – I would object as speculation to the witness opining on how the medical community or how doctors are responding to these guidelines. I think that is beyond an expert opinion and delves into the realm of speculation.

THE COURT: I agree. Sustained.

BY MS. SPRECHER:

Q As a pharmacist –

A Yeah.

Q – are you taught that appropriate prescribing practices that a doctor should look to when prescribing opioids? For example, strengths of opioids, when to start those? Are you taught that as to look – this is a horrible question.

Are you taught to look at strengths prescribed to individuals by doctors before you fill the prescription at the pharmacy?

A Yes. So – and remember that most of these guidelines are the pharmacy community has taken part in development of these guidelines as well. So if you look at the CDC guidelines or if you look at the Federation of State Medical Boards, there was a pharmacist that was participating on those guideline

* * *

[123] A Okay.

Q All right. "30 day prescription of 90, 8 milligram hydromorphone and 90, 10 milligram Percocet for 30 days, and 180 oxy 30s, as well as 90, 350 milligram Soma." First of all, would that raise any red flags to you?

A Yes.

Q Okay. And what is the MME equivalent of that prescription?

A 411.

Q "411"?

A Uh-huh.

Q Is that per day?

A Yes. MME are always given per day. I think – if I go back, I think the example that you had earlier of – it equated to 240 milligrams of oxycodone. Looking at – this is the MME calculator, that would be 360 MMEs a day. So four times what is recommended by the CDC.

Q You are looking up here at this "240/360"?

A I am. Yes. Right.

Q The – okay. Thank you. Now, does the – the MME alone, is that what raises the red flags for you?

A No, that is just one of the red flags that would –

Q When I am talking about "red flags," I mean warnings. What do you mean?

A Yeah. So "red flags" are terms that we use pretty commonly or things that we need to watch out for. There is a variety of [124] different examples of that. Some pharmacies will use the term of "first tier warning" that you have to take extra precaution in doing above and beyond perhaps normal due diligence. But red flags, there are a variety of ones that I teach and that are commonly referred to. Those include really high doses of opioids; opioids that – or combinations of prescriptions that we might consider cookie-cutter type medicine.

We would also look for things like patients traveling far distances to get their medications. Other types of red flags are combinations of mixed antagonist or agonist uppers and downers is a good way of thinking about. A different individual picking up the medication other than for whom it was prescribed is another red flag. There are a variety of them. You know, there are things that we even prescriptions that look too good to be true, so thing that – we would look for things like forgeries. But above and beyond forgeries, we are also looking for signs of misuse.

Q Would any red flag include paying only cash for prescriptions when insurance is available to them?

A Yeah. Absolutely. Patients, as a rule, get pretty angry when they have to pay a lot of money for prescriptions. I know I do, but if you have a person that is paying cash, that should be an immediate red flag –

textbook red flag of something that is probably most likely misuse or potentially diversion.

Q I should clarify. When I talk about prescriptions, I am [125] talking about the drugs that we have been talking about today.

A Yes.

Q Okay. Can you think of a reason why a person would choose to pay with cash rather than use their insurance to pay?

MR. BRINDLEY: Objection; speculation as to what some person would do.

THE COURT: Sustained.

MR. BRINDLEY: Thank you.

THE COURT: It is a red flag.

BY MS. SPRECHER:

Q Do insurance companies put limits on the amount of drugs that they will pay for?

A Yes. So for example, in Colorado, we implemented within our Medicaid population a quantity limit, and that is true for most all of the states. But in Colorado specifically, our limits for short-accounting opioids is a quantity limit of 120 tablets per month.

Q So beyond that, Medicaid won't pay for it?

A Right. If we were to try to run a prescription through – so meaning we are processing a prescription,

and it gets what we call "adjudicated real time" meaning it is transmitted electronically to the insurance company. If there is a problem with the prescription, we will get an alert back that there might be a problem – alerts come for all different reasons, but quantity limits are one type of alert.

[126] Q Okay. Is there any red flag presented when somebody other than the patient picks up their opioid prescriptions?

A It depends. If it is a case giver or a wife of somebody that we know, for example, the husband has had knee surgery, and the wife is picking up the prescription, that's not uncommon. But if it is somebody that we don't know or if it is not a family member or caregiver, then absolutely.

Q In your experience, it is common for medical professionals or their employees to pick up filled prescriptions for their patients?

A No, that should be an immediate red flag.

Q Why?

A That either the prescriber is writing it for potentially office use or –

MR. BRINDLEY: Objection. This is speculation as well.

THE COURT: I will overrule your objection.

BY MS. SPRECHER:

Q Go ahead.

A It's – there really is no valid reason I can think of for a medical professional or an office worker or family member to be picking up the prescription. It could suggest that they are using it for office use or potentially diverting it.

Q I will show you Exhibit 2024. Have you seen this before?

A Yes.

* * *

[141] a pain management policy?

A Yes.

Q Have you seen that before?

A I have.

Q And do you know if pharmacists have access to that?

A They do. It is on the Internet. There are the Wyoming Pain Management Guidelines. Withing those guidelines; it links to the document that you are referring to.

Q Do lay people have access to that document?

A Yes. It is on the Internet.

Q That can access the Internet?

A Yes.

Q I will show you Exhibit 7000. It is at the bottom. Do you recognize that document?

(Exhibit 7000 was identified.)

THE WITNESS: I do.

BY MS. SPRECHER:

Q What is it?

A So that is the Wyoming Board of Medicine policy. And you can see that it basically adopts and references the Wyoming Healthcare Licensing Board Uniform Policy for Use of Controlled Substances. So those licensing boards are inclusive of the various boards including pharmacy.

Q Generally, what is contained in this seven-page document?

A Best practices for controlled substance, prescribing and [142] dispensing.

Q All right. And it has been available since 2009; is that right?

A Yes.

Q Did you have an opportunity to review the Arizona and Wyoming PDMP data for Shakeel Kahn's prescribing practices from 2011 to 2016?

A I did.

Q What were your observations?

A That –

MR. BRINDLEY: Objection, Your Honor. I object to the form of the question as being too vague, because I can't determine whether it is going to call for something beyond the witness' knowledge based on the way the question was asked. I would ask for a more specific question.

MS. SPRECHER: I can do that.

THE COURT: Please.

BY MS. SPRECHER:

Q Did you notice any red flags?

A Yes.

Q What did you notice?

A I noticed that there were a couple of things going on that you would see individuals or family members getting the same exact prescriptions from Shakeel Kahn. In some instances, there were up to six family members or people living at similar [143] addresses getting prescriptions for the same – for opioids and other controlled substances. Not uncommon for two family members to be getting those at the same time.

I also noticed that oftentimes there were the same patients being prescribed the same medications under the two separate DEA numbers from the two states.

Q And what two separate DEA numbers?

A The Wyoming DEA number, as well as the Arizona DEA number.

Q Did you notice in the PDMP data that there were decreases in dosages that were significant from month to month?

A No. They were fairly consistent. In fact, most all of the doses that were prescribed were at the highest strengths that the medications in particular oxycodone or alprazolam were available.

Q Okay.

A I might also add in many times the patients were paying cash for those prescriptions. As well the other element that you can see in the PDMP is the method of payment for a controlled substance prescription. You can see what the patient paid for out of pocket and if it was run through the insurance. There was a high number of patients that were paying cash for those medications as well.

Q Were there any patients that traveled long distances, that you noticed?

A Yes. It wasn't uncommon for a patient to have an Arizona [144] address. I think there was one patient that had an address that might have been of the office – the medical practice that was used as opposed to the patient's home address. So – and I think there was one individual from Massachusetts who showed up on the PDMP as well.

Q Are opioids safe to prescribe to pregnant individuals.

A No. Unfortunately, if an individual is pregnant, and oftentimes you want to advise a woman of childbearing age, before they are started on chronic opioids of the dangers of opioids. If they do become pregnant, and they are on opioids, that it is – generally, the baby is going to be born with an addiction to opioids as well and go through what they call neonatal abstinent syndrome in which they withdrawl from opioids.

Q What about prescribing alprazolam to pregnant individuals?

A That is discouraged as well.

Q After reviewing the PDMP for both states Arizona and Wyoming, pertaining to the individuals treated by Shakeel Kahn, have you formed an opinion about whether the prescriptions he wrote between 2011 and 2016 were for a legitimate medical purpose and should have been filled by a reasonable pharmacist?

A I have.

MR. BRINDLEY: Your Honor, I would object to the issuance of that opinion. That is beyond this witness' knowledge. Whether or not these are appropriate prescriptions [145] would be addressed by a medical doctor expert, and I think we will have one in this case, and it is ultimately going to be a question for the jury, but it is beyond this witness' knowledge.

MS. SPRECHER: Your Honor, Dr. Moore has discussed her corresponding responsibility as a pharmacist about whether or not these things should be filled. And if they aren't for a legitimate purpose, the pharmacist has to make that determination before filling them, so I think it is within her province.

THE COURT: Overruled.

THE WITNESS: Yes. My opinion is that his prescribing practices were inconsistent with all the best practice guidelines that were issued from early on as 2009 and numerous medical bodies and guidelines are not consistent or his prescribing practices are inconsistent with all of – with those best practices.

In addition, it appears that he was prescribing at the highest possible dose of the medications that were available and prescribing oftentimes to multiple patients within the same household.

BY MS. SPRECHER:

Q If a practitioner were to prescribe the dose and strengths that you observed in the PDMP to individuals who were addicted to those drugs, would that be in the usual course of [146] professional practice?

A No.

Q What concerns might a reasonable pharmacist have if they observed this prescribing behavior to known addicts?

A I'm sorry. Could you repeat that?

Q What concerns might a reasonable pharmacist have if they observed this prescribing behavior to known addicts?

A Yeah. I would be concerned – he would be treating addiction and not pain; that the patients may very likely be misusing or diverting the medications.

MS. SPRECHER: No further questions. Thank you.

THE COURT: Do you wish to approach for a second? (At sidebar.)

THE COURT: I notice it is close to 5:00.

MR. BRINDLEY: Judge, there will be –

THE COURT: I'm willing to go later, but the question is how long?

MR. BRINDLEY: Judge, there will be substantial cross-examination for this witness. We wouldn't – I can't say we would be finished by – with even my cross-examination not taking into account Mr. Barrett's by 5:30. I don't think I could be finished by that time. It might be better to start with cross-examination tomorrow.

MS. SPRECHER: I will leave it to the Court's discretion.

* * *

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF WYOMING

UNITED STATES OF AMERICA, Plaintiff, vs. SHAKEEL KAHN, NABEEL AZIZ "SONNY" KHAN aka Nabeel Aziz "Sonny" Kahn, Defendants.	DOCKET NO. 17-CR-29-J Casper, Wyoming April 30, 2019 8:37 a.m. VOLUME III of XX (Pages 1 to 265)

TRANSCRIPT OF TRIAL PROCEEDINGS

BEFORE THE HONORABLE ALAN B. JOHNSON
UNITED STATES DISTRICT JUDGE
and a jury of twelve and three alternates

* * *

[24] A I don't know his thinking.

Q Okay. Now, you talked yesterday a lot about what you were calling "guidelines" for the prescription of oxycodone, right?

A Among others, yes.

Q And those guidelines are put out by the Center for Disease Control, CDC, right?

A That is one of the guidelines, yes.

Q Now – and there was State of Wyoming guidelines too? You talked about that. I think you did.

A Yes.

Q All right. Fine. Now, oxycodone is a drug that has been approved by the Federal Drug Administration?

A Yes.

Q The FDA, Food and Drug Administration, is the body or the institution that determines what medications can be legally prescribed, true?

A True.

Q The FDA, the Food and Drug Administration, has not set any upper boundary on what opioid dosages doctors can prescribe, has it?

A That would be correct.

Q Okay.

A Just in that narrow of a question.

Q Okay. The FDA has – more specifically, the FDA has not set any upper boundary on the amount of oxycodone that a doctor [25] can prescribe to a particular patient, have they?

A Again, that is correct in that narrow question.

Q The FDA has not prohibited the prescription of oxycodone 30-milligram tablets in combination with

oxycodone 15-milligram tablets for particular patients, have they?

A No. But they – you would hope that they would not be prescribed at the same time.

Q So then the answer to my question that I asked whether the FDA prohibited the prescription of oxycodone 30-milligram tablets in combination with oxycodone 15-milligram tablets, they have not prohibited the prescription of those drugs at the same time for a particular patient, have they?

A That's correct.

Q Okay. Nor has the FDA prohibited the combination of oxycodone with Xanax or with Soma, have they?

A That is not quite correct. Would you like me to explain that?

Q You are saying the FDA has a prohibition on prescribing those drugs in combination?

A What I am saying is that the FDA has issued a "black box warning" or a "box warning" that appears at the very top of the labeling of all opioids including oxycodone, which is the strongest warning they have that those drugs should not be prescribed together.

Q They issue a warning indicating that there is a risk, [26] right?

A It is a very strong risk, yes.

Q Okay. But they have not said that it is prohibited to prescribe those drugs in combination in certain circumstances, have they?

A That's correct.

Q Okay. Now, ultimately, the combination of drugs to be prescribed is a decision that is left to the discretion of the doctor talking to the patient, true?

A Yes. But, however, the pharmacist does have a corresponding responsibility to understand if that is appropriate.

Q Okay. I am not asking – I will ask you about pharmacists later. Right now my question is: Doctors –

A Okay.

Q – the decision about what is going to be prescribed is a decision left to the discretion of the doctor, right?

A That's correct.

Q And that is based on the doctor's discussion with his patients, right?

A True.

Q Now, the CDC guidelines you are talking about, those are guidelines, right?

A That's correct.

Q They are suggestions or guides that doctors should rely on, [27] right?

A Yes.

Q But they are not absolute rules or laws that bind doctors, are they?

A Although you would likely have to have a good reason to go outside of those guidelines.

Q All right. I am not quite sure – maybe the question wasn't clear, so I will try it again. Here is the question: These guidelines are not absolute rules or binding laws that doctors have to follow in every case, are they?

A That's correct with that narrow of a question.

Q Okay. And we got into this a little bit earlier. Now, let me put it to you this way, and maybe you would agree, and then we will go through it, but over the course of the last – between 2000 and 2015 or even a little bit before 2000, isn't it true that there have been differing schools of thought on prescribing high dosages of opiates to patients long term?

A Those guidelines began to change in around mid 2000, 2004.

Q All right. So my question wasn't about the guidelines, though. My question was: Haven't there been differing schools of thought about that? "Yes?"

A That's not quite correct. The guidelines have all been fairly consistent since that time –

Q I am not talking about guidelines. Set the guidelines aside. When I ask about the guidelines, I will ask about the

* * *

[167] truth of the matter asserted, then they would be irrelevant. It is too specific of a thing. They can ask what he did in response, but I don't think it is appropriate to put the contents in not for their truth under these circumstances.

BY MS. SPRECHER:

Q Generally, what information did you learn about the – from the complaint filed by this person?

MR. BRINDLEY: Objection; hearsay.

THE COURT: What did you do after receiving the complaint?

THE WITNESS: I verified through a banking record that Shakeel Kahn charged $500 per visit whether you actually get an exam or you pick up a prescription.

BY MS. SPRECHER:

Q And you say you determined that through a banking record?

A Correct.

Q Who was the individual that made that complaint?

A Lynn Hamar.

Q Do you know the approximate date of that complaint?

A I believe it was – I want to say August of 2016.

Q Did you end up speaking to Lynn Hamar?

A I did.

Q Did you speak to anybody else that had knowledge about this complaint?

A I did.

[168] Q Who was that?

A Her husband, Blake Hamar.

Q Did they give you any information that led you to further your investigation?

MR. BRINDLEY: Objection, Your Honor. It would be hearsay for him to testify to the contents of what they told him. He could – she can ask if he talked to them and what he did as a result, but we can't give them the contents. They would be hearsay.

BY MS. SPRECHER:

Q My question was: Did they give you any information? It is a yes or no.

A Yes.

Q What did you do with that information?

A We verified that information through the banking record and also through the pharmacy records.

Q What banking record did you receive?

A I was provided a copy of their bank statement.

Q And you also looked at the PDMP?

A I did.

Q Did you also look at the pharmacy records themselves?

A I did. This particular prescription was not listed on the PDMP, and so I had to actually go to the pharmacy and pull the record.

Q And what did the pharmacy record show you?

[169] A It showed me a prescription for oxycodone.

Q During the course of your investigation, did you employ the use of a wire intercept?

A Yes. Working in conjunction with the Wyoming DCI and their special agents with DEA and also the Internal Revenue Service, investigative strategy was developed to attempt to obtain a wiretap.

Q What was the purpose of the wiretap?

A To determine who all was involved in this conspiracy or this investigation. We knew there were people flying in from the flight records. We knew there were very large quantities of oxycodone being prescribed by Shakeel Kahn. We knew there was lots of money being wired to Shakeel Kahn or his family

members, but we did not know what – how many people were involved.

Q Did you have any concern about whether or not Shakeel Kahn was charging money for prescriptions rather than actual treatment?

A Yes.

Q And was there anything in the wire investigation that confirmed or did not confirm that suspicion?

A The wiretap or the wire transfers?

Q Sorry. The wiretap?

A Yes. The wiretap confirmed that if you could not afford $500 –

[170] MR. BRINDLEY: Objection, Your Honor. If the investigator is testifying to whatever the content of the wire conversations were, that would be hearsay. If they wanted to go through wire conversations and talk about what was said, if they're admissible, that's fine, but I don't think he should be able to testify to the contents of them in some general way.

THE COURT: Overruled.

BY MS. SPRECHER:

Q Go ahead.

A So we determined that if you got – if you paid $500 – first of all, the price was $500 to get a controlled substance prescription. If you didn't have $500, and you could pay $275, you could get half the prescription.

Q Okay. And do you have phone calls that you've – we have chosen today to demonstrate that?

A Yes.

Q I would direct you to Exhibit 1020.

MS. SPRECHER: And these have already been offered and accepted into evidence, Your Honor. So we would ask that it be published to the jury as Ms. Wait brings it up.

Do we have it?

THE COURT: What is the number again?

MS. SPRECHER: 1020.

THE COURT: 1020.

[171] BY MS. SPRECHER:

Q Okay. Investigator, this particular exhibit has three parts. We have 1020A, B and C. Sorry – 1020A, B and C, four parts.

A Okay.

Q And are you familiar with the parts of the exhibit, for example, we have got the transcript itself, the call itself, and then the PowerPoint that runs with it?

A Yes.

Q All right. And have you reviewed these?

A I have.

Q And is Exhibit 1020 and its corresponding A, B and C, an accurate representation of those calls – that call?

A Yes.

THE COURT: I don't see C as having been received.

MS. SPRECHER: C is the PowerPoint that goes along with it, Your Honor.

THE COURT: Any objection?

MS. SPRECHER: The PowerPoint is a running transcript, so you will hear the call. You have the transcript. The transcript will just run as the call is played. There is nothing changed or different.

MR. BRINDLEY: Your Honor, I didn't get that exhibit is the problem. I don't know –

THE COURT: Generally, the offer what it was 18-A was [172] received. 18-B received. 18-C was not offered.

MS. SPRECHER: We are not asking that C goes back to the jury. It just is – may I have just a second?

THE COURT: Yes.

(Off the record.)

MR. BRINDLEY: Judge, I think it is just going to be used for demonstrative purposes. I think it is okay.

THE COURT: Very well.

MS. SPRECHER: May we play it?

THE COURT: You may.

(Audio was played, not reported.)

BY MS. SPRECHER:

Q I didn't ask who it is. Are you aware of who at least one of the speakers are in this call?

A Yes.

Q Who is that?

A I am familiar with both of them, Lyn Kahn and Shakeel Kahn.

Q All right. We have the date there of October 10 of 2016. Is that an accurate date?

A Yes.

Q This is an incoming call into the phone line that you have tapped?

A Yes, incoming.

(Audio was played, not reported.)

(Off the record.)

[173] THE COURT: Why don't we take a break and let the jury go back to the jury room while we get this straightened out.

(Jury exited the courtroom.)

(Recess was taken.)

(Following in the presence of counsel, the defendants and the jury.)

THE COURT: Thank you. Ladies and Gentlemen, please be seated. We recessed. We were having some technical difficulties with exhibits in this matter.

MS. SPRECHER: I think we found a workaround, Your Honor.

THE COURT: Proceed.

MS. SPRECHER: I will need to put the transcript on the overhead, and we'll play the actual audio from a CD from our computer and put the microphone down to it.

THE COURT: Okay.

BY MS. SPRECHER:

Q So this is Exhibit 1020-B – A and B. We left off right about here, which is the fourth square from the bottom on the transcript.

MS. SPRECHER: Ms. Wait, would you play that, please. (Audio was played, not reported.)

BY MS. SPRECHER:

Q So Agent, what about that particular call indicated to you [174] that these prescriptions were being sold by Shakeel Kahn rather than a treatment visit?

A It was the pricing and the term 120/120. And I knew that throughout the investigation and review of the PDMP, that that is two separate strengths of oxycodone.

Q Your review of the PDMP of Alan Friday's PDMP?

A Yes.

Q Okay. And Alan Friday was getting 120 and 120 of what type of oxy?

A I know the terminology is generally, "120, 120, 180, 120," those combinations. Sometimes the milligrams would vary, but it was the – if you basically got one – like 120, it is $500. If you got 120,120, or 120 plus something else, then the price would vary and go up.

Q All right. So the discussion about whether it was $800 or $1,000 was based in your opinion on 120/120?

A Correct.

MR. BRINDLEY: Objection, Your Honor. The witness should not be allowed to speculate about what was meant by the people in the call. That's an opinion. It is beyond – that's speculation. Nobody can give that opinion.

THE COURT: Sustained.

MS. SPRECHER: Okay. Before I move onto the other call, I need to go back. Ms. Harris reminded me. There is a series of exhibits in 4000 that I offered.

All right. I [175] didn't specifically offer individually the subsets of 4000. You will see, for example, on the exhibit list, there is a "4000JD." I meant to include all of those in my offer. I think that was unclear.

MS. BOWEN: Could you tell me those numbers, again, please?

THE COURT: It is 4000 to 4103.

MS. SPRECHER: Does that clear that up for the record, Ms. Harris?

THE COURT: I think it does. For example, if 4035 and 4035, 4035DA, 4035PB, 4035CM, et cetera, these all refer to different locations, different scripts.

MS. SPRECHER: Correct. So the initials designate a patient. So that shows up – it helps us look at that exhibit and know who it means, but it is – those specific documents are included in the 4000 to 4103 that I offered.

Okay. Are we good?

THE COURT: They are all received.

MS. SPRECHER: Thank you, sir.

BY MS. SPRECHER:

Q Agent, do you have another call that exemplifies whether scripts were – Shakeel Kahn was charging patients for writing prescriptions or office visits?

A Yes.

Q Are you familiar with Exhibits 1021A, B and C?

[176] A Yes.

Q All right. Is C also a PowerPoint that goes along with the phone call and the transcript?

A Yes.

MS. SPRECHER: And if we could – are you ready?

If we could link to Ms. Wait's computer? 1021 has already been offered and accepted. We would offer Exhibit C of 1021 at this point? May we publish.

THE COURT: Yes.

BY MS. SPRECHER:

Q Who is this phone call between?

A So this is between Lyn Kahn and Shakeel Kahn.

Q The date this occurred?

A October 12th, 2016.

MS. SPRECHER: Would you please play that, Ms. Wait?

(Audio was played, not reported.)

BY MS. SPRECHER:

Q Is there a phone call that follows this call?

A Yes.

Q Is that Exhibit 1022?

A Yes.

MS. SPRECHER: We would offer Exhibit 1022 including "C" at this time, Your Honor.

THE COURT: You may.

(Thereupon Government's Exhibit Nos. 1022-A through 1022-C [177] were received in evidence.)

BY MS. SPRECHER:

Q Agent, are these the same individuals talking?

A Yes.

Q On October 12, 2016?

MS. SPRECHER: Ask that it be played at this time?

THE COURT: You may play it.

(Audio was played, not reported.)

BY MS. SPRECHER:

Q Agent, do you have any knowledge of whether or not Tamara Volker received her prescription on or about October 12 of 2016?

A I do not believe she did.

Q Did you speak to David and Stacy Drndarski?

A Yes.

Q And when did you speak to them?

A It was November 17th, 2016.

Q All right. Was there anything that you learned in the investigation in speaking to them that caused you to do something else?

A I need you to be more specific.

Q That was a bad question. After you spoke to them, what did you do with the information that they provided? Don't tell us what the information is.

A We had Stacy Drndarski make a phone call to Lyn Kahn.

[178] Q Okay. And did she do that?

A Yes.

Q Did you also further down the road look at payment tickets that you found that belonged to Shakeel Kahn's medical office?

A Yes.

Q Did that confirm any information that you had learned from the Drndarskis?

A Yes.

Q I will show you Exhibit 6145-A.

MS. SPRECHER: And, Your Honor, just for the record, all the payment tickets have been accepted into evidence or received into evidence. 6145 is a subset

of those payment tickets. This is 6145-A – excuse me.

BY MS. SPRECHER:

Q Do you recognize that document, Agent?

A Yes.

Q What is it?

A It is a payment ticket dated 7/17 of 2014.

Q And do you see David and Stacy Drndarski's name on there?

A I do, second from the bottom.

MS. SPRECHER: Your Honor, I would ask that Exhibit 6145-A be published to the jurors? Oh, thank you.

BY MS. SPRECHER:

Q What do you see there, Agent?

[179] A Second from the bottom is Drndarski, David and Stacy, who were the people who I spoke to in Arizona. Under the cash paid, there is zero dollars. Check paid zero dollars. Credit card paid type zero dollars, but there is a "1997 Harley traded" typed in that spot.

Q All right. Did you also speak to Randy Moody?

A I did.

Q And were you able to determine what relation, if any, Randy Moody had to Charles moody?

A I did.

Q What did you determine?

A They were brothers.

Q Were they also patients of Shakeel Kahn?

A Yes.

Q Where did Randy Moody live?

A Randy lives in Wenatche, Washington State.

Q Where does Charles live?

A Charles lives in both Kingman, Arizona, and Portland, Oregon.

Q Were they both patients of Shakeel Kahn?

A Yes. They were both patients receiving controlled substances.

Q During the course of your investigation, did you also come across billing data for Shakeel Kahn's office?

A I did.

[180] Q Did that offer any evidence of potential diversion?

A I need you to be more specific.

Q Did you find any evidence supporting that prescription pills were being diverted when you looked at financial data – billing data? Excuse me.

A So – the billing data as far as the PDMP is concerned, and then we saw the payment ticket where they paid with cash.

Q And what did that mean to you?

A If you are eligible for Medicaid, which means you are at a lower income level to be eligible for that benefit, then it might be very difficult to pay the price that Shakeel Kahn was charging for prescriptions.

Q Are you aware of in your training and experience of whether Medicaid monitors or limits the amount of prescription pills that they will pay for that are opiates?

A Yes. Medicaid programs have lock-in programs. They have drug utilization review programs, so there is oversight on the Medicaid billing system.

Q Are you familiar with other insurances like private insurance companies and whether they have any limits?

A Yes. Private insurance, I don't know all of their limits, but they do have certain amounts that will require additional documentation. There are oversight mechanisms within their billing practices.

[181] Q You indicated that you and others had done some surveillance in this investigation?

A Yes.

Q What type of surveillance was that?

A There was a lot of surveillance. We had a remote camera on Shakeel Kahn's doctor's office. We had the DCI agents and the DEA agents out doing surveillance of patients who were suspected of selling their prescriptions. We also acquired a lot of video surveillance from different businesses, such as pharmacies and other stores.

Q Based on the information in those videos, were you able to confirm whether or not individuals were filling prescriptions?

A Yes.

Q For example, who did you observe?

A One particular video was Randy and Charles Moody, the brothers, one from Wenatche and one from either Arizona or Portland. They were both at a pharmacy in Casper filling prescriptions at the same time.

Q Did you also observe Shakeel Kahn's office?

A Yes.

Q In both Arizona and Wyoming?

A I observed them. We did not have a remote camera on the Arizona office.

Q Okay. In your observations were – what were the office hours that were kept at Shakeel Kahn's office in Arizona?

[182] A At one point at the end of the investigation, I remember it was by appointment only.

Q I'm sorry?

A By appointment only.

Q And in Wyoming?

A I don't recall the specific office hours.

Q Okay. Did you also conduct undercover operations in this case?

A Yes. Undercover operations were conducted in this investigation.

Q What is the purpose or objective of an undercover operation?

A It is like a test. It is – we send an agent in posing as patient. We can verify do they charge $500? Will we get a opioid prescription? What needs to be said or demonstrated to get that opioid prescription?

Q And have you used undercover operations – undercover operators in other investigations into diversion?

A Yes.

Q In your experience, is it possible for undercovers to investigate all of those things that you are talking about in one or two visits?

A No. Usually, depending on the case, it takes a while to establish rapport with the provider or trust that they will trust you not to report them to the police or suspect you of

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

UNITED STATES OF AMERICA, Plaintiff, vs. SHAKEEL KAHN, NABEEL AZIZ "SONNY" KHAN aka Nabeel Aziz "Sonny" Kahn, Defendants.	DOCKET NO. 17-CR-29-J Casper, Wyoming May 1, 2019 8:35 a.m. VOLUME IV of XX (Pages 1 to 261)

TRANSCRIPT OF TRIAL PROCEEDINGS

BEFORE THE HONORABLE ALAN B. JOHNSON
UNITED STATES DISTRICT JUDGE
and a jury of twelve and three alternates

* * *

[9] A To restore function and quality of life.

Q And what is the goal of pain management?

A To restore function and improve quality of life.

Q What are the ways that you can achieve that goal?

A We achieve those goals. We start with the simplest things. You call your doctor. He tells you to take a Tylenol. Then if the Tylenol doesn't help, you call him back. You go visit with him, and he might prescribe you

some nonsteroidal antiinflammatory medication for your headache. If that doesn't work, then he might decide to send you to physical therapy. He might decide to obtain an X-ray and MRI to see if there are other issues involved. And if he sees that there are other issues involved like a herniated disc in your neck, which is causing the headache, he might decide to send you to a surgeon to see if there are surgical remedies.

So to treat anyone in medicine, we start with simple, and we try the least invasive measures. The reason is that we do not want the harm to come to our patients. When you start simple, and you try for example a TENS unit for low back or neck pain – TENS is transcutaneous electrical nerve stimulation. If that helps, then we might decide to hold off on any further aggressive treatment because our treatment has resulted in our objective or treatment being met, the pain has improved, and the patient expresses satisfaction with the treatment and says, "I returned to work. I have been able to [10] walk with my grandkid, because I used the traction belt that you prescribed or TENS." And these treatments, we – we recommend, because there is really minimal to no risk with those treatments. It might take care of the problem.

Q Is that philosophy the same even outside of pain management?

A Yes. It is – the philosophy is correct across the board in medicine.

Q In pain management, has there been changes over the last decade?

A Yes.

Q That is change in the philosophy is what I mean?

A Yes.

Q Could you describe that, please?

A Yes. Back in 1980s, late ’85, we were not really treating pain. And then just about 1990s, there was this big push that take – that pain needs to be treated aggressively. And by the time I finished my residency in 1995, we were all ending out, “You got to treat pain. Just prescribe narcotics.” But even then, we were also conscientious that you start slow, because there is no ceiling effect to the therapeutic effect of the opioids. And so there was a class that said, “Okay. Just prescribe narcotics,” and I graduated from that class in 1995. And when I came out, and I started looking at my own patients, I realized we really need to go slow. Some of us took that as [11] a free reign that just prescribe narcotics. But most of us took it as it is an option to be explored, but you have got to really pay attention to what are the other problems you create by exercising that option? Have you achieved that objective of restored functionality of the patient. That is the question that we ask ourselves. I tell all of my mid-levels, “Ask yourself standing in front of the mirror before you go to work today and tell yourself if the patient that you are prescribing narcotics, am I meeting the objective of restoring functionality in their life and happiness?” Patients are not going to tell you that they are totally unhappy or they are happy, or they are totally in pain or

they are not in pain. You have to extract that information. So it is not – we can't just rely on what the patient tells us. We have to dig a little deeper to see, and we do physical examination. We do urine drug screening. We look at the previous medical records, and see how the other doctors treated these patients. What were their opinions? So treating pain is you have to look at the entire spectrum of patients' health and assess it objectively not subjectively.

Q And is that the philosophy that you ascribe to now?

A Yes.

Q In 1995, was that the same philosophy that –

A Absolutely. Yes. That is – you know, like I said, in medicine, when you go to medical school, and that is medical [12] school 101, "Start simple. Make simple changes. One at a time. Go slow." So not just with pain medication, just with anything. You are not – if the patient comes to you, you are not – and says, "I have pain in my body," you are not going to order an MRI from head to toe. You are not going to X-ray your patient just because the patient says, "I have pain from my head to toe." You are going to ask more questions. So before you arrive at your treatment recommendation, you have to objectively assess the patient.

Q Now, you received this training while you were in medical school; is that right?

A Yes.

Q And is there – are there standards or philosophies that are out there for doctors and even the public to access about the treatment of pain management now and have been through the years?

A Yes, there is.

Q What sort of things are there?

A There are. It is a very basic philosophy. The very basic requirement is that the Board of Medicine of the State of Wyoming that has been assigned to make sure the well-being of public is met, and that the standard of care has been met. It has certain requirements. It does not mandate certain duties to the patients – by doctors with patients, but it wants to see certain things in your medical records, and the Wyoming [13] Medical Board has that. So you cannot come practice in the State of Wyoming if you do not believe in that, and it is your responsibility to know it is available to you. It is nothing more than what you learned in medical school or residency or your practice, except that now there are a set of rules that the Wyoming Medical Board has to evaluate your practice. Are you treating your patients appropriately? Are you over treating? Are you under treating? You are not treating effectively.

So anyone can go to the medical board and say, "This doctor is doing inappropriate pain management," and the medical board has to have certain guidelines to abide by. Like this court, there are certain guidelines. So medical board has certain guidelines. If you don't meet the requirements of the medical board, stay

outside of Wyoming; stay outside of this court if you cannot believe and respect our laws and our requirements.

So the very basic thing and requirement is you got to know what the guidelines are and if medical board comes visits your medical records, they have to be convinced that you practice medicine properly, and those guide rules Federation of State Medical Boards in 1997, they realized they really need to add a guideline about the time I got out of residency –

MR. BRINDLEY: Objection, Your Honor; at this point the witness –

[14] THE COURT: Sustained.

MS. SPRECHER: I will ask a question, Your Honor.

BY MS. SPRECHER:

Q You talked about the Federation of State Medical Boards. What is that?

A Federation of State Medical Boards is an organization that helps the state medical boards with their conduct of business. And what does that mean? They research, and they put together certain things that they believe are in the well-being of the public. And then they publish those. Respective states adopt those guidelines.

In 1997, they realized there was a need, just about the time this opioid epidemic was coming out.

Q The what?

A Opioid epidemic. They realized they needed to have certain guidelines so that the state medical boards know how to go about it evaluating their physicians and their conduct. Also, this guidelines was – has been adopted by all in public health, American Pain Society, DEA, the nursing board, so everyone is aware of these guidelines. They published the first one in 1998, and they revised it. They haven't revised – they have just kept adding to it, so that is the basic principal that you need to have.

Q I'll interrupt you for just a second. These guidelines that are put out by the Federation of State Medical Board and [15] have been for a period of years, are they out there to instruct or help the state medical boards form their own policy and guidelines?

A That's right.

Q Are there medical boards in every state?

A Yes.

Q All right. Are they responsible like you explained the Wyoming Medical Board is responsible for setting out policies and guidelines for people practicing in their state?

A Yes.

Q As I understand your testimony, you are saying that some of those policies and guidelines are based on the Federation of State Medical Board?

A They recommended these guidelines, and they said, "You can use this guidelines in adopting your own rules in your own states," so each state may decide to say, "No. I like this. No. I don't like that," but, generally, uniformly they have adopted those guidelines.

Q I am going to show you Exhibit 7018-A.

MS. SPRECHER: This has already been accepted as evidence, Your Honor, so I would ask that I be able to publish it?

I see that Ms. Harris has already allowed that.

THE COURT: You may.

[16] BY MS. SPRECHER:

Q Dr. Shay, are you familiar with this?

A Yes.

Q And this is a multipage publication from the Federation of State Medical Boards?

A Yes, this is what I was referring to. In 1997, they came out with this.

Q What we are looking at is one dated May of 2004; is that right?

A Yes.

Q I want to go over some of the highlighted information. You talked about them coming out with publications in 1997.

A Right.

Q Down here in this highlighted area, is that what you are saying that it has been widely distributed to medical boards and professional organizations?

A That's correct.

Q And I think you also mentioned that the American Academy of Pain Medicine endorses it, as well?

A That is correct.

Q Go ahead and flip to page 2 of that. Second paragraph, which I have highlighted there, says that, "The federation called for an update to its model guidelines." Do you recall that happening?

A I don't specifically recall, if there was anything changed, [17] but they have just emphasized that more. In recent updating 2017, they make other recommendations for doctors to consider CDC guidelines. They are not mandating the doctors to follow CDC – guidelines are just not mandatory. Doctors have confused with guidelines is that as doctors, we are recommending that you consider, so the State Medical Board in 2017 specifically said that, "Hey, Doctors, be aware of the CDC guidelines and consider it." It does not say, "Oh, you cannot prescribe this," or "You cannot prescribe that," or "You cannot go over this amount," but it says, "Hey, do you know about the sentencing guidelines?" They have put that in the 2017 updates.

Q And in this particular document, the 2004 document, they indicated that there are some uses for this, and they place responsibility on the physicians which I have underlined. Do you see that?

A Yes.

Q And do physicians have a responsibility to minimize the potential for abuse and diversion in controlled substances?

A Yes, they do.

Q I want to go to page 4 of that document. I highlighted a portion of the second paragraph. It says, "Appropriate pain management is the treating physician's responsibility, as such the Board will consider the inappropriate treatments of pain to be a departure from the standards of practice, and will [18] investigate such allegations recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis." So, Doctor, reading that paragraph, the question I have for you is is the goal of pain management to completely, 100 percent alleviate pain?

A No.

Q What is the goal?

A Restore function and quality of life.

Q All right. And are there tools that you use to assess that?

A Yes.

Q All right. I want to make sure that the jurors are clear. When the board puts – the Federation of State Medical Boards puts this information out, even

in 2004, are they saying that opioids should not be used to treat pain?

A No.

Q What are they saying?

A They are saying, “Be careful.”

Q Okay. I want to turn to page 5 and talk to you about the guidelines. Here it says, “The Board has adopted the following criteria when evaluating the physician’s treatment of pain including the use of controlled substances.” Are you familiar with Items 1, 2 and 3 there?

A Yes.

[19] Q All right. And that includes evaluating the patient, a treatment plan and informed consent?

A Yes.

Q They gave different ways to meet those goals. And on page 5 – page 6, it continues with four, five and six, “Periodic review, consultation and discussion about medical records”; is that correct?

A Yes.

Q And, finally, compliance with controlled substance laws and regulations?

A That is correct.

Q Okay. Now, the Federation of State Medical Board policy was updated?

A Yes.

Q I have a copy which has been accepted into evidence as 7018. Showing you Exhibit 7018, are you familiar with this document, as well?

A Yes.

Q This is from July of 2013?

A Yes.

Q There was some updates or revisions as you said – maybe editions. I don't want to put words in your mouth –

A Updates.

Q – from 2004 to 2013.

A Yes.

[20] Q Was the philosophy essentially the same?

A Yes.

Q I want to turn to page 5 of that document. Looking at the conclusion part, could you take a second to read that, please, Doctor.

A "The goal of this model policy is to provide state medical boards with a updated guideline for assessment physicians management so as to determine whether opioid analgesics are used in a manner that is both medically appropriate and in compliance with the applicable state and federal laws and regulations. The revised model policy makes it clear that the state

medical board will consider inappropriate management of pain, particularly chronic pain, to be a departure from accepted best clinical practices including but not limited to the following."

Q So we look at those things that will be outside the guidelines, and it includes, "Inadequate attention at initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain." Are you familiar with that?

A Yes.

Q Also, they note that "inadequate monitoring during the use of potentially abusive medications could be a problem as well," correct?

A Yes.

[21] Q They also indicate, "inadequate attention to patient education and informed consent," are you familiar with that?

A Yes.

Q And the "unjustified dose escalation without adequate attention to the risks for alternative treatments," are you familiar with that, as well?

A Yes.

Q "Or excessive reliance on opioids, particularly high dose opioids in pain management," are you familiar with that?

A Yes.

Q As well as are you familiar with, “not making use of available tools for risk mitigation”?

A Yes.

Q Do you rely on the information contained in the Federation of State Medical Board publications as well as other items in your practice?

A Yes.

Q And do you also rely on those publications and other information in doing your independent evaluation?

A Yes.

Q And also in your professional capacity, when you review other doctor’s work?

A Yes.

Q Did you also use those guidelines when evaluating Dr. Shakeel Kahn’s work?

[22] A Yes.

Q Was there any other – besides the Federation of State Medical Board’s publication that we have gone over that you included to kind of think about as you looked at and evaluated Shakeel Kahn’s medical files?

A I wanted to be complete. I wanted to look at the issue from multiple angles, and I used two studies, and another one was the CDC guidelines to just see if – if I

look at the medical treatment were those alarming or were they raising any flags? So I used those other guidelines and recommendations by insurance company what happened to the patient? And see if those issues were present with the practice of Dr. Kahn.

Q All right. You just wanted to get an overall idea of how other people had looked at it?

A I wanted to be complete, yes.

Q Are you familiar with the chronic pain management tool kit?

A Yes.

Q Is that for the Wyoming Medical Board?

MS. SPRECHER: Just one second, Your Honor. I seem to have misplaced it.

BY MS. SPRECHER:

Q I will show this to you. It hasn't been entered into evidence yet. This is Exhibit 7001.

A I am familiar with this.

Q And what do you know this to be?

[23] A I'm sorry?

Q What is this?

A This is Wyoming Medical Board when they got the Federation State Medical Board when they adopted that, they wanted to make sure that the providers understood. They essentially broke it down, the

guidelines, what they were looking at. They put this together, and they called it a tool kit. So it is telling you, "Hey, consider these things in your practice."

Q Do you know how physicians can access this tool kit?

A It is available on the website.

Q Can the public also access the website?

A Yes. Public has access, and I believe that they send it to our office. I believe I received a copy from them. 2012, 2013.

MS. SPRECHER: I would offer at this time, Your Honor, Exhibit 7001?

MR. BRINDLEY: Your Honor, I would not object to the admission of the document if it is not offered for the truth of the matter asserted, but only as a guide that was available to Dr. Kahn. I would object to it otherwise. But if it is offered not for the truth, but just to be a tool that he could have evaluated in that instance, I wouldn't object to that.

MS. SPRECHER: Agreed, Your Honor.

THE COURT: It is received.

(Exhibit 7001 was received in evidence.)

[24] BY MS. SPRECHER:

Q Are you also familiar, Doctor, with the Wyoming Board of Medicine policy set forth February 13, 2019?

A Yes.

Q How are you – how are you familiar with that?

A I seen it on the website, and I think that you also sent this to me. I may have received this from you.

Q All right. And I have marked this as Exhibit 7000.

THE COURT: Previously received, I believe.

MS. SPRECHER: Pardon?

THE COURT: I think it has been received.

MS. SPRECHER: Yes.

BY MS. SPRECHER:

Q I want to talk about 7001, the tool kit. I am turning to page 4. It references the American Academy of Pain Medicine. Are you familiar with that academy?

A Yes.

Q What is it?

A It is a group of doctors getting together for enhancing professional education and public policies.

Q Can you become a member of that academy?

A Yes.

Q Who can become a member?

A Any doctor.

Q All right. What do they have to do?

[25] A Just believe in their principles and have a license to practice.

Q All right. On page 4, the American Academy of Pain Medicine has three statements addressing legislation of prescribing opioids. Are you familiar with that?

A Yes.

Q So they don't discourage it, right?

A No.

Q What does it mean in paragraph 2, "Prescription of opioids for chronic and practical pain is appropriate when more conservative methods and treatment plan is reasonably designed to avoid diversion, addiction and other adverse effects"? What do they mean?

A What we learned in medical school: Start simple. Know the side effects. It applies to diagnosis of pain and treatment is narcotics, and you say, "Hey, go simple. Try simple things first. Look for side effects such as addiction and make sure that your prescription doesn't go out into public and kill people. Avoid diversion and adverse side effects; respiratory depression and death," that is what it is saying.

Q And, finally, in paragraph 3, "Opioids should be prescribed only after full evaluation of the patient, consideration of alternatives, development of a treatment plan tailored to the needs of the patient and minimization of adverse effects and ongoing monitoring

documentation," are you familiar with that [26] philosophy?

A Yes.

Q What does it mean?

A That's being a doctor. That is what doctors do.

Q So you don't just pick one therapy and stick with it continuously?

A No.

Q Why not?

A You have to assess and see if you – if there are issues developing, side effects developing, that you maybe the director and you have to look for. Patients are not going to tell you, "I'm becoming addicted to it." The patient is not going to tell you, "I am giving my medication to other people. I am taking other drugs." So it is your responsibility to look further. That is the assessment. Assessment is not just what the patient tells us. It is what you find out, the objective things that you find out.

Q All right. You have talked about assessment, and I want to talk a little bit about pain treatment options. This is not in evidence yet. I want to direct your attention to 7005. Have you seen this before, Doctor?

A Yes.

Q Right, and did you help me create this?

A Yes.

Q All right. What is it?

[27] A Starting –

Q I'm sorry. Is it a treatment – is it pain treatment options, a list of those?

A Yes.

Q And is it something that you use in your evaluation of patients?

A Yes.

MS. SPRECHER: I would offer Exhibit 7005, Your Honor?

MR. BRINDLEY: Your Honor, I don't object as long as it is demonstrative purposes. This is not to be a substantive exhibit.

MS. SPRECHER: Agreed, Your Honor.

MR. BRINDLEY: No objection to that.

THE COURT: It is received for demonstrative purposes.

(Demonstrative Exhibit 7005 was received.)

BY MS. SPRECHER:

Q Describe how you go through these treatment options when you evaluate a patient.

A So to treat chronic pain, we have to look at a number of things to see if those treatment options are available and appropriate. And first, we have to make

sure that we are really treating chronic pain, and we are not treating anxiety and depression. Symptoms can develop, and if they have anxiety [28] and depression, if you do not diagnosis anxiety and depression and throw pain pills at it, you are going to aggravate both the chronic pain and anxiety and depression. So the number one concern that a doctor should have for a chronic pain patient is development of premorbid issues, specifically anxiety and depression. I put that number one because if you do not diagnose that, then you are going to go to number two and number three and number four and number five, and you miss the boat with number one. And you end up with unnecessary surgery, narcotics and all these injections that were not appropriate, and all these others had good intentions, but that very first doctor who missed the anxiety and depression and started on this cascade of events didn't really do the patient justice. So you have got to really treat psychological issues of the patient.

So your objective assessment should include psychological assessment of the patient. Very simple things, "Tell me about your psychiatric history. Have you had depression? Are you taking antidepressants? How does your depression and anxiety tobacco use affect your pain?" Those are the questions that you should ask before we get to two and three and four and five. So narcotics which is number three oxycodone, down there, you see very far from number one. So you don't just jump in to a lot of narcotics when you haven't explored if the patient is anxious, depressed or suicidal. We [29] have all had back injuries and back ache,

and all that. So what do we do? Most of us take over-the-counter. We rest a little bit. We try to exercise it. And then we go to physical therapy. Go see the doctor. They send us to physical therapy. Gives us a TENS unit. Maybe a traction belt. That is physical medicine. You are still not putting any medicine in a person – patient's body. You are not subjecting them to all of those potential side effects. You are not injecting them with steroids, and you are not doing surgery and cutting open to remove a disc. You are just doing simple measures. If that helps hallelujah. You restored function.

Now, if that doesn't work, you go to number three. And, again, you start with simple things. "Take some Tylenol. Take some Motrin. Give it two weeks. Let me write your prescription for physical therapy. Come back and see me, and we will see if – if PT hasn't worked and over-the-counter medication hasn't worked, we are going to explore other options, and then you continue on. Then, you go stronger: Non-steroidal antiinflammatory drugs like Motrin 200 milligrams over the counter. You go pick it up." When it becomes 800 milligrams, the doctor has to write it. The doctor has a responsibility to tell you, "This is four times as strong as over-the-counter medicine that you take, and it has potential for side effects." And what is the doctor doing? He is informing the patient and obtaining consent to give him a [30] stronger medication albeit a non-steroidal anti-inflammatory drug, still the principle applies. It is stronger anti-inflammatory medication, and it can cause gastric upset or renal problems.

So if that doesn't work you, you go to muscle relaxants. What are muscle relaxants? Flexeril, Zanaflex, like Soma. These muscle relaxants also have sedative effects. So you don't want to give a patient a muscle relaxant because they have a lumbar injury without telling them, "This is a muscle relaxant that I am giving you, and it is going to make you sedated. It may slow down your heart rate. Ms. Jones, you are 82 years old, and I recall that you have some issues with your heart. So you have to be very careful with this."

So then adjunct medication – there are other medications that we can prescribe for treatment of chronic pain which are not narcotics, but help other medications become more effective; such as gabapentin, Cymbalta, duloxetine, and these medications are in our toolbox available to us to prescribe to our patients before going anything further and stronger with more potential for harm. Let take – if all that doesn't work and comes back to you and says, "Doc, I am still in pain. I tried the over-the-counter. I have tried the muscle relaxants." Then, you can consider narcotics. You know we in our society, we treat pain. We respect human life. We want happiness for our patients. That is our objective. So we are not going to deny you – I am not going to write a [31] prescription, because I don't believe in pain medication. No. I shouldn't be practicing medicine if I didn't believe in providing appropriate pain management – sufficient pain management.

MR. BRINDLEY: Narrative response, Judge. I would ask for more questions, Your Honor.

THE COURT: Sustained.

BY MS. SPRECHER:

Q So when you get to the narcotics level, are there certain strengths of narcotics that are weaker than others?

A Yes.

Q And is this listing under 3F a list of narcotics that can be prescribed from lowest to highest strength?

A Yes.

Q All right. And are those options that you choose when treating patients with chronic pain?

A Yes.

Q What is "tramadol"?

A Tramadol is a weak narcotic, and it can be used and may not have a sedative effect as the full agonist opioids such as Norco or Percocet, but it is good.

Q Norco and Percocet, you said it has a different – it is not a full agonist?

A They are full agonists, Norco and Percocet. Full agonist means that, "Hey, I am a narcotic. I am all the narcotic you [32] want. I am full agonist," versus partial agonist. We have different narcotics, and these are different classifications. We have partial. We have full. So Norco the active ingredient is hydrocodone, which is full agonist. Percocet the active is oxycodone, full agonist. Oxycodone and OxyContin, they are both

full agonists with a different formulation, the makeup of the drug itself, they are all full agonists. So we consider full agonists to be strong opioids. And then there are different potency, so different narcotics can have different potency. For example, Percocet is one-half times more potent than hydrocodone or morphine.

Q Oxycodone and OxyContin are – oxycodone is an immediate release drug?

A Yes.

Q And oxycodone is an extended release drug?

A Yes.

Q Why is oxycodone before OxyContin in the tools that you would use first?

A So if a patient is getting oxycodone, and he comes back and says, "This oxycodone that you are prescribing to me is very short lived." And you say to him, "I have another recommendation for you. I can give you this oxycodone in a form that is released over time in your stomach and absorbed into your system, so you always have a background pain medicine in your system. And then I am going to give you the immediate [33] release for those instances during the day, three times per day or four times per day you are doing certain activities that make it prone for you to have worsening of your pain. I am going to give you immediate release. So you maintain in a background a form of extended release, and then you continue with immediate release for breakthrough pain."

Q So, for example, the OxyContin would put a person at a level amount of pain control, and the immediate release would give them a little extra pain control, but they don't last very long?

A Yes. That's correct.

Q When you take another one, it goes down?

A That's correct.

Q Okay. Other types that aren't listed on this pain treatment option of narcotics, does that include hydromorphone?

A Yes. These are the different narcotics. There are natural occurring narcotics and there are semi-synthetic, and then there are synthetic. So oxycodone is a semi-synthetic like hydromorphone; synthetic drugs like fentanyl, so we have – so these are all derived from the same molecule, but we can also synthesize narcotics in laboratory, and they're called synthetic narcotics.

Q Is hydromorphone also known as Dilaudid?

A Yes.

Q Do you use it very often?

[34] A It is in our toolbox.

Q Suboxone, are you familiar with that?

A Yes.

Q What is that?

A Suboxone is also a pain medicine – believe it or not that we found out Suboxone helps with treatment of addiction. And that is another medication that we have available, but we use Suboxone for treatment of addiction. Some doctors use Suboxone for treatment of pain.

Q Can Suboxone be used at the same time as oxycodone?

A No.

Q Why not?

A Because they can interact and can cause significant problem – withdrawal problem.

Q Why?

A One is full agonist. The other one is partial agonist.

Q Oxycodone is a full agonist?

A Full agonist. And then all of a sudden you take the Suboxone, that Suboxone can make the oxycodone be released – occupies a full agonist receptor, and oxycodone is gone, Suboxone is not as strong as – Suboxone is not as strong as oxycodone, so it is going to precipitate severe withdrawal. So you have to be very cautious when you are prescribing Suboxone to a patient who is on narcotic. Now, we treat opioid addiction with Suboxone. One of the instructions that we give [35] patients who is on oxycodone says, "Doctor, I am addicted. I want to get off."

MR. BRINDLEY: Objection; narrative response, Judge.

THE COURT: You may followup.

BY MS. SPRECHER:

Q So is there a danger of a person going into severe withdrawal if a person takes Suboxone with oxycodone?

A Yes.

Q Why is that a danger?

A Because you can go through severe withdrawal, and that severe withdrawal is not what we want for our patients in medicine. You are going to have diarrhea. You are going to be puking your guts out. You are going to be shivering. That's not what we want. You are subjecting your patients to withdrawal symptoms knowing full well that this medicine can do that.

Q And you were explaining that you would counsel your patients if you were to prescribe Suboxone while they were on the oxycodone, what would the counseling be?

A First of all, they are not supposed to be taking Suboxone if they're on oxycodone. We convert them from oxycodone to Suboxone when patient comes and change a diagnosis from chronic pain to opioid use disorder. So what that means is a patient can develop dependency to narcotics – opioids, and can see a pain doctor. But then the doctor recognizes that the patient

[36] the narcotic is no longer achieving the objective of restoring function. This patient has become dysfunctional. So I meet with Mr. Jones and say, "Mr. Jones, we had been treating your chronic pain, but it appears to me after the admission today chronic pain is not the only concern here for you. It is opioid use disorder. Do you agree?" And he says, "Yes." "I recommended Suboxone for treatment of your addiction, but Mr. Jones, there is a way to take the Suboxone. You cannot be taking the oxycodone just an hour before you came in here and take the Suboxone. You have to wait until such time that the withdraw symptoms set in, and then take the Suboxone." There is specific instructions that you have to give the patient. That is only one.

Second, in practice of medicine, I am responsible for a diagnosis. "I recommended oxycodone for chronic pain, but on today's examination, Mr. Jones, your diagnosis has changed to opioid use disorder. I am going to prescribe Suboxone." So you cannot have a diagnosis of chronic pain for your patient and prescribe oxycodone and prescribe Suboxone.

Q Okay.

A To do that, you have to do it right. You have to tell the patient and tell them what is going on, and you inform the patient and obtain his consent.

Q Okay. Are you familiar with the term MME?

A Yes.

[37] Q What is that?

A That is "Morphine Milligram Equivalent."

Q How is that used in your practice in pain management?

A We have these different narcotics. We have Norco. We have Dilaudid. We have Morphine. We have oxycodone. We have methadone. We have fentanyl. And how do you know how much of this is equivalent to this much of this? How do we know? So what we came up with is that we said – these smart doctors, they looked at these drugs in the laboratory, and they said that we are going to establish equal potency tables for these drugs. We are going to choose Morphine as the mother drug, and we are going to compare everything to Morphine. Now we know how to compare, for example, Percocet to Dilaudid or fentanyl.

Q Okay. Just finishing up with this slide a little bit, what is interventional pain therapy?

A Interventional pain therapy is an area of pain management that targets specific anatomy of a patient's body as the cause of pain and tries to see if placement of medication or ablation of the nerve provides pain relief.

THE COURT: When do you decide a patient may be in three and goes to four?

THE WITNESS: Both you and the patient decide.

BY MS. SPRECHER:

Q How do you do that?

A The patient come and says the medication that you [38] prescribed is not effective, you can recommend interventional pain therapy. So you can recommend all the options on the very first visit that you have the patient. You can say this is part of being a doctor, educating your patient, "Ms. Jones, we want to make sure that we have tried everything. You know, you are on Paxil. I don't think that depression is really affecting your pain. We tried the TENS. There is also availability of injection and even surgery."

So it is not like you don't tell the patient any of this. You tell the patient all of this from the get-go and inform the patients. When you inform the patient, you empower the patient when patient knows what options are available that are not in always in dark wondering what is going to happen. In fact, a good doctor does that on the very first visit, discuss all the treatment options, and not that the patient is appropriate for any or all of them, but say, "These options are available. Now let's look at your specific case, and let's just go step by step."

Q Okay. Are there certain individuals that come to you after they have tried many, many things, and they are not working?

A Yes.

Q Do you still go through this same process with them?

A Yes.

Q And do you continue to evaluate the patient as he comes or she comes to see you, looking at all of these options?

[39] A Yes.

Q Do you discuss that with the patient as well?

A Yes.

THE COURT: What kind of information do you have about the patient?

THE WITNESS: What information do I have about the patient?

THE COURT: What do you know about this patient that walks in this office?

THE WITNESS: I want to know about past medical history. I want to know what the patient says. I listen to the patient. That is the first thing I want to know. Then I want to know about their past medical history. I want to know what medical conditions they have had, what surgeries they have had, what diagnoses they have had, and what treatment they have had?

Specifically, I want to know about their psychiatric history. I want to know that there is no risk of suicide. I don't want to give narcotics to someone with the risk of suicide. I want to know if there is past medical history of depression. And if so, has it been treated? That's what I want to know.

Then after what the patient told me, then after I review the medical records that patient brought me or

didn't bring me, but I should request – after I have done that, then [40] I am going to give a urine drug screening to the patient to see what is in his system. That's what I am going to do. Then I want to know the other doctors what prescriptions the other doctors have written for this patient. That is the Prescription Drug Monitoring Program report that you check to make sure that this patient's prescription regimen is consistent with what he is telling you. He might be telling you something, but something else might be going on. How do you know? As a doctor, it is your responsibility to check. You can't just accept what patient said, so that is what you do.

I want to know what the patient said. I know what the other doctors said. I want to know what the past medical history was, and then I am going to touch my patient. I'm going to touch. I am going to look. I'm going to palpate. I will see evidence of surgical scar. I am going to do range of motion. I will do provocative testing to see if what he is saying is consistent with the physical examination. If the physical examination is normal, not that he is telling me a lie, and he doesn't have pain, because pain doesn't show in physical examination.

I believe a patient coming in with absolutely normal physical examination can be in chronic pain. But as a doctor, I have a responsibility to assess the objective evidence, and the patient is my objective evidence in front of me. If a [41] patient is pregnant, I need to know the patient is pregnant, because I can see the

belly. If I document physical examination, then I got to say, you know, "Patient is pregnant." So that is what you do.

So you complete an assessment, listening to the patient, listening to the other doctors. Your eyes and ears and what you see on physical examination – only then can you arrive at a diagnosis. You cannot arrive at a diagnosis just because the patient said, "I have chronic pain." You cannot. That is an incomplete evaluation. That is no evaluation. It is not even incomplete, because it is no evaluation –

MR. BRINDLEY: Objection, Judge; nonresponsive.

THE COURT: Sustained.

BY MS. SPRECHER:

Q Doctor, if you have all the information that you have talked about, do you ever ask for more information? For example, X-rays or MRI? Things like that?

A Yes.

Q Okay. Why do you do that?

A If a patient tells me that they have radicular low back pain, and they haven't had any diagnostic studies. They have gone to family doctor, prescribed them medication and nothing has helped, and I am thinking of maybe doing an epidural steroid injection, I want to see if there is a disc herniation and what

level, and that will help me with my placement of the [42] needle.

Q So when you order those types of tests or follow-up studies, do you use them?

A Yes.

Q Do you discuss them with the patient?

A Yes.

Q You have talked a lot about opioid use disorder. Does that have to do anything with addiction?

A Yes.

Q And do you look in the patients that you are treating with opioids for opioid use disorder and addiction?

A Yes.

Q When people first come to you, are there tools that you can use to assess whether a person might be prone to or actually experiencing opioid use disorder?

A Yes.

Q What are those types of tools?

A We ask the patient specifically about opioid use disorder, we don't call it addiction anymore. I don't like to call it addiction. You know, this patient has been coming to me for years, and I have been writing narcotics, and he has been functioning, but lately, I don't

see that. I ask him, and he says, “No, Doctor. I don’t have any of these issues.”

So there are 11 questions I ask, and they all say no. So if they answer two or more of these questions, I know that [43] this patient can be classified with opioid use disorder. So I ask them those questions. And some patients say no, and then I have to dig in further.

So if I establish that based on what the patient told me, based on those 11 questions I asked, and my evaluation and my objective, physical examination, urine drug screening, Prescription Drug Monitoring Program review of the other doctors that this patient has opioid use disorder, then I will discuss it with the patient. I will say, “Mr. Jones, I believe you have opioid use disorder.” He says, “No.” I am not going to tell him, “You are addicted.” He is not going to have that – he is going to walk out. That is why we changed the term to opioid use disorder. This is what happened. “You have a true, legitimate medical condition, and we gave you narcotics,” we wanted to treat that –

MR. BRINDLEY: Objection, Judge.

THE COURT: Sustained.

BY MS. SPRECHER:

Q I want to ask you one more follow-up question. When you order follow-up studies, if they don’t do that, what is your response? You tell them to get X-rays or go get an MRI, or refer them to another doctor for a complaint, for example, if they suspect they have cancer, what if they never follow-up on that?

A That is unacceptable.

[44] Q And what happens to that patient?

A Well, let's say, you know, you are ordering an MRI, and I don't follow up, and then there is cancer, and then five months later, the patient is dead. How can I forgive myself, and how I can forgive what I did to that patient? It was my responsibility. How can I live with myself? The patient trusted me, coming to me and trusting that I ordered a diagnostic study, and I have an obligation to follow up, but I never did. That is totally unacceptable.

Q Certainly, you can't make patients get an MRI or X-rays; is that right?

A No. I cannot make them.

Q What can you do in response if need to see an X-ray or see an MRI in order to treat them, what can you do without those results?

A If I need those results, and the patient is not compliant, then the likelihood of me achieving my treatment objective is – becomes very small. So I will discuss it with the patient, and say, "I don't believe that I am the right physician for you."

Q I want to hand you Exhibits 7003 and 7004, and ask you if recognize them.

MS. SPRECHER: May I approach the witness, Your Honor?

THE COURT: You may.

[45] BY MS. SPRECHER:

Q Do you recognize them?

A Yes.

Q What is Exhibit 7003?

A This is an intake form that we have in our office. We give it to patients to fill out.

Q What is Exhibit 7004?

A Also another intake form for followup. So the first one is the new patient and initial evaluation, and the second one is the follow-up evaluation.

Q And these are tools that you use in your office?

A Yes.

Q Are they created based on the philosophies of the Federation of State Medical Boards?

A Yes.

Q And are they also in compliance with what you learned in medical school about assessing patients?

A Yes.

MS. SPRECHER: I will offer 7003 and 7004, Your Honor?

MR. BRINDLEY: No objection to those.

THE COURT: They are received.

(Thereupon Government's Exhibit Nos. 7003 and 7004 were received in evidence.)

BY MS. SPRECHER:

[46] Q I am showing you Government's Exhibit No. 7003. Is this the initial paperwork, Doctor?

A Yes.

Q This is a nine-page questionnaire for a patient; is that right?

A Yes.

Q And generally, without going through every page, what are you looking to? What are you assessing?

A This is what we talked about earlier about what we want to know from the patient. So this is the patient telling me about their medical condition, and I am asking, "Tell me where is the pain in your body," and to – pain characteristics, the first page is all pain characteristics. The second page goes through all the conservative and pharmacological and interventional pain modalities. Starts with physical therapy, traction, topical medications, anti-steroidal –

Q I have to interrupt you. We have to take this down – Ms. Gentry does, so you have to go slower, please.

A So the second page this lists all the treatment that the patient has had. As a pain doctor I want to know what patient has had for their chronic pain condition. So "Mr. Jones, tell me if you have had

chiropractic. Tell me if you have TENS. Tell me if you have tried non-steroidals or not. Tell me if you have tried different muscle relaxants. Tell me if you have tried these adjunctive medications such as gabapentin. And [47] tell me if you have tried these mild narcotics, such as hydrocodone. Have you tried the potent narcotic such as Dilaudid or such as fentanyl or such as methadone? Tell me if you have had injections in the past. And also tell me if they were effective, and if you had side effects or didn't have side effects?" I am the pain doctor. I need to know that. And then continue to page 3, "Tell me how treatment of your pain condition helped you with your functionality. I am giving you some example. Look at this and tell me." Of course, patient can try to fool you and not respond correctly, but it is your job as you are going through this and discussing this with the patient, using your skills as a physician to write down if the treatment the patient is receiving is restoring functionality.

Q May I ask you a question?

A Yes.

Q The top portion here, does that talk about functionality?

A Yes.

Q So you are assessing how a patient functions daily?

A Yes.

Q While they are in pain?

A Yes.

Q Then the second portion down here, what are you assessing here?

A Yes. The questions down there goes back to asking the patient for symptoms that can happen with opioid use disorder [48] or what we used to call addiction. So I am asking them and if a patient marks two or more of these, then a doctor has to consider opioid use disorder as the diagnosis, and that is the purpose. So I am not asking for pain. I am asking for side effects from treatment of pain. This is what this section is trying to gather from the patient.

Q All right.

A And then on page 4, then we asked questions about the risks associated with me giving them narcotics. So if a patient has a history of alcohol abuse, illegal drug use, prescription drug use or if the patient's family has that history, or if a patient has a history of depression, bipolar disorder or schizophrenia, then that elevates the risk. In particular if I have a female patient and she says that she was a victim of preadolescent sexual abuse that increases the risk –

MR. BRINDLEY: Objection, Your Honor; nonresponsive at this point.

THE COURT: Sustained.

BY MS. SPRECHER:

Q So what you are looking for is any indication as you mentioned earlier that there might be a mental

problem that would subject them to opioid use disorder to be more receptive – susceptible to that?

A Right. I am evaluating the risks. These numbers that I obtain in here gives me a number that I add up, and it is [49] called "ORT," Opioid Risk Tool. So if a person's Opioid Risk Tool is more than four, then I should be cautious. Not that I shouldn't be prescribing narcotics, but I should be cautious. If an Opioid Risk Tool is eight, I should be double cautious. This defines the degree of risk.

Q There are some other questions on page 5 that talks about "pain and disability." Is that more just assessing quality of life again?

A Yes. So a patient can tell you that their pain is so much and so much, and that they are functional or they're dysfunctional, but really you need to dig a little bit more and try to objectively put what the patient is saying to you and be as objective as you can. And the pain and disability questions area is an attempt to do that.

Q All right.

A So we administer this, and if we see as we are treating the patient, the pain and the disability questionnaire or score is improving, that is a positive indicater of our treatment.

Q How often do you give this pain and disability questionnaire?

A There is no set requirement. Any doctor can choose however they want, but we usually do it at the initial evaluation and every four to six months after that, or when we are considering change of pain medication or going stronger. We are doing that if there is a change in the social status, like they lose their [50] job, they go through a divorce. If something is telling me that I have got to be careful, then I administer one of these questionnaires to get more objective. Patients can give you some history and I have got to be able to objectively assess what they are telling me over a period of time. This is a tool that we use in medicine to objectively assess that.

Q And when you look at this, do you actually look at the answers that the patient gives them? Do you evaluate them and speak to them about the answers?

A Yes.

Q Page 6 of this exhibit asks some questions about pain and health. What is the purpose of those, because I see at the bottom there is a total score?

A Going back to what we said earlier about treatment algorithm for chronic pain, it always starts with the simplest symptom. I want to make sure there is no depression. Unrecognized depression is very prevalent with chronic pain patients. For us to detect that we ask the patient, "Do you have depression?" So you ask the patient. The patient might say, "Yes." "Are you taking an antidepressant? Have you seen your doctor for this?" They say, "No." And then I have a pain and health questionnaire nine in here, and the score is 22,

which is very severe. So I'm going to tell Ms. Jones, "I think that there is a degree of depression that can affect your pain. So let me see if we can start you on some antidepressants. I [51] will talk to you about this or see your family doctor about this." This documents that the depression was assessed. And if you are not an expert in treating depression, then refer the patient to whomever is and consider that when you write your narcotics for this patient.

Q Thank you, Doctor. The other pages here which audits a person's potential problems with alcohol on page 7.

A Yes.

Q And then on page 8 and 9, they indicate these are for office use. Is this information that you use –

A Yes.

Q – after you evaluate or while evaluating the patient?

A Yes. So this is the objective evidence. This is what I did. I measured the vital signs. I did the Opioid Risk Tool. I assess what pain and disability questionnaire was, and then I reviewed the imaging. I reviewed the records. So I am checking all of those things for myself that I have to do. That's my checklist to make sure that I am complete. Then I move onto my hands-on physical examination, and this is what I want to see in a patient. I mark the positive findings. And if there are abnormal problems, then I circle them. And so it is just a systematic approach to different body areas. It

starts with the mental status, with cervical/lumbar examination, neurological examination –

Q And you get to the assessment?

[52] A Yes. And the last page, page 9, assessment – my primary diagnosis is chronic pain. I am a pain doctor. My diagnosis is chronic pain. "You are here because you have chronic pain." And my second one is long-term opioid therapy. If a patient comes to me and tells me that, "Doctor, I have been taking this pain medicine for the past five years," I am going to mark that long-term opioid therapy, because that is my documentation to my peers to my medical boards that this patient has chronic pain, and that conveys a lot of information to those people. Those people need that because we are all trying to help the patient. I have to tell what the patient has or not. And also up there, the other thing that we look at with narcotics, opioid induced constipation happens a lot with those, and we need to treat that. Opioid Use Disorder, and it is all in the primary diagnosis all up there. I, as a pain doctor, have a responsibility.

And then the second is comorbid diagnosis. The lifestyle choices that we make will affect our perception of pain. Anxiety, depression and alcohol abuse, those are all comorbid issues that can aggravate the pain. I have to put that as a comorbid issue, because if I don't pay attention to that, I am going to throw more narcotics, but I am not going to get any results because the patient is continuing to smoke tobacco. This cycle

of anxiety, depression and narcotics is never going to get better.

[53] Then, the historical diagnosis –

MR. BRINDLEY: Objection; nonresponsive.

THE COURT: Sustained.

BY MS. SPRECHER:

Q What is the historical diagnosis for?

A The historical diagnosis is my review of the medical records, what the other doctors said this patient's diagnosis is, and that includes a history of, like, back surgery, post laminectomy syndrome, fibromyalgia, osteoarthritis. The patients comes to us – they come to me because they have post laminectomy syndrome. So that was the diagnosis to the primary care provider that is the surgeon. When they come and visit the pain specialist, my primary diagnosis is not post laminectomy syndrome. My primary diagnosis is chronic pain, because that is what I am seeing not post laminectomy syndrome. I am treating chronic pain.

So this is how doctors talk. We put things in order, and we all follow the same protocols of subjective/objective, assessment and plan. This is anywhere in the world that you go. It is not only U.S.

Q Moving down to the objective, that is something you also include?

A Yes.

Q Why do you put objective in your plan?

A I put this there because I am – we have four clinics. One [54] of the things that we discussed that we discuss among ourselves – our objective with our treatment plan is to improve quality of life and function. So let's just put that right up there. It is not to make the pain go to zero, because you will never achieve it. Never give the patient the expectation that, "I'm going to treat your pain. It is going to go to zero." It will never. You are not going to be successful, and your patient is going to suffer.

What I learned, that is the reason I want everyone to know that the objective of a pain doctor is not to write narcotics to make the pain zero. The objective of a pain doctor is to provide treatment to his patient to improve quality of life and function. I want all to know – everyone to know that. That's why I put it right there. I don't want anyone to forget that.

Q Okay. You also have a plan for aberrant behavior?

A Yes.

Q What is that?

A The next one is discussing anxiety and depression. I am not a psychiatrist, so – but I have a responsibility to say, "Hey, I am detecting some problems in here with depression. I am detecting problems with alcohol. I am detecting that there is some psychosocial issues you are going through. You are going through a divorce. You are taking too much medicine. So let me

start you on an antidepressant. Why don't you stop [55] tobacco use? That is right up there – maybe I am not a psychiatrist, but I am a doctor. I have to recognize that you are depressed. And you shouldn't be taking all this pain medication, because it is for the wrong reason." That is why I put that right there.

Then it continues with physical medicine modalities that we can give in our office, traction and TENS. And if that doesn't work, we also have a physiatrist. We refer the patient to our physiatrist.

Then we move to medication which starts with topical. You go slow and simple – topical like Bengay gel. If that works, you don't even have to take the Motrin by mouth that has a potential of putting a hole in your stomach, so let's keep it simple.

It goes on – and the last one is the opioids, and we are going to start – these are all the choices that I have. I'm not denying patients pain medication if there is a legitimate medical reason documented in medical records, and you have been on – taking 1,000 milligrams of Morphine a day, and there is –

MR. BRINDLEY: Objection, Judge; nonresponsive. THE COURT: Sustained.

BY MS. SPRECHER:

Q I'm going to go up to objective and down to the opioids. When you look at the – across the second row from the [56] bottom –

A Yes.

Q – do you see there “Education to patient” and “Education to family caregiver”?

A Yes.

Q “After Naloxone”?

A Yes.

Q What is Naloxone?

A Naloxone is antidote to narcotic.

Q And what – when – do you ever prescribe that?

A Whenever we go above 50-milligrams of morphine milligram equivalent per day. If we prescribe more than five hydrocodone tablets per day, we tell the patient that there is a risk for overdose. And then, “We are going to send Narcan to the pharmacy. Please, next time, come with your family member so we can educate them on the proper use of Narcan in the event of accidental overdose.”

Q Okay. That is at what level of MME?

A It is 50. It is lower than what CDC guidelines are. We just do that. We are a high-risk practice. I am pain management, so my standards are significantly higher than the other doctors could be. So if CDC guidelines – I think it is higher, but so we are even lower than that.

Q All right. What is this, the “plan for aberrant behavior”?

A Plan for aberrant behavior, so one of the things that you [57] discuss with part of your treatment plan with your patient is compliance with the treatment plan. So if you break your arm and you are noncompliant, you don't go to physical therapy and remove the cast early, it is not going to heal. There is going to be a non-union. So if you are on narcotic pain medication, you are taking more than prescribed, and you come in, and your urine drug screen doesn't show it, then, "Mr. Jones, you are the kind of thing that we are going to implement." So part of the treatment plan for a pain doctor includes plan for the abhorrency in patient's behavior as observed with the use of narcotics.

Q Okay. Is this just a form that a patient fills out, and you look at it only, or do you discuss this information with the patient?

A The form is only part of what the patient does, and then we do the physical urine drug screening, we do the PDMP, and then I have a responsibility to review with the patient the diagnosis, "Mr. Jones, I believe that you have chronic pain, and you are taking long-term opioids for pain medication. My plan is to continue with this pain medication, and I am going to visit with you on a monthly basis. I may be doing urine drug screenings from time to time. We check the Prescription Drug Monitoring Program every time. As long as this pain medication improves your quality of life and function, then I will continue doing." So next time he comes in, he is going to [58] tell me, "My pain is better. My quality of life is better." I am just not going to be content with that. I am going to say, "Tell me

more," which takes us to the follow-up. And then, so – tell me more.

Q I will interrupt you just for a second. Excuse me. This first Exhibit 7003 that we have been looking at, is that a form that is filled out at the patient's visit or before the patient's visit?

A We send this form to the patients before they come in. We mail it to them. We get our referrals from doctors. And then we contact the patient, send the forms, they usually get it two weeks before they come in, and they fill it out. And when they come in, we go through the forms with them. And then we make our notations. There is a lot of blank areas in here. We can never fill out these forms. Patient sign and they scribble. It is my responsibility to make my own notations. I dictate. I go back to my office, and I just dictate off of this, and that is my progress notes.

Q So those are your progress notes, is that what you said?

A Yes.

Q Do you make that after every visit?

A Yes.

Q You said that took us to Exhibit 7004?

A Yes.

THE COURT: We have been at it since 8:30. Would it

*　　　*　　　*

[98] would you render – would you diagnose that that person is opioid naive?

A Yes.

Q Would it be appropriate and within the usual course of professional practice to start them at a high dose of opioid?

A No.

Q Why not?

A They can die.

Q What is a high dose of opioids?

A There is no ceiling. But we know that Norco 5 milligrams one, two, three tablets a day, it is pretty safe. Now, when you get to above 40 or 50 MME, then it becomes less safe.

Q Okay.

A So when you are 100 of oxycodone, it is not safe.

Q Is it important in medication to see a patient periodically to assess whether they need that continued prescription regimen?

A Yes.

Q Would you continue to write a prescription without seeing a patient for a long time?

A No.

Q How long would you go – what would be medically appropriate before assessing a patient?

A There is no time.

Q What –

[99] A It is, again, art and science. You look at your records. You believe Mr. Jones and his wife their statements, you review the PDMP, you saw the scar on his body, and you saw them, and he was working and that he lives three hours from you, and – you say, "Okay. I am going to see you every two months, maybe every three months, but the prescription I am just going to write for four weeks. We do not write for more than four weeks. Then when the time comes in, we call it in the pharmacy. The reason is we don't want three month's worth of medication sitting in the cabinet at your home."

So as a doctor, "I believe you are the patient. I trust you," but now the medical board has asked me, "Hey, Doc. You've got to watch out for the well-being of society." So what we do – I will not write medication for three months. I will give it four weeks. Let's keep it limited. "I am not denying it. Call. Call, and we will send it in, or we can put on auto send. We can send it next month for you."

Q When you looked at Shakeel Kahn's patient files for review, you talked about earlier in your testimony that you were looking for a broad spectrum of things to evaluate; is that right?

A Yes.

Q And as I read your report, I notice that you looked at the Federation of State Medical Board Policy for July of 2013, and that is an exhibit that we talk about which is Exhibit 7018. [100] Have you made notes and helped me put into an overhead about what sorts of things you were looking at based on the Federation of State Medical Boards?

A Yes.

Q I want to show you Exhibit 7002. Is this the overhead you helped me create?

A Yes.

Q All right. And would it assist in describing what factors you were using to evaluate Shakeel Kahn's patients?

A This is all from medical board, Federation of State Medical Board.

Q They can't see what you are looking at. I just need to ask would it help you to read from it or use it to explain what it is you were doing?

A I can explain it.

MS. SPRECHER: Okay. May we – I offer 7002 at this time?

THE COURT: Just a moment.

MR. BRINDLEY: Judge, as long as it is only for demonstrative purposes, no objection.

MS. SPRECHER: That's the purpose, Your Honor.

THE COURT: Thank you. It will be used for that purpose.

(Demonstrative Exhibit 7002 was received.)

[101] BY MS. SPRECHER:

Q We have some bullet points that are under the treatment of chronic pain as per Federation of State Medical Boards. What are these? So I guess what I want to ask you is: Looking at the Federation of State Medical Boards, did you make some opinions or determinations about Shakeel Kahn's files and their adequacy or inadequacy?

A Yes. So I used the Federation of State Medical Boards Guidelines as if I was the medical board, and I was looking at these charts, and I was trying to see if his practice of medicine was consistent with what the Wyoming Medical Board's policies are. And then I looked and see if there was attention to initial assessment, if there was potentially monitoring for abusable medication, if there was attention to patient education and informed consent, if any dose escalation was justified, if he was not relying on high doses of narcotics, and he was making use of available tools, and –

Q I will stop you right there. What are these available tools? You talked about the ORT and the PDMP. I don't remember you talking about the COMM or the SOAPP.

A Yeah. These are – these tools are as objective as you can get obtaining history from a chronic pain patient. So when a patient tells you, "I am 100 percent improved in functionality. I am 100 percent improved with pain." Well, that is great, but these tools you can use to objectively document what he is [102] saying. Because, you know, improvement of functionality in one person may be different than another. This year may be different than last year or the next year. So these tools we use to ask questions from patients that will direct us to our treatment plan being concerned about misuse and abuse.

We administer – for example, current opioid misuse measures. It is 17 questions. It can go score of zero to four. A score of nine and higher indicates that, "Doctor, this patient may be not using the medication that you are prescribing appropriately." Okay. Maybe. It is not saying, "Don't write prescription." It doesn't say that. It is just a tool. You know, I can not have any tools, stethoscope, any of my doctoring tools, and I have to diagnose a patient. Then I can have an MRI and X-rays and all that. So think of these tools like a pain doctor's X-ray and MRIs to see through the patient and see what is going on.

Q So overall, did you make an assessment based on the Federation of State Medical Boards about Shakeel Kahn's patient files? And was there an adequate attention to initial assessment?

A No.

Q Was there adequate monitoring of potentially abusable medication?

A No.

Q How about attention to the patient education and informed [103] consent?

A No.

Q And talk to us about what you found about dose escalation in the patient files.

A It was rampant.

Q What do you mean?

A It was; every single patient. In particular, starting the first office visit and the second and third, he would just quickly ramp it up. And then after that, it would just stay steady. Here and there he would throw in maybe some methadone, some Xanax, some fentanyl, but his Oxy IR was there. And he was at Oxy IR 30-milligram by the third visit. He was starting with Percocet 10 or Oxy 10 or 15. Go to 20, and then he would use 20 and 30s extensively.

Q Did you find that there was an excessive reliance on opioids?

A Yes.

Q And at high doses?

A Yes.

Q And did Shakeel Kahn make use of the tools for risk management?

A He documented that actually using the tools, and they were positive, yet he continued.

Q Continued to do what?

A Prescribe narcotics.

[104]Q And they were positive for what?

A Positive, "Hey, Doc. Be on the lookout. Your flags need to go up. Do another urine drug screen. Confirm there is oxycodone. Have you have checked PDMP? Did you check the X-rays? MRIs? No." He has the COMM positive, but that is just C-O-M-M means the same thing to you – maybe he did to him. No action on positive COMM.

Q You have also mentioned CDC guidelines. I want you to take a look at Exhibit 7002. It is page 3.

MS. SPRECHER: This has been admitted. Sorry. I should probably be clear for the record. That is a three-page exhibit. I am going to page 3 of that exhibit.

THE COURT: Very well. You may proceed.

MS. SPRECHER: Now, may we publish, Your Honor?

THE COURT: Yes.

BY MS. SPRECHER:

Q You mentioned that you don't have – doctor isn't required to do exactly what the CDC says. It is just giving you suggestions and guidelines, but you did use the CDC guidelines to evaluate Shakeel Kahn's files?

A Yes.

Q And are three things that you found contained in this slide?

A Yes.

Q Could you describe what you found.

[105] A So it was not consistent with the CDC guideline. Determine when to initiate and continue opioids. He failed. Opioid selection dosage duration and discontinuation. He failed. Assess risk and harm of opioid use. He failed.

Q All right. Now is that similar to what you just described under Federation of State Medical Boards?

A Yes.

Q Same similar problems?

A Yes.

Q I want to talk to you about your patient file review, your actual patient file review. You reviewed 22 files.

A Yes.

Q Was one of those files for Deni Antelope?

A Yes.

Q Okay. And when you looked at Deni Antelope's file, did you find there was a thorough evaluation done?

A No.

Q Did you find that Shakeel Kahn considered alternatives to opioids?

A No.

Q Did you find that he used any screening tools?

A No.

Q I want to direct your attention to Exhibit 3000, which has previously been entered into evidence, pages 1 through 24. This is the driver's license of Ms. Antelope, right, [106] Doctor?

A Yes.

Q All right. We were just identifying who the patient is. We have the new patient paperwork.

MS. SPRECHER: Ms. Wait, would you scroll down to the pain contract, please?

Just one second, Your Honor.

We need to go to another program. That program has the pages bookmarked. We know what we are looking for.

Ms. Wait, if you want to go to the initial visit. Scroll down. Go back to the top on that SOAPP. Okay. One more up. There you go.

BY MS. SPRECHER:

Q This COMM, is that the COMM you were referring to before?

A Yes.

Q This particular patient, she filled out the COMM?

A Yes.

MS. SPRECHER: Ms. Wait, would you scroll down one. Another one.

BY MS. SPRECHER:

Q And the SOAPP, you also discussed the SOAPP, correct?

A Yes.

Q And that was also done by Shakeel Kahn?

A Yes.

Q Informed consent. All right. This is on the initial [107] visit, Doctor. This is an informed consent for use of opioids; is that right?

A Yes.

Q Have you – are you familiar with this paperwork, this informed consent of Shakeel Kahn?

A Yes.

Q And does it adequately inform a patient on paper about the things that a doctor should inform a patient about?

A On paper.

Q And if there was no follow-up with this by speaking to the patient, would that be in the usual course of professional practice?

A No.

Q Would it be an adequate way to advise the patient about the dangers of opioid misuse?

A No.

Q Are you familiar with this drug addiction statement, Doctor, that appeared in Shakeel Kahn's files?

A Yes.

Q I want you to look at this drug addiction statement, Doctor, and then continue to refresh your recollection.

A Yes. I have seen this.

Q Have you seen anything like this before?

A This is the only time I have ever seen anything like this. I have been in practice since 1995.

[108] Q Is this something that is presented to a patient in the usual course of professional practice?

A No.

Q Can you think of any legitimate medical purpose why a person would be required to sign this by a doctor?

A No.

Q Do you see at the very bottom where it talks about – right there – agreeing to pay – I can't read that. Are you familiar with the amount of U.S. dollars that has to be paid?

A Yes. "Finally, by signing this release, I agree to pay Shakeel Kahn, its officer and agents $100,000 for each and every action, investigation, complaint or other legal or administrative proceeding."

Q Is this an appropriate way to advise a patient about the care that you are going to give them?

A No.

Q Is that an acceptable way to advise a patient in the usual course of professional practice?

A No.

Q Can you think of any legitimate reason why you would threaten a patient to sue them for $100,000?

A No.

Q Okay. In your review of the files, was this drug addiction statement common throughout?

A Yes.

[109] Q How often did you see it?

A I think every chart had it.

Q Okay. In Deni Antelope's file was there a treatment plan?

A Well, his treatment was writing narcotics, if you call that a treatment plan.

Q Was there ever a referral of Deni Antelope to another specialist, for example, for physical therapy or things like that?

A No.

Q Was there anything about the treatment plan that was designed to avoid or safeguard against diversion or addiction?

A No.

Q The course of treatment that was – was there a course of treatment that was indicated in the treatment plan?

A Yes.

Q As you looked through the file was there any evidence of a continued assessment of opioids as the appropriate course of treatment?

A No.

Q Was there any indication that Shakeel Kahn continued to screen for diversion or addiction or opioid use disorder?

A No.

Q So after that first initial use of the COMM and the SOAPP, you didn't see any other sort of questions or interrogatories about that?

[110] A No.

Q Looking at the choice and implementation of therapy chosen by Shakeel Kahn, what did you notice as the initial prescription of opioids?

A She came and said that she was taking a large number of – a lot of pain medication. He said he did a urine drug screening, and that there was no testing for oxycodone. Supposedly she was taking Percocet. So he says there was opioids, but he didn't test for oxycodone. And he goes and writes oxycodone 15-milligram, 120 tablets. So Dr. Kahn initiated therapy with high dose narcotics. And in this particular patient, her indices for those COMM and SOAPP were both positive, and there was no testing for oxycodone.

Q All right. If those – the COMM and the SOAPP are indicative of abuse or opioid use disorder, and there was no testing, urine drug screen testing, is that outside the usual course of professional practice for pain management?

A Yes.

Q Why?

A Because that is what you do. If the patient says they are taking Oxy, you have got to confirm that it

is present. It doesn't show that the urine contained oxycodone.

Q Did you have an opportunity to review the PDMP?

A Yes.

Q And did that confirm what Deni Antelope was telling Shakeel [111] Kahn or allegedly telling Shakeel Kahn about what she had used before?

A No.

Q And so the first prescription that Shakeel Kahn wrote Deni Antelope was what?

A The first prescription that he wrote was for oxycodone 15-milligram, 120 tablets, and Morphine Extended Release 30-milligrams, 90 tablets.

Q Was there any indication in the PDMP that she had been on any sort of oxycodone recently?

A No.

Q Would that be an appropriate prescription to prescribe to somebody like Deni Antelope?

A No.

Q Why not?

A She wasn't on it.

Q Was she opioid naive at that time?

A Well, the urine showed no use of opioids. She was taking some narcotics, but we don't know what it was. So it may be hydrocodone, hydromorphone – he didn't test specifically.

Q Okay. Were there any subsequent urine screens?

A I didn't see any.

Q Were there any increases in dosages?

A Yes.

Q And were those properly documented for their purpose?

[112] A No.

Q Can you – can you describe that, please?

A Well, patient comes in and says, "My pain is six." And then he writes, "Six; oxycodone." Next time patients comes, "My pain is seven." And he goes to 10. So depending on what you tell him, he will just go up. Never go down. You go back after 10 oxycodone and say, "My pain is six," he doesn't go down.

Q Okay. Would that be appropriate to go down?

A It may be appropriate to go down if patient exhibits side effects, but he didn't document that, and he didn't go down.

Q I want to direct you to whether or not you felt that he made sufficient documentation to support his

clinical decisions. Do you see paragraph 4, page 31 of your report?

A What page? It is not numbered – my pages.

Q Yours is not?

A No.

Q Let me give you an extra copy of 7006.

A Okay. So we are looking at page – okay. Okay. My opinion. Yes. Paragraph 4, yes. "Insufficient documentation and/or support for clinical decision making. Dr. Kahn's record do not support the clinical decision to increase the doses of opioids. He even relies on patient's subjective statements without considering all other objective measures such as work activities, family statements, pain and disability [113] questionnaires or urine drug screen."

Q All right. I want to direct your attention to that, what you just read, why do you say that?

A Because he didn't do those. He relied heavily on high dose narcotics, and he did not document patient's functionality by talking to family or asking about the patient, what they mean by improvement in functionality. He didn't use any tools. The tools that he use are positive, and he totally ignored it.

Q All right. I want to look at the May 10, 2016, visit?

A Yes.

Q And that is page 29.

A Okay.

MS. SPRECHER: Can you find that, Ms. Wait?

BY MS. SPRECHER:

Q You made a notation on the May 10 of 2016 –

A Yes.

Q – visit?

A Yes.

Q That the PDMP record indicated that there was a prescription for oxycodone 15 and oxycodone 30?

A Yes. So the PDMP indicated that he had written those prescriptions on May 10, but there were no progress notes indicating that visit, and the reason why he increased the oxycodone numbers from 120 per month to 150.

[114] Q So if an increase in medication was made without appropriate documentation, would that be within the usual course of professional practice?

A No.

Q Why not?

A Because you have to document it. "Usual course" means that you visited with the patient or a visit occurred, and it was documented. It didn't happen that way.

Q If there is not a documentation for why there was an increase in medication, is the increase in medication for a legitimate medical purpose?

A No.

Q These visits for Deni Antelope continue from the beginning which is April 4 of 2016 when he did the initial assessment, correct?

A Yes.

Q Through several months – all the way up to October of 2016, correct?

A Yes.

Q Looking through the visits, did you notice that there was a special two-week follow-up?

A Yes.

Q When did that occur?

A July 13th, 2016.

Q And what caught your attention about the special two-week [115] follow-up?

A Just the fact that he would call it a special two-week at two for one.

Q What do you mean?

A Well, you get two things for the price of one.

Q Two – what things?

A Two doughnuts, pancakes or prescriptions for narcotics.

Q Okay. So looking at the July 13 visit, would there be any reason to see patients every two weeks when you were seeing them every 30 days?

A No.

Q Does Shakeel Kahn document a reason to do that?

A No.

Q After this special two-week follow-up, was there any indication by Deni Antelope about what her pain relief was at that time?

A No.

Q And are you aware in the special two-week follow-up of what her prescriptions were that were written by Shakeel Kahn?

A So I wrote that he documented – he is writing the same prescription now twice.

Q All right. So he saw her two weeks ago, and gave her the prescriptions of oxycodone – two different dose strengths of oxycodone, correct?

A Right.

[116] Q And then the two-week – special two-week follow-up, he writes the same prescriptions?

A Right.

Q Does he document a need for that?

A No.

Q So now the 30 day dose he gave before, he is now doubling up on?

A Right.

Q And is that in the usual course of professional practice?

A That is not usual.

Q Is there any documentation that it was for a legitimate medical purpose?

A No.

Q I direct your attention to July 29, 2016. Do you see your notes which appear at page 30?

A Yes.

Q Were the same prescriptions written?

A Yes.

Q All right. And were all the same prescriptions given to Deni Antelope on that same date?

A No.

Q Did that cause you concern?

A Yes.

Q Why?

A Because why would you write a prescription now, and then [117] give it to the patient two weeks later?

Q All right. Did you find inconsistencies in Shakeel Kahn's notes; for example, saying that he checked the PDMP when there was no indication that he had done so?

A No. He says he is checking PDMP, but if he checked PDMP on the first visit, then he would have seen that this patient was not on 1000 Morphine milligram equivalent or what she was saying. He says he is checking the PDMP, but the treatment plan is not consistent with what he had observed had he looked.

Q I direct your attention to the August 12th visit of 2016, now on August 12, he indicates that he checked the PDMP. Can you see that on this portion of the exhibit that is in front of you?

A Okay. Yeah. He says he checked the PDMP, but I don't see it in here. So if – he wrote "PDMP checked without issues" way at the bottom.

Q Okay. You noted right here – is that what you are talking about?

A Yes.

Q And you noted in your report that that was contradictory?

A Yes.

Q What did you notice when you checked the PDMP for the same person?

A "However, this is contradictory to the PDMP records of May 10, 2016, at which time patient received additional pain [118] medication prescribed." Either Dr. Kahn did not check the PDMP or pharmacist had not entered the May 10th prescription.

Q All right. And did you see that May 10th prescription?

A Yes.

Q So it was there in the PDMP at some point?

A Yes.

Q I am looking at this page 184 of her patient file, October 28, 2016, do you see all this blank area?

A Yes.

Q What is going on? What did you notice?

A This is a progress note that was not completed, and there is patient vital signs, and there is a nurse's note, and there is no documentation of what happened during that office visit.

Q All right. There should be something that appears in this blank area to indicate that Shakeel Kahn saw the patient, assessed the patient and had a treatment plan?

A That is correct.

Q All right. Would you – there is nothing there at all?

A No.

MS. SPRECHER: Go down to page 185, please.

BY MS. SPRECHER:

Q There is some indication here that something happened. Do you know what that is?

A Well, this is what the patient filled out.

MS. SPRECHER: Okay. Go down a little more please, [119] Ms. Wait, to the prescriptions. Down a little bit more.

BY MS. SPRECHER:

Q It indicates in the patient file there were prescriptions written, but there is no documentation about the treatment plan. Is that appropriate?

A No.

Q And is that within the usual course of professional practice?

A No.

Q Were these prescriptions for a legitimate medical purpose?

A No.

Q We picked out a few of the things that you found throughout Deni Antelope's patient file. Doctor, have you formed an opinion whether Shakeel Kahn prescribed medications to Deni Antelope for a legitimate medical purpose throughout her care?

A He did not prescribe it for legitimate medical purpose.

Q And were these prescriptions that he prescribed throughout her care from April to October of 2016 in the usual course of professional practice?

A No.

Q What is your opinion about his treatment of Deni Antelope?

A Not good.

Q And for the reasons that you mentioned previously?

A Yes.

[120] Q You also did an assessment of an individual named Paul Beland. Are you familiar with him?

A Yes.

Q And he was – in alphabetical order of patients you assessed, he would be third one, correct?

A Yes.

Q In between Deni Antelope and Paul Beland, there was Christopher Bearse?

A Yes.

Q Did you review Christopher Bearse's file?

A Yes.

Q Was he a patient of Shakeel Kahn?

A Yes.

Q Do you remember the date of the initial office visit?

A May 2nd, 2016.

Q And the last office visit?

A In June 30th, 2016.

Q And did you make an assessment of Shakeel Kahn's treatment of Christopher Bearse overall?

A Yes.

Q What was that assessment?

A Well, he – inappropriate selection and management of therapy. Dr. Kahn starts a narcotic naive patient on high dose of narcotics. Errors in monitoring the patient, and Dr. Kahn prescribed high dose opioids urine drug screen shows absence of [121] such.

Q All right. High dose opioids in this case, what would the MME equivalent be?

A 210.

Q And how does that relate to the CDC of daily equivalent should be?

A Way above it.

Q Is it about 90 from the CDC?

A Yes.

Q So this individual, his first prescription that was given to him by Shakeel Kahn to an opioid naive patient was 200 MME?

A Right.

Q Is there a danger with that?

A Yes.

Q What?

A Dying.

Q Why?

A Your breathing rate gets low, and you forget to breathe, and you go to deep sleep and never wake up.

Q Were there also dangerous combinations that were prescribed by Shakeel Kahn to Christopher Bearse?

A Yes. He also prescribed Lorazepam, a sedative that can work synergistically with Oxy, cause more sedation and respiratory depression.

Q Does it appear that Shakeel Kahn used any assessment tools [122] for opioid use disorder?

A No.

Q Did he have Christopher Bearse fill out opioid use disorder –

A Well, actually, he did. He has, "positive COMM."

Q What does that mean?

A He is high risk. Don't go fast. Don't go high. Take it easy.

Q And did Shakeel Kahn's notes support not doing that?

A No.

Q All right.

THE COURT: Are we ready to take our lunch break?

MS. SPRECHER: Yes, sir.

THE COURT: I will simply mention the court's admonition that I usually give. Stand in recess until 1:15. (Jury exited the courtroom.)

(Lunch recess)

THE COURT: Let's bring the jurors in.

MS. SPRECHER: I want to alert the court that we need to finish this witness today. So with the Court's permission, may we go late if we need?

THE COURT: We'll go until we get him done.

MS. SPRECHER: Thank you.

(Off the record.)

THE COURT: Please, be seated.

[123] Ladies and Gentlemen, when we recessed, we had just introduced the subject of Paul Beland.

MS. SPRECHER: Thank you, Your Honor.

May we go to the screens, please?

Thank you.

BY MS. SPRECHER:

Q Doctor, did you review Shakeel Kahn's file regarding Paul Beland?

A Yes.

Q And I am going to direct your attention to Exhibit 3002, which is his file. That will pop up on the screen. The first visit for Paul Beland that was recorded was October 14 of 2015. Are you familiar with that?

A Yes.

Q And did you look at all of the visits that were documented for Paul Beland over the course of the time that he saw Shakeel Kahn?

A Yes.

Q Did you notice anything in the first visit that caught your attention?

A Yes.

Q What was it?

A There was no urine drug screening performed when he was taking a large amount of oxycodone.

Q Why would that be important?

[124] A Because if he is taking oxycodone, you want to confirm that, in fact, he is taking it, and it is present. Especially at the very first office visit when you are establishing your boundaries, your medication agreement with the patient, you have them sign the paperwork. It is a good opportunity to show what a urine drug screen is and why you are doing it, and explain it to the patient, so patient is aware going forward that you may be doing that to confirm presence or absence of medication.

Q Okay. In the first visit, what is your opinion about the appropriateness of the therapy selected by Shakeel Kahn?

A If you look at the Prescription Drug Monitoring Program report, it indicates that the last prescription that Paul Beland got was in May 27, 2015, for 10-milligrams oxycodone, 180 tablets. So he knows that this patient was on oxy back in May, and now it is October.

Q And so when you independently looked at the PDMP is there an indication on this chart towards the bottom that Shakeel Kahn said he looked at the PDMP?

A Well –

Q Right there?

A Yeah. He says he looked at the PDMP, but if he did, he would have noticed his patient was on narcotics back in May. It is October. The question would have been, “Well, what did you do when the prescription ran out? Where did you go? I [125] don’t see anything in here.”

Q Okay.

A “If you are not taking anything” – so if you saw that and he saw there was not any narcotics, then he should assume the patient was narcotic naive unless he asked the patient and the patient said otherwise. If he had done a urine drug screening, so he was shooting in the dark.

Q None of those things were done?

A No.

Q What was the dose that he started Paul Beland on?

A He writes a prescription for – patient was diagnosed with chronic low-back pain and recommended to take oxycodone 30-milligrams every six hours, that means 120-milligrams a day, plus another Oxycodone IR every four to six hours meaning 180.

Q So he has 180 oxy 15-milligram immediate release and 120 oxycodone 30-milligram immediate release tablets?

A Yes.

Q To an opiate naive patient?

A Yes.

Q Is that appropriate?

A No.

Q Is that within the usual course of professional practice?

A No, it is not.

Q And is there any documentation that supports that it was for a legitimate medical purpose?

[126] A No.

Q I want to next direct your attention to November 12 of 2015. You noted in your report that there was an increase dosage on this date?

A Yes.

Q And was there any documentation to support that dose increase?

A No.

Q Why do you say that?

A There is – a documentation means that you have done appropriate assessment what we talked about, subjective/objective, urine drug screening, PDMP, asking those questions about opioid use disorder, those are considered appropriate evaluation. He

didn't document that in here. It is the same copy and paste progress note from one visit to another.

Q So what you are saying is what we see in this –

MS. SPRECHER: Ms. Wait, would you scroll down? I say "down" when I mean "up."

BY MS. SPRECHER:

Q The progress note right here, this paper –

A Yes.

Q – do you see this paper throughout Paul Beland's file?

A Yes. It gets repeated with really minor changes. The major changes are when the prescription changes, the amounts go [127] up or a new drug is added.

Q So all this stuff that we see on this first page of this paper is what you are calling as copying and pasted on the next visit?

A Yes.

Q Does that occur anywhere else in the files that you reviewed?

A Throughout all of them.

Q Is that an appropriate way to keep and manage your records as a professional?

A No, absolutely not.

Q Is it within the keeping of the Wyoming Board of Medicine policy?

A No.

Q How about the Federation of State Medical Board policy?

A No.

Q I want to next take you down to – I want to note to you December 3 of the 2015.

A December 3, 2015?

Q You made a notation in your report about checking the PDMP and noticing that there was a prescription in Rhode Island that was filled. Do you see that on page –

A Yes.

Q Okay. Just to be clear so the jurors know, you were able to check the Wyoming PDMP and the Arizona PDMP. Did [128] Investigator Churchwell supply you with other PDMP information from other states?

A Yes, they did.

Q Did that include information from Rhode Island?

A Yes.

Q And so that PDMP – that information is how you checked the PDMP from Rhode Island?

A Yes.

Q What happened in December of 2015 that caught your attention?

A There was one visit, but two prescriptions for the same drug for the same amount in two different states under two different DEA registrations.

Q Is this for Paul Beland?

A Yes.

Q And what is the prescription for?

A The prescription is for oxycodone 15-milligram, 180 tablets.

Q And that was the same prescription for both locations?

A Yes.

Q What about that concerns you?

A It is not medically necessary. There is no legitimate medical reason for second prescription, and it is outside the usual course of practice. You don't write two prescriptions for the same medicine on the same day.

[129] Q For the same period of time to be taken?

A Yes.

Q Directing your attention to January 5th of 2016, there is a note that you made, again, about the Rhode Island PDMP. Do you see that?

A Yes.

Q What happened on January 5th of 2016?

A The same thing as December 3, 2015.

Q All right.

A Double prescription.

Q Was there any office visit or notes that corresponded with this prescription?

A There is no progress note in the chart indicating this, no.

Q All right. And would that also be outside the usual course of professional practice?

A Yes, it is.

Q Does that make those not for a legitimate medical purpose?

A Yes.

Q Moving on, I want to direct your attention to April 8. On that date, there is a prescription for a different drug. Do you see that?

A Methadone 10-milligrams, 90 tablets.

Q Were there any progress notes made about why that was prescribed by Shakeel Kahn?

A No.

[130] Q And would that be outside the course of professional practice?

A Yes.

Q Is there any dangers about prescribing methadone without giving appropriate counseling?

A Many.

Q What are those?

A The most important thing about methadone is how it works in your body. It takes two to three days for methadone to stabilize in your body when you start taking it. It is only then that you will know if methadone is working for you or not, as opposed to Norco that if you took it right now, you would know within one hour if Norco is good for you or not, if it is helping. With methadone, you don't. So the doctor prescribes methadone. He doesn't tell you about this. You think it is a pain pill. You have always taken your pain pill one or two tablets every four hours which is how you always remembered it, and so you take one pain pill. You don't see any difference. You take a second one, you don't see any difference. You wait four hours. And you take a third one. You don't feel a difference. Once you take a fourth one, a couple hours after that, you are dead.

So it is that particular characteristic about methadone that makes it extremely dangerous. It is a very good medicine. It is cheap. It is very cheap. It is very [131] affordable, and it works really well. But look at the side effects, and look – if I don't tell you about how it is going to creep up on you and kill you.

The second thing about methadone is that it can slow down your heart, and your heart can stop working. It prolongs the QTC interval in your heart.

Heartbeat starts getting slow. Your breathing slow, and then you are dead. Methadone is a very dangerous drug. You can prescribe it, but extreme caution is required and proper documentation in the chart every single time that you start it, increase the dosage or when you stop it. It is just not a simple thing. It is not Tylenol. "Take a Tylenol. Call me in the morning." It is not that. It is very different.

Q Is it important to do EKGs for individuals who are taking methadone?

A Yes.

Q Why is that?

A Because it can slow down your heart rate, and it is recommended that you do EKG before initiation of therapy, 30 days after and then annually, or if there is any change in the patient's condition.

Q And looking at Shakeel Kahn's medical records for Paul Beland, was he ever given an EKG before starting methadone?

A No.

Q Or after receiving methadone?

[132] A No.

Q Was methadone continued again in June 8 of 2016, with a prescription in Connecticut?

A Yes.

Q And during this time that Paul Beland was getting methadone by Shakeel Kahn, was he still receiving the same amount of oxycodone?

A Yes.

Q And had also, in addition to that, there been an addition of Xanax?

A Yes.

Q Was there any counseling that was documented in Paul Beland's chart about the lethality of Xanax and oxycodone and methadone?

A No.

Q I want to next move down to your overall opinion of how Paul Beland's treatment corresponded to being within the usual course of professional practice and for legitimate medical purpose. What is your opinion on whether or not the medications prescribed by Shakeel Kahn were for a legitimate medical purpose?

A They were not.

Q And were they prescribed in the usual course of professional practice?

A No.

[133] Q I would like to next look at Dawn Cabana. I will go quickly through these charts and highlight some of the things that you saw. I want to make sure the jurors are clear, did you do a thorough investigation of each chart, Doctor?

A Yes.

Q With Dawn Cabana in her first visit, did you make any opinion about the choice of therapy that Shakeel Kahn made to treat her initially?

A Yes.

Q What do you – what opinion do you have?

A So Dr. Kahn – there is no records of any PDMP in the charts. And so he didn't check the PDMP, and he says that his patient was in Massachusetts Hospital and was prescribed a large amount of pain medication that he was going to consider nonsteroidal antiinflammatory drug.

Q What does that mean to you?

A Like, Motrin, like Celebrex, and that he was going to consider those medications.

Q Was that what he prescribed for Dawn Cabana?

A No, he did not.

Q What did he prescribe for her?

A Oxys.

Q How many?

A 120 tablets of 15-milligrams and 120, 30-milligrams.

Q Is there any documentation that Dawn Cabana had previous [134] experience with oxycodone?

A No.

Q Would you consider her opioid naive?

A Yes.

Q And would – what could these sort of doses do to a person who is opioid naive?

A It can kill them.

Q Is there any indication that Shakeel Kahn counseled Dawn Cabana on that lethality of that drug? Did he counsel her on that danger?

A No.

Q I want to direct your attention to March 28 of 2016, were her medications subsequently increased?

A Yes.

Q And was there any documentation supporting that by Shakeel Kahn?

A No.

Q What were they increased to?

A So Dr. Kahn increased the narcotics again. The prescription for oxycodone 30-milligrams is increased one tablet every four hours to 180 and oxycodone 15 to a total of 180. So he goes from 120 to 180.

Q To both?

A Both; 50 percent increase.

Q Is that a 50 percent increase in MMEs?

[135] A Yes, 50 percent increase on everything.

Q If you were to learn that the patient was unaware that – of this medication increase, would that cause you any concern?

A Yes.

Q Why?

A Because if I increase the pain medicine and I don't tell the patient that I increased it, and he looks at the bottle and he trusts me – I am the doctor. I am supposed to know. "My doctor knows. He told me to take this. I am going to take it." If I don't tell him, "Hey, I increased it," but with that goes increased risk of respiratory depression. So the patient is going to take, and then they die. We all look at the prescription bottle. We trust our doctors – what your doctor said, "Well, he must know. If he gave this to me, he must know," that is what the patients expect from us.

Q So the difference in the pill bottle is that they are taking it more often?

A Yes.

Q Okay. As prescribed by the doctor?

A As prescribed by the doctor.

Q Is there any indication in Dawn Cabana's chart that she was counseled on the increase in medication or the danger of that?

A No.

Q Did you observe boilerplate notes similar in Paul Beland's chart in Ms. Cabana's chart?

[136] A Yes.

Q Dr. Shay, in your opinion, were the medications prescribed by Shakeel Kahn for Dawn Cabana done for a legitimate medical purpose?

A No.

Q And were they in the usual course of professional practice?

A No.

Q I want to talk to you about this. When we look at the increase in the dosages, I noted that you said there was an increase by 12,000 percent and 3,150 percent over three months. Do you see that?

A What page are you looking at?

Q I am looking at page 40, first paragraph of your opinion.

A Okay. Yeah.

Q I will give you a chance to look at it, if you want a second.

A Yes. Dr. Kahn increases the pain medication significantly. He increased the total dose of narcotics by 1,200 percent by changing from Norco 20-milligram a day to oxycodone 180-milligrams a day on the first visit. 1,200 percent on the first visit. The dose was then

increased to to 420-milligrams of oxycodone, or 3,150 percent in three months.

Q And does this go against the philosophy of doing little changes at a time?

A Yes, it does. Specifically Dr. Kahn said that he was going [137] to consider nonsteroidal antiinflammatory drugs but that was a lie. Instead, he –

MR. BRINDLEY: Objection, Judge.

MS. SPRECHER: Stop.

THE COURT: Sustained. The jury will disregard.

BY MS. SPRECHER:

Q You can say what he said in there, and then say what happened, but you can't say what you –

A Okay.

Q – what your opinion is on that.

A Okay. He said he was going to consider nonsteroidal antiinflammatory drugs, but he never did. Instead, he went up by 3,150 percent on oxycodone.

Q For what purpose would a medical practitioner document they were considering nonsteroidal antiinflammatory drugs and not do it?

A Just giving the illusion of practicing medicine, filling the chart.

Q Moving on to James Campbell, you had an opportunity to review the file of James Campbell.

A Yes.

Q Looking at his – looking at his initial visit which is March 29 of 2016, and referring you to your report on page 42, did Shakeel Kahn again prescribe high dose opioids to what appears to be an opioid naive patient?

[138] A Yes.

Q What increase did you observe?

A Dr. Kahn recommends oxycodone 30-milligrams every four hours, that is 120 tablets; plus, oxycodone 20-milligrams another 120 tablets to this patient on the first visit, and this patient had been previously only hydrocodone.

Q And not to the extent or the levels that were prescribed by Shakeel Kahn?

A No.

Q You also noted that over the course of the treatment of James Campbell by Shakeel Kahn that there were significant dosages increases?

A Yes.

Q That his dosage of oxycodone were increased 13 times in two months; is that right?

A The total dose of Morphine Milligram Equivalent was increased. This is – so on May 27 after he

wrote his prescription, what the patient was taking was 420-milligrams of oxycodone per day. This patient's narcotic dose was increased 13 times in a span of two months.

Q Okay. Is there any documentation in the patient file to support that change?

A No.

Q I want to ask you a question about the patient files in general. Do you see this page in front of you, which is from [139] May 27, 2016?

A Yes.

Q Do you see how the writing – the typing is kind of at an angle?

A Yes.

Q Did you see that type of angling or not lining up quite often in these patient files?

A I don't specifically recall that.

Q You don't? Okay. Was James Campbell's file another example of a copy and paste?

A Yes.

Q James Campbell also was prescribed methadone by Shakeel Kahn; is that right?

A Yes.

Q Was that also – was that documented, the reason for it, in the patient file?

A No. There is no documentation. There is no progress notes on July 11th when he wrote the prescription for methadone.

Q And so there is no indication that there was counseling like the sort that you discussed earlier?

A No, there is none.

Q In your opinion, Dr. Shay, the prescriptions that Shakeel Kahn prescribed over the course of the time that he treated him, were they for a legitimate medical purpose?

A No.

[140] Q And were they prescribed in the usual course of professional practice?

A No.

Q Corissa Dickinson is a little different. Did you also treat Corissa Dickinson?

A I did.

Q And did you in – when looking at Corissa Dickinson, let's first see when she was treated by Shakeel Kahn. The first documented visit is June 27 of 2016. Do you see that?

A Yes.

Q Now, this particular exhibit on page 12 has nothing in the progress notes section.

A Nothing.

Q But were there prescriptions prescribed?

A Yes.

MS. SPRECHER: Are you showing them?

BY MS. SPRECHER:

Q And you know that by checking the PDMP that there were prescriptions prescribed?

A Yes.

Q Does this continue this no documentation throughout the course of her time spent with Shakeel Kahn to October 28, 2016?

A Yes.

Q Yet there were still prescriptions prescribed?

A Yes.

[141] Q All right. Dr. Shay, in your opinion, were the medications that were prescribed to Chorissa Dickinson – and I should be specific. What did she get prescribed?

A She was prescribed oxycodone, hydromorphone – those two.

Q Throughout the course of her seeing him?

A Yes.

Q Were they for a legitimate medical purpose?

A No.

Q Were they prescribed in the usual course of professional practice?

A No.

Q Did you see an increase in dosage from the first visit to the last visit?

A Yes.

Q What did you see?

A So this is page – they increased. I can't find it – where I said that.

Q Okay.

A Do you know where I said it? What page it was?

Q No. But you are familiar with the file? You are familiar with the file and that they did increase?

A Yeah. They did increase. Yes. It did increase.

Q All right.

A I don't recall specifically what percentage. It is 126 pages they I –

[142] Q Right. What I would like to show the Ladies and Gentlemen of the Jury is what you put in your report, which has some progress notes. Do you recall that?

A Yes.

Q And I am looking at page 44, 45, 46 and 47. Why did you include this information?

A Page 44 is – I saw this patient on May 5th, 2016.

MR. BRINDLEY: Your Honor, I have to object at this time. I do not believe that Dr. Shay's report itself has been admitted into evidence. I think that is what we are looking at, unless I am confused.

THE COURT: I don't think it has been shown to the jury. It's all right.

MR. BRINDLEY: Oh, I thought he was showing it to the jury. That is my mistake. I'm sorry.

THE COURT: It should be muted.

BY MS. SPRECHER:

Q So you put this particular – can you see that?

A Yes.

Q You put these notes in here which were taken from your file as an example of what you think the best practice is; is that right?

A Yes. And this is only a part of it. It is not all of my evaluation. This is my assessment and plan. Remember we said subjective and objective, and then that was much more. But [143] this is the assessment and plan that is in here, which is based on what this patient told me. It was important for me to put this

down in here for the jury to understand what a pain doctor does.

Q All right. So what you are saying is that these are part of what would be your progress notes and treatment plan –

A Yes.

Q – but what you did not include was, like, the intake forms?

A Yes, all of them.

Q The SOAPP, the COMM and all of that?

A Yes.

Q And would this demonstrate to you what you are looking for when you are reviewing a medical physician's records?

A Yes.

MS. SPRECHER: Your Honor, I would offer Exhibit 7006, pages 44, 45, and 46, please, and 47?

MR. BRINDLEY: Judge, I would object to these pages constitute hearsay. These are not medical records that we have agreed to. These are portions of the doctor's expert report. He can testify to his opinion. He can testify to what he did, but I would object to the admission of these documents as an exhibits because they constitute hearsay. His restating of various notes that he took about this patient and some over time.

[144] MS. SPRECHER: It is not offered for the truth of the matter. It is offered as an example or demonstrative aid for the jurors to understand what Dr. Shay is looking for.

THE COURT: Objection is overruled. It will be received for that limited purpose, Ladies and Gentlemen, not for the truth of anything that is stated in there, other than the fact that this is the nature of his things that he looked for.

BY MS. SPRECHER:

Q Now, Doctor, I don't want you to read this whole thing, but just go through –

THE COURT: Tell me again what are the numbers.

MS. SPRECHER: It is Exhibit 7006, pages 44 through 47.

THE COURT: It will be received for that limited purpose.

(Exhibit 7006 was received in evidence.)

THE COURT: You may proceed.

MS. SPRECHER: Thank you.

BY MS. SPRECHER:

Q So, Doctor, what information are you documenting for yourself or whoever might review the records in this treatment plan?

A This patient has chronic pain. I know that as a pain doctor. Now how am I going to go about treating it? We go [145] back to the principles. And you start with the least aggressive, and you go to the most invasive, and you want to make sure that concurrent disease like depression/anxiety is not present, number one. This patient to me was also about anxiety and depression, number one. That is what I concentrated on. I said, "I don't want to do any injections. There is really nothing surgical. So what we want to do – consider physical medical treatment at the beginning. And once you are more stable, and I can assess you at that condition, then I can consider more invasive treatments or narcotics or interventional pain therapy."

This is important as a doctor when you are treating a pain patient, your number one concern is to make sure that anxiety and depression other things than pain are not presented as pain, and you are not treating patients for depression with pain medicine. And this patient highlights that.

Q All right. So, for example –

MS. SPRECHER: If I touch the screen, it still works, Becky, right?

COURTROOM DEPUTY: Yes.

BY MS. SPRECHER:

Q As you go through looking at those things, do you caution her, for example, you say, "The medication might interact and cause severe sedation"? Do you talk to her about things like that?

[146] A That is I am documenting that a real conversation is occurring. And it is not the same paper you just sign and put it in the chart. It is real, and I am discussing it with her. She is an individual patient. It is not like just a bunch of cheap comments here, and I am writing a prescription. She is an individual patient. I am having an individual conversation with this patient, and I am telling her that she needs to seek counseling, and she needs to address the issue with the depression. I am counseling her about the problems with the medication. This is what we are talking about in here.

Q Well, she has another visit with you on May 4?

A Yes.

Q That is not necessarily with you, but with somebody else?

A Yes. This is with Abigail Bell.

Q Then at some point she transferred to Dr. Kahn; is that right?

A Yes.

Q And when you look at this, do you see then the information that you were looking for before?

A You know, it was – this was an easy chart for me to look at, because there was nothing in it. I looked at the Prescription Drug Monitoring Program report, and I saw those drugs listed. I went looking for the progress notes. I didn't find them, so this went rather quickly.

Q And then she comes for another visit?

[147] A Yes.

Q All right. And what did you do in that visit?

A So Dr. Kahn is no longer in practice of medicine, and she comes back and says, "Dr. Kahn was giving her oxycodone up to 10 tablets per day, and 30-milligram – oxycodone 15-milligrams every four to six hours." And then Abigail Bell reviewed the PDMP and documented that she had received so much narcotics in between, and no additional narcotics were prescribed. So that is what you do. You review the PDMP. We believe the patient. She says she has pain. At that time, we believe her, but we didn't give her any narcotics. She still had plenty, but we talked to her about considering rotating to buprenorphine, which is another drug. It is a narcotic also, and we are going to see her back for pain control after that.

Q Eventually she comes to you on March 23, 2017, with a problem.

A Yes.

Q What do you do? What is the problem?

A She comes back with her husband, and she reports a long history of chronic pain associated with multiple abdominal surgeries. She has come to be dependent on oxycodone in excess of 50-milligrams a day and sometimes up to 100 milligrams a day. And she has been running out of her medication early. So when they run out, we say, "What is was going on?" She has tried

to cut back. So this is the patient telling you they are [148] running out early. They are trying to cut back. These are signs of opioid use disorder. She is out of her medication, and that she and her husband, they decide that – they realize, "Hey, this is – narcotic is not really the thing for us. We want to get off narcotics." They wanted to be switched to Suboxone, which is treatment for opioid use disorder.

So, yes, she does have chronic pain. Now the diagnosis is not chronic pain. It is opioid use disorder. Chronic pain moves to the second on the order. Opioid use disorder becomes the problem. This is when we recommended consideration for Suboxone.

Q When reviewing Corissa Dickinson, did you form an opinion about whether or not the medications he prescribed to Corissa Dickinson were for a legitimate medical purpose?

A No.

Q They were not?

A They were not. Patient had legitimate medical reason. When a doctor sees a patient and documents, but if the doctor just documents and writes a prescription, then the doctor did not write that prescription for a legitimate medical reason. That doctor didn't know. In the beginning this patient says, "I have chronic pain." Here is the prescription, that is not legitimate. Legitimacy means that you have evaluated the patient that gives an evaluation legitimacy to that prescription.

[149] MR. BRINDLEY: Your Honor, object to the witness defining the terms legitimacy, because that is a legal term that will be defined by the court, or I would at least – I'm not sure – I guess that may be his opinion of what legitimacy means, but I would like the court to advise the jury that the legal definition of legitimacy will be provided by the court at a later time. It is not the doctor's place to be defining those terms.

MS. SPRECHER: Your Honor, I have the same response to the same objection.

THE COURT: He may express his opinions. Overruled.

BY MS. SPRECHER:

Q Dr. Shay, the initial dose of oxycodone 30-milligram at 120?

A Yes.

Q And 15-milligrams at 120, what is your opinion on starting Corissa Dickinson on that?

A If the patient was not on that high dose before, that is totally inappropriate.

Q Is there any indication in Shakeel Kahn's notes that she was?

A No.

Q And so were they prescribed in the usual course of professional practice?

A No.

[150] Q I want to move next to the review of Stacy Drndarski, that should be at page 48. And for the record, I am using – we have Bates stamps on this particular exhibit. So I am using the page number at the bottom of everyone's exhibit.

BY MS. SPRECHER:

Q Looking at Ms. Drndarski's patient file, we have it on the screen. It appears that she first went for an initial visit to see Shakeel Kahn on January 25 of 2012?

A Yes.

Q And you made some notes about that initial visit. Do you see that?

A Yes.

Q And we see here the patient file that you were looking – page 8 of the patient file, what notes did you make regarding this initial visit?

A So the review of Prescription Drug Monitoring Program database of Arizona indicated that this patient has never been prescribed full agonist opiates prior to her visit with Dr. Kahn. And Dr. Kahn had documented that the patient was taking oxycodone 30-milligram and Dilaudid 8-milligram for breakthrough pain. There was no documentation of the PDMP. There was no urine drug screening or review of the previous medical records indicating that anyone had diagnosed her with any condition and given her those medications.

Q All right. So although a doctor should ask for prior [151] medical records, there should be a purpose behind it? They should look at them, right?

A Yes.

Q And use them to develop a treatment plan?

A Yes.

Q Not to just put in a file and let it sit there; is that right?

A Yes.

Q The first prescription that was prescribed to Stacy Drndarski by Shakeel Kahn is – it appears to be a 30-milligram oxycodone tablet, 180 of them; is that correct?

A That's correct.

Q In addition, she got Percocet 10-milligrams tablets, 90 of those?

A Yes.

Q And as well as Flexeril, 10-milligramss three times a day. So there was 90 of those. What is Flexeril?

A It is a muscle relaxant.

Q She was also given Xanax, 2-milligrams three times a day; is that right?

A Yes.

Q So there is that lethal combination again?

A Yes.

Q Is there any indication in these notes that he counseled Stacy Drndarski about that?

[152] A No.

Q And what – is this a high dose to give a person who potentially – who has this history that Stacy Drndarski does?

A Yes. Not only that, she was prescribed Suboxone previously by PDMP – looking at the PDMP. If I am seeing Suboxone, I'm going to be asking the patient, "Did you have a problem with narcotics, and someone had to treat you with Suboxone?" That is what we would ask the patient. That never occurred here.

Q Again, do you see the "copy and pasted" habit repeated in the Stacy Drndarski file?

A Throughout.

Q I want to skip ahead to May 21 of 2014. There is a note that you have on page 48 of your report. What is it that caused you concern of this May 21 visit?

A He increased the Xanax, and he didn't explain why.

Q Is there any indication that there was any counseling to Stacy Drndarski about this?

A No.

Q Let's look at October 11th, 2013, which is at the bottom of page 48. In your notes, you note that she has returned after a year absence; is that correct?

A Yes.

Q All right. And what was your concern about the way that prescriptions were prescribed by Shakeel Kahn?

A This is more than a year. Last time she was seen was [153] July 1 of 2012. Now it is October 11, 2013. Patient returns after almost one year of absence. There is no explanation as to what has occurred in the interim. Dr. Kahn indicated that the patient is taking oxycodone 30-milligram for chronic pain relief. Patient reports 100 percent reduction in pain and 70 percent improvement in functionality. Prescription for oxycodone 30-milligram, one tablet four times a day. 180 tablets were given. And he does a urine drug screening. He writes "patient shows benzos and opioids." So to me, opioid is hydrocodone, so there is no evidence of oxycodone.

Q And does – did you also review the PDMP?

A Yes. PDMP does not show that any oxycodone has been prescribed.

Q So that high dose of narcotics prescribed after not having it prescribed for that long of time, was that dangerous?

A Yes, because the patient should have been considered to be naive even though there was urine drug

screening that showed positive opioids, there was no oxycodone.

Q And would that be outside the usual course of professional practice?

A No. She would not be naive, but going from oxycodone that much when the patient wasn't on anything before would be.

Q Would be outside?

A Outside the course of practice.

Q Is there any indication that it was for a legitimate [154] medical purpose?

A No.

Q Now, Doctor, when a person –

THE COURT: Let me interrupt you for a second. There is a stamp on these what is being shown on the screen. That was added by your office?

MS. SPRECHER: No. That is what the pharmacy puts on there. It is the paper. So it is a device to ward against forgery – watermark, correct?

THE COURT: I'm going to ask the jury to disregard.

MR. BRINDLEY: It is not an indication that the prescription was illegal or that anyone did anything wrong – oh, okay.

May I explain, Your Honor?

THE COURT: Yes.

MS. SPRECHER: What happens is, if it gets copied, this appears. For example, if a patient was to go photocopy it to try to get two prescriptions filled, this would appear through the photocopy.

THE COURT: Magically.

MS. SPRECHER: Yes, magically.

BY MS. SPRECHER:

Q Doctor, if a person who was opioid naive who gets a prescription of this magnitude, and they don't die, what is the risk of addiction?

[155] A It is very high. And when – you can rapidly develop a dependency tolerance. And taking it for seven days, 10 days it is fine, you can get off, but when you go past the third week, it becomes hard.

Q I want to keep going through Ms. Drndarski's records. Looking at July 17 of 2014, here you note in your report on page 49 that there is an addition of Suboxone. Can you explain why you noted this?

A Because Suboxone is given for treatment of opioid use disorder. This patient is not documented that she has opioid use disorder and was prescribed Suboxone. The patient had returned and complained of muscle spasm that causes her to lose vision, and Dr. Kahn wrote the prescription for that condition.

Q He wrote the Suboxone for that condition?

A Yes.

Q Is there –

A He wrote this cervic algia. Doctor – he writes it is for neck pain, but the patient is telling that she has muscle spasm, that she is losing her vision. When someone tells you that and you write Suboxone, that just don't exactly go together.

Q All right. So is it your opinion that that was not for a legitimate medical purpose?

A No.

Q And was it outside the course of professional practice?

[156] A Yes.

Q Additionally, is there an indication in this progress note that she was counseled on how Suboxone and oxycodone counteract each other?

A No.

Q Over the course of time that she continues to Shakeel Kahn, she – does she continue to get oxycodone prescriptions?

A Yes.

Q And do you continue to see cut and paste notes?

A Yes.

Q I'm going to move to October 14 of 2015.

A Yes.

Q Directing your attention to your note on October 16th of 2015, what was your concern about the prescription that was written that corresponds to these dates, October 14 and 16 of 2015?

A I didn't see any progress notes for those dates.

Q For the prescriptions?

A Yes.

Q And what you are noting is that there was a prescription written on October 16th and filled on October 23?

A Yes.

MS. SPRECHER: Ms. Wait, would you go back up a little bit?

[157] BY MS. SPRECHER:

Q So this progress note is for October 14?

A Right.

MS. SPRECHER: And then go down, Ms. Wait. Thank you.

BY MS. SPRECHER:

Q So what is in here, in your opinion, is not supporting the prescription?

A No. On October 16, he writes that prescription.

Q All right. Then I would like to go to August 25. Do you see this at an angle?

A Yes.

Q Was that something that you did, or did they come to you that way?

A Came to me that way.

Q Okay. On August 25, you made notation about the prescription that was written by Shakeel Kahn for Stacy Drndarski both in Arizona and Wyoming. Do you see that?

A Yes.

Q What was your concern about that?

A Two states the same prescription is not acceptable.

Q All right. And I'm going to show you Exhibit 2033.

MS. SPRECHER: On the overhead, please. This has already been entered into evidence.

[158] BY MS. SPRECHER:

Q So, Doctor, does this chart demonstrate the concerns you have?

A It does.

Q And how does this support that these are not for legitimate medical purpose?

A I don't see any legitimate medical purpose for this amount of pain medication to an individual.

Q We are talking about quantity and strength overall. And then when you look at the prescriptions themselves for – so the red prescriptions have to do with the prescriptions that were written on the Arizona DEA registration. The greens ones have to do with the ones written on the Wyoming DEA registration from Shakeel Kahn. What do you see that is wrong with those?

A There is overlap –

Q And so –

A – within the state – and within the states, inter and intra state, you can call it.

Q So what you are saying is that this August 25th is overlapping with October 16?

A Yes.

Q So there was a 30-day supply prescribed, but they are filling it before 30 days is up?

A Right.

[159] Q Then October 16 there is another 30-day supply written to November 5th?

A Right.

Q What causes you concern about this type of prescription?

A Just a lot of overlap.

Q So if the prescription was legitimate assume for August 25 of 2015, would there be any legitimate reason to have the same prescription written on September 14th, 2015?

A No.

Q So in your opinion these overlap of prescriptions, are they also outside the course of professional practice?

A Yes.

Q Dr. Shay, in your opinion were the medications overall for the whole time that Shakeel Kahn prescribed to Stacy Drndarski prescribed for a legitimate medical purpose?

A No.

Q Were they prescribed in the usual course of professional practice?

A No.

Q Are there any special precautions that have to be taken with individuals both being prescribed opioids that live in the same household?

A Yes.

Q Why?

A So the husband will have access to the wife's, and wife [160] vice versa. And God knows, who is going

to break up with whom, and who is going to get angry, and not that it doesn't happen, but extra precautions and counseling needs to occur.

Q Okay. It appears that David Drndarski's first visit was January 30, 2012. And on page 54 of your report, you made some notes that concerned you about these patient notes. What do you see?

A Well, there is no documentation of the urine drug screening or PDMP check on the first visit.

Q And nonetheless was David Drndarski prescribed opioids –

A Yes.

Q – by Shakeel Kahn?

A Yes.

Q Were they high dose opioids?

A Yes.

Q What was it?

A He was prescribed – let's see – oxycodone, 30-milligram, 180 tablets.

Q Does that carry the same danger that you described before?

A Yes.

Q Is there any indication he was counseled about that?

A No.

Q Next move to June 4th, I guess he got more than one oxycodone. He got 180 oxycodone 30s and 120 oxycodone 15s?

A Yes.

[161] Q And additionally got Xanax?

A Yes.

Q And again no counseling on the dangerousness of that mixture?

A Yes.

Q I would like to move to June 4, 2012. Do you see your note on page 54 and 55, Doctor?

A Yes.

Q Did you have a concern about what was going on in this particular visit?

A Yes.

Q What was your concern?

A So the patient has some withdrawal and Dr. Kahn continued to write high dose narcotics while attempting to treat withdrawals with Suboxone, which is opioid use disorder.

Q Why is that a problem?

A You do not give patients both oxycodone and Suboxone at the same time for treatment of the pain and side effects.

Q He was also prescribed Xanax, as well?

A That is even worse.

Q And is there any indication that he was counseled on that?

A No.

Q Is there anything in the record that supports that that should have been done?

A It should have been done.

[162] Q And in your opinion, was this prescribing habit outside the usual course of professional practice and not for a legitimate medical purpose?

A Yes.

Q Moving forward to November 4th of 2013, while we are moving there, I want to make sure, Doctor, you looked at all the visits between these two dates; is that right?

A Yes.

Q Did you find any legitimate medical need for the prescriptions that were given by Shakeel Kahn to David Drndarski?

A No.

Q Would they all be outside the usual course of professional practice?

A Yes.

Q You had a concern on this date, which I believe is November 4th of 2013. Your note is on page 57.

A November 4, 2013 – okay.

Q It appears that there, again, is the Suboxone again; is that correct?

A Yes.

Q Is that the same problem you just talked about?

A Yes.

Q He is sill getting the oxy drugs as well as the Suboxone?

A Yes.

[163] Q I would like to move down to May 21, 2014. Did you also observe in this patient file that there were cut and paste progress notes?

A Yes.

Q You noted that a few times in your report, but I want to direct you to May 21 of 2014. Do you see what you have written there?

A Yes.

Q And so if there is a cut and paste progress note that indicated that a person returns to the office for a follow-up of his chronic low back pain which I am looking at page 204 of Exhibit 3007, but there is also a progress note that says he can't keep his appointment –

A Yes.

Q – those seem in conflict. Do they to you?

A Yes. That's what happens when you copy and paste.

MR. BRINDLEY: Objection; speculation, Judge.

THE COURT: Overruled.

BY MS. SPRECHER:

Q And if, in fact, he wasn't making his appointments, but they say that – but Dr. Kahn says he was, is that within the scope of medical practice?

A No.

Q Shakeel Kahn also indicates throughout his medical record that he is checking with the PDMP. Are there occasions that [164] you actually see where he has checked the PDMP? For example, he has a copy of the PDMP?

A Right.

Q Did you see that very often in the other patient charts?

A No.

Q And Paul Beland's to be clear happened early on, but not throughout the time he Shaw Shakeel Kahn?

A That's correct.

Q Moving forward to September 3 of 2015, you noted here, Doctor, the same problem for Stacy Drndarski. Do you recall that?

A Yes.

Q And what is that problem?

A Two prescriptions two states.

Q All right. And are they prescriptions for oxycodone?

A Yes.

Q And are they prescriptions for 30-day supplies of oxycodone?

A Yes.

Q And showing you Exhibit 2032, again, we see a similar pattern to the one we just looked at. Is there any – does this exhibit change your opinion about whether these were prescriptions for a legitimate medical purpose?

A It confirms it.

Q Confirms that it was not?

[165] A Yes, it wasn't.

Q For what reasons?

A For pain. It was not for pain.

Q Doctor, in your opinion were any of the prescriptions written by Shakeel Kahn for David Drndarski done for a legitimate medical purpose?

A No.

Q Were they prescribed in the usual course of professional practice?

A No.

Q You also reviewed a file of a person named Debra Elkboy. Do you see that on page 52 of your report?

A Yes.

Q You made some initial observations about the first visit which was April 1 of 2016. Do you see that?

A Yes.

Q What concerns did you have?

A So he says that he checked the PDMP, but the PDMP indicates that this patient had visited multiple physicians in the past and obtained prescription narcotics with the last prescribed narcotics in June of 2015. That was for tramadol, which is a weak narcotic. There is no indication that this patient was prescribed oxycodone prior to her visit with Dr. Kahn; however,

the patient's urine shows evidence of opioids, and no indication of oxycodone. The presence for opioids in the [166] urine – absence of prescription for it in PDMP indicates that the patient had obtained narcotics through other means; however, this point is totally ignored. He says he reviewed the PDMP. But if you did, then what happened to this? Didn't you see this?

Q So there is no objection in the progress note that he saw it or counseled Ms. Elkboy about that?

A No.

Q Were prescriptions written?

A Yes.

Q Did they continue to increase in strengths over the time that Shakeel Kahn saw Debra Elkboy?

A Yes.

Q Which appears to be until October 28 – excuse me – August 12th of 2016?

A Yes.

Q You have an opinion about the treatment of Debra Elkboy by Shakeel Kahn there on page 64 of your report.

A Yes.

Q What is your opinion?

A There was no legitimate medical purpose to start a narcotic naive patient 180-milligram of oxycodone per day.

Q That is what Shakeel Kahn did?

A Yes.

Q What else did you observe about Shakeel Kahn's treatment of [167] Debra Elkboy?

A Inappropriate selection and management of therapy, errors in patient monitoring, patient assessment for risk and contraindications to opioids; insufficient documentation to support clinical decision making; failure to take psychiatric or abuse history, and patient reported that she took her mother's Xanax. This should have prompted Dr. Kahn to further inquire about the use and abuse of drugs. That is why we ask about psychiatric history, past medical history, family history – communication errors with the patient and their family; clearly did not obtain appropriate informed consent from the patient. He prescribed the patient high dose narcotics.

You have to tell the patient that was in error. Patient factor including noncompliance with the plans. So he didn't discuss negative urine for oxycodone with the patient. "If you are telling me you are on oxy, there is none. So can you explain that?" He doesn't.

Q So he does a urine drug screen, doesn't see oxycodone, but doesn't stop the prescriptions and doesn't counsel the patient?

A He didn't say anything.

Q And I directed you to the wrong page. There is a Debra Elkboy and a Denissa Elkboy. The summary of Denissa Elkboy was at page 64. That was only a one-page report or –

A Yes.

[168] Q – evaluation by you.

A Yes.

Q Denissa Elkboy was 18 years old at the time she started to see Shakeel Kahn on June 10 of 2016; is that right?

A That's right.

Q And what you reviewed and observed was what you just told us?

A Yes.

Q Now, I want to go back to Debra Elkboy. I am sorry I made that mistake.

For Debra Elkboy, your opinion that you found was on page 53. What was your opinion about whether or not Shakeel Kahn's treatment of Debra Elkboy was outside the usual course of professional practice?

A Dr. Kahn's treatment of this patient was a gross violation of acceptable medical practices.

Q Why?

A In the span of four months –

Q I said why. Why was it outside?

A In the span of four months, patient became dependent on 120-milligram of oxycodone per day; 200 tramadol and 3 Somas per day. This is on page 63, Debra Elkboy.

Q Is there any justification in the patient notes kept by Shakeel Kahn that indicates that this was an appropriate way to treat her?

[169] A No.

Q And were any of these prescriptions for a legitimate medical purpose?

A No.

Q I want to ask you quickly about Brian Hatcher. He appears at page 66. You had an opinion about the prescribing practices of Shakeel Kahn as they related to Brian Hatcher, were they outside the usual course of professional practice?

A Yes.

Q Was there any indication in the patient file that they were for a legitimate medical purpose?

A No.

Q What was Shakeel Kahn prescribing Brian Hatcher?

A He was on oxycodone 30-milligram 180 tablets. That's six tablets, and oxycodone 15-milligram oxycodone, 150 tablets a month, that's five tablets.

Q Was there any documentation in Brain Hatcher's patient file to support that?

A There is no progress notes at all in his chart.

Q Okay. Did it look similar to that of Corissa Dickinson?

A Yes.

Q You also reviewed a patient file for a person named Reynold Hereford.

A Yes.

Q Mr. Hereford started seeing Shakeel Kahn on May 10 of 2016, [170] and that continued until October 7th of 2016. Did you review those records?

A Yes.

Q And did Shakeel Kahn prescribe opioids –

A Yes.

Q – for Mr. Hereford?

A Yes.

Q Did you find any legitimate medical purpose for those opioids contained within the patient file?

A No.

Q And was the prescribing of those outside the usual course of professional practice?

A Yes.

Q Could you briefly describe why?

A So inappropriate selection management of therapy, he initiates opioid therapy with negative urine drug screen for opioids. And he should have considered other measures. He didn't. On presentation patient stated he was on Morphine, but the urine drug screening was negative for it, so that is what he was saying. He should have considered a false negative, noncompliance or diversion. He should have said it in his records, and he didn't.

Q So because it didn't appear here, Shakeel Kahn should have noted it in his records that there was either noncompliance with the prescription and the treatment plan or there was [171] diversion –

A Right.

Q – or other concerns?

A Yes. You have to document why you are doing urine drug screening, and you have to document what you did with the results in the context of what the patient was taking and not taking, but that never happened.

Q All right. Next I would like to move to Lauren Klokis. It appears that Lauren Klokis was under the care of Shakeel Kahn from November 24, 2015, to November 21, 2016.

A Yes.

Q Were there progress notes contained in each one of those visits?

A There were progress notes, yes, but they were not completed.

Q All right. What do you mean?

A They were not completed, and they were not dated.

Q All right. Did you have an opportunity to look at the prescribing history for Lauren Klokis?

A Yes.

Q All right. And what did you find about the prescribing history for Shakeel Kahn and Lauren Klokis?

A Again, starting with high dose narcotics.

Q Was there a basis or a reason for that documentation?

A No.

[172] Q What else did you find that was outside the course of usual –

A He started large amounts of narcotics without justification by medical facts, including checking the PDMP, verifying urine drug screening, and that the PDMP had actually said that the last prescription was for Norco back on November 4th, 2015. And there is no record of fentanyl in PDMP that he was taking. So he just does not document what the patient has been – past medical history has been. It is not consistent with his documentation. Patient claims to be on oxycodone,

and yet urine drug screening did not indicate any evidence of it.

Q And so with that initial visit, the urine drug screen doesn't indicate that he is on oxycodone –

A Yes.

Q – but yet oxycodone is prescribed?

A Yes.

Q And at what level, do you see that?

A The first – one of the first office visit was on November 4, 2015. Oxycodone 30-milligram, 120 tablets and fentanyl 100 milligrams, one patch every 48 hours. This patient had not been on fentanyl. There is no record of it in the PDMP.

Q So the choice of therapy was outside the usual course of professional practice?

A Yes.

[173] Q And the high dose, did it indicate that it was for a legitimate medical purpose?

A No.

Q Was there any indication that other considerations were made by Shakeel Kahn for treatment other than opioids?

A No.

Q I want to move to Charles Moody. Charles Moody first visited Shakeel Kahn that was documented on April 4th of 2012; is that right?

A Yes.

Q You noted in your review on page 71 that you had some concerns about the first prescriptions that were written for Charles Moody. What were your concerns?

A He had told – Dr. Kahn had documented that patient was receiving 1,000 milligram of MME, but when I reviewed records, there is no indication that he was ever prescribed that much narcotic by any provider. He says he did a urine drug screening, and it didn't show any evidence of oxycodone as claimed that he was.

Q So there is evidence that there was opioids, but not necessarily oxycodone?

A Right.

Q And nothing to support his – his being Charles Moody's statement that he was receiving 1,000 morphine equivalent a day of opioids, right?

[174] A Yes.

Q Okay. And yet what prescription is given by Shakeel Kahn that concerns you?

A Well, he was prescribed, again, the usual medication oxycodone 30-milligram, 180 tablets, and methadone 10-milligramss 120 tablets.

Q Is there any indication that Charles Moody had been on the methadone as you had described before?

A No.

Q I want to fast forward to October 29, 2013. While we are getting this, I want to ask you a question. When a pain management doctor treats patients, is it appropriate – well, are there times it is appropriate to do the same treatment plan for every person?

A The treatment plan is to improve quality of life and functionality. That is the treatment plan. And then underneath it, you are doing counseling. You are doing physical medicine, nonsteroidals, non-narcotics and injections. You do that every single time that you see the patient. And so in the case of Charles Moody that is what he is documenting, that he is doing that, but it is all the same from one visit to another.

Q For Charles Moody. Did you also find between patients that it is same regimen that is prescribed by Shakeel Kahn?

A Yes.

[175] Q And is there any indication in your review of the records that Shakeel Kahn looked at these individuals differently and tries to treat them differently?

A No.

Q Would that be an appropriate way to manage pain?

A That is not appropriate.

Q If you did treat them differently and looked to prescribe differently, would that be appropriate?

A That would be appropriate.

Q So as we look at October 29 of 2013, you have made a notation that there is no documentation of an MRI study. You also indicate that there is boilerplate progress notes which continue talking about the MRI. Do you see that?

A Yes.

Q What is your concern? Why are you noting this?

A Because he just, again, confirms to me boilerplate copy and paste. You order an MRI. You never follow up with it, but because you copy and paste, it keeps appearing in your medical records. A year later, you realize, "Opps. What is this? I haven't looked. I better remove it from this time going forward," so that was my concern that that is what happened.

Q So you make a note at page 74 of your report for November 12, 2013, which is the next visit, that says quote, "He is still in the process of obtaining a new MRI on his lumbosacral spine." And then you note that the prescriptions [176] for methadone 10-milligrams, number 120, and oxycodone 30-milligram 300 is written.

A Yes.

Q Then, Doctor, you note in your report that that occurs again on November 20, December 4, December 18, December 31, and December – January 14th of 2014, and January 28 of 2014, February 11, 2014, February 25 of 2014, and March 11th of 2014. Although, you make a note at page 75 under March 11th of 2014, that that, then, starts to go away?

A Yes.

Q But then we see it again on March 24th of 2014?

A Yes.

Q The same copy and paste?

A Yes.

Q And April 7 of 2014?

A Uh-huh.

Q And April 21st of 2014?

A Yes.

Q And May 5th of 2014?

A Yes.

Q And again on May 18th of 2014?

A Yes.

Q In that period of time through May 18 of 2014, the prescription is changed; is that right?

A Now he is taking Methadone 10-milligrams 120 tablets and [177] oxycodone 30-milligram 300 tablets.

Q Does he also have fentanyl? Is that new?

A May 5th?

Q May 18.

A Yes. May 18 methadone is added, and fentanyl is added.

Q Is there any indication in the progress note that this individual, Charles Moody, needed this change in prescription?

A No.

Q Or any indication that he was counseled on the change?

A No.

Q So would this be outside the usual course of professional practice?

A Yes.

Q Also not for a legitimate medical purpose?

A Yes.

Q These prescriptions and behaviors of Shakeel Kahn in making progress notes, do they continue on for some time?

A Yes.

Q I want to direct your attention to page 77 of your report. Something changes right before February 19 of 2015, and you make a note of it. What happens then?

A Dr. Kahn keeps accurate records of the number of pills that he writes, and the follow-up needed to refill those pills. Dr. Kahn removed any references to the order of an MRI of his spine from his progress notes going forward. The boiler plate [178] progress notes have indicated the recommendation for MRI for over 16 months now with no evidence of obtaining one. This indicates that the results of MRI findings would have not made much difference in the patient's treatment course.

Q I want to direct your attention to the date of December 8, 2014, which is back one page, and January 5 of 2015.

A December 8. Okay.

Q I'm sorry. "November 20th and December 8." There is an increase in medication from oxycodone 30-milligram where he is now receiving 300, which has occurred for several months to 600 on December 8. Did you see that?

A Yes.

Q Was there any documentation for this doubling up of the oxycodone?

A No.

Q And that prescription for the 600 oxycodone continues for some time; is that correct?

A Yes.

Q All right. Looking at May 18 of 2015, on that date, it appears that the oxycodone prescription was increased from 600 tablets to 720 tablets per month. Do you see that?

A Yes.

Q Was there any explanation in the progress notes that we are seeing in front of us for that increase?

A No.

[179] Q Do you have any idea what the MME is of 720 oxy 30 tablets?

A Yes. It is about 1,080 Morphine Milligram Equivalent.

Q And the CDC recommends 90 per day?

A Per day.

Q I don't want to harp too much on CDC, but that – is that a high dose?

A It is a very high dose.

Q Is it a dangerous dose?

A Yes.

Q Is there indication that Charles Moody was ever counseled on that?

A No.

Q You also make a note that Charles Moody seemed to present with the same subjective improvements in pain and quality of life as before this change was made. So what is your concern about the medication increasing if nothing had changed?

A I don't know. Why would you?

Q So there is nothing that medically supports the increase?

A You can't even rely on patient saying that, and now the patient is saying, "I am perfect," and yet, you add? You increase? There is no justification.

Q I want to move to – does the copy and paste continue throughout Charles Moody's file, as well?

A Yes.

Q Okay. And are there occasions where prescriptions are [180] given and progress notes are not made?

A That is correct.

Q Finally, I want to direct your attention to August 8 of 2016. It appears that "720" number has now been made into "780" oxycodone 30-milligram tablets. Do you see that?

A Yes.

Q And that is still in conjunction with 240 oxycodone 30-milligram tablets and methadone; is that right?

A That is correct.

Q Is there any indication in the patient chart why there was a need for this increase in medicine?

A No.

Q Is there any indication that there was any counseling for Charles Moody given by Shakeel Kahn?

A No.

Q Overall, from the beginning to end, the treatment of Charles Moody by Shakeel Kahn, Doctor, what is your opinion about whether or not it was inside or outside the usual course of professional practice?

A It was outside.

Q And were any of these prescriptions for a legitimate medical purpose?

A No.

Q I want to move next to Randy Moody. Were you able to discern whether or not there was any relation between Randy and [181] Charles Moody?

A I think they are brothers.

Q It appears that Randy Moody first came to Shakeel Kahn on November 5th of 2012. Is that what your records reflect?

A Yes.

Q You note some concerns that you had with Randy Moody's first visit and the treatment by Shakeel Kahn. Can you describe those, please?

A So this patient is recommended – he is 57 years old. He has coronary artery disease, heart problem, and he recommends methadone. When I reviewed the medical records, he had previously obtained an EKG. It was in the chart, but Dr. Kahn never reviews this. He never documents it in his records. And you should do that when you prescribe someone methadone, you should document that you have looked at the EKG and discussed this with the patient. And so I also reviewed PDMP of the state of Wyoming and Arizona. It didn't indicate that there were prescriptions for this patient before. Medical records indicate that this patient had been on oxycodone 30-milligrams up to six tablets per day, lorazepam and Norco per day. Dr. Kahn should have checked urine drug screening to document if those drugs were present. So the PDMP didn't show anything. Then the medical records that the patient should have been taken this, he didn't do a urine drug screen. So all of these things just leaves a lot of questions ambiguity about what is [182] the best treatment plan for this patient.

Q It could be possible that Randy Moody had pain and needed to be treated, but Shakeel Kahn, in your opinion, didn't do what he needed to do to look at that?

A Yes.

Q All right. Instead, what treatment does Shakeel Kahn give to Randy Moody?

A He gives him methadone with heart disease.

Q Is methadone given to Randy Moody in combination with any other drugs?

A With oxycodone on the first visit.

Q And what strength of oxycodone and amount, if you know?

A It is 30-milligrams of oxycodone, 240 tablets per month; that is eight tablets per day; that is 240 milligrams of oxycodone per day or 360 Morphine equivalent.

Q And that prescription is later increased?

A Yes.

Q And that happened on December 4th of 2012?

A Yes.

Q To 300 oxycodone 30-milligram tablets?

A Yes.

Q Was there any indication in the patient chart of why that was done?

A No.

Q Was there any indication that it was necessary?

[183] A No.

Q At some point, this patient, Randy Moody, starts to see Shakeel Kahn every two weeks. Do you see that?

A Yes.

Q And every two weeks now is he getting the same prescription he was getting every 30 days?

A Yes.

Q Is there any indication that there was a need for that medically?

A No.

Q Additionally, Shakeel Kahn adds Soma to this mix that Randy Moody is getting. Do you see that on page 82?

A Yes.

Q Was there any need for that?

A No.

Q Or that there was counseling for that dangerous combination?

A No.

Q What is Ativan?

A It is a sedative benzodiazepine medication like Valium or Xanax.

Q And was Randy Moody on Ativan?

A Yes.

Q Was he prescribed that by Shakeel Kahn?

A Yes.

[184] Q Was that in combination with the Soma and the oxycodone and the methadone?

A Yes, all four of them.

Q And, again, was there any indication that Randy Moody was counseled on that danger?

A No.

Q Does this behavior continue for some time?

A Yes.

Q And the notes that you see with Randy Moody, are they cut and paste, or do they change over time?

A They are cut and paste.

Q I want to look at the date of December 15, 2015. On that date, the oxycodone 30-milligram prescription changes. Do you see that?

A December 15?

Q Of 2014 on page 82.

A Yes.

Q Actually, that might have been changed on June 30 of 2014. Do you see that?

A Uh-huh.

Q What is it changed to?

A So the December 15, 2014, prescription for oxycodone 30-milligrams 600 tablets and Norco 10, 60 tablets. He didn't explain why did he add Norco.

Q The 600 of oxycodone 30 has changed from what it was before [185] as well, right?

A Yes, so it was 600 back on June 3, 2014.

Q And prior to that in December of 2013, he was getting 300 oxycodone 30s?

A That's right.

Q All right. And so all of a sudden it changes sometime in 2014 to 600 30-milligrams?

A Yes.

Q Is there any indication that that was medically necessary?

A No.

Q April 21 of 2016, page 83, I would like to direct you to page 83. There had been steady increases in prescribing – in the prescription medication that is given to Randy Moody, but I want to talk about April 21st. It indicates again that the Norco was increased. Was there any reason documented for that in the patient chart?

A There was never any reason for starting Norco or increasing it from 60 to 90 and now to 120.

Q Okay. I also want to direct you to June 27, 2016. You made a notation on your review about prescriptions that weren't filled, and then prescriptions that were written despite that. Do you see that?

A Yes.

Q What happened in June of 2016?

A There is documentation that patient saw Dr. Kahn and [186] prescriptions were written for oxycodone 600 tablets, Norco 120 tablets and Morphine 90 tablets. When I look at the PDMP, I didn't see that those prescriptions were ever filled. So that made me think if that progress note was actually a true progress note or the patient just didn't fill his prescription, which I found it unlikely.

Q All right. But then that same prescription was given on the next visit despite not having filled the prescription the previous visit?

A Yes.

Q Would that be an appropriate prescription to write?

A No.

Q Doctor, do you have an opinion about whether the medications prescribed by Shakeel Kahn for Randy Moody were within – were they for a legitimate medical purpose?

A No.

Q “No,” they were not?

A They were not.

Q And were they prescribed in the usual course of professional practice?

A They were not.

Q Next, let’s look at Chris Muehlhausen. When you look at Chris Muehlhausen, Doctor, overall when you look through all the patient files – he started in March of 2012, and the last patient file appeared to be an entry date of December 22 of [187] 2014.

A Yes.

Q When I look at your report, you said that there appear to be duplicate progress notes or second progress notes. What did you see?

A What page are you talking about?

Q It is kind of all throughout your report. Let me – look at March 13, 2012, on page 85.

A Page 85, March –

Q 13th.

A March 13th. Yes. So there were two progress notes that he filled out for the same date of service. We just don’t do that. When patient shows up, you write one progress note.

Q All right. So, for example, on the screen in front of you, there is this progress note that we are looking at for March 13 of 2012. Do you see that?

A Yes.

Q If we go to the next progress note, March 13 of 2012, it appears to have some new information.

A Yes. This repeats the pattern and continues throughout the clinical course – yeah, he does it twice.

Q Twice for every visit?

A Yes.

Q Is there any indication to you in the patient chart about why this is being done?

[188] A I don't know.

Q Chris Muehlhausen overall whichever patient note you choose to look at, did you find that the prescriptions that were given to him for oxycodone were outside the usual course of professional practice?

A They were.

Q And were any of them for a legitimate medical purpose?

A No.

Q Let's start with when he was first prescribed medication by Shakeel Kahn. You made a notation on page 85 after review of the PDMP, what concerned you?

A So I reviewed the PDMP. It indicates that the last prescribed narcotic for this patient prior to visiting Dr. Kahn occurred in August of 2011 for Tylenol Number III, and only 20 tablets. There is no evidence this patient had ever been prescribed oxycodone or Dilaudid in the state of Arizona as Dr. Kahn states.

There is no legitimate medical reason to start a 20-year-old with a diagnosis of low back pain and migraines on 180-milligrams of oxycodone and 30, 2-milligram of Dilaudid per day.

Q But, in fact, that is what he does?

A Yes.

Q Does this sort of dosage have the same dangers as you described before of the high dose regimen?

[189] A Yes.

Q Is there any indication Chris Muehlhausen was counseled about that?

A No.

Q Does this prescribing behavior escalate over time?

A Yes.

Q So the dosages are increased of oxycodone?

A Yes.

Q Eventually is Soma added?

A Yes.

Q And is there an indication in the patient files that supports the adding of Soma?

A No.

Q Or the increase of oxycodone?

A No.

Q Dilaudid is hydromorphone, correct?

A Yes.

Q Is it very often prescribed?

A Not very often.

Q Are there dangers with Dilaudid and oxycodone and Soma as well as just oxycodone and Soma?

A Yes.

Q I want you to look at your report on page 87, which is bolded, talking about beginning in September 2004 – it says 2004, but I think it means 2014.

[190] A Yes.

Q It says that Shakeel Kahn is requiring the patient to return every 15 days for an evaluation.

A Yes.

Q Was there anything documented in the patient's chart that indicates that that was an appropriate course of treatment?

A No.

Q Did the prescription that Shakeel Kahn was writing for the 30-day-treatment continue to be the same, even though he was seeing Chris Muehlhausen every 15 days?

A Yes.

Q Was there any indication that that was appropriate?

A No.

Q September 24 of 2013, there was a urine drug screen done. Do you see that?

A September –

Q It is right below that bold. September 24, 2014?

A Yes.

Q And that drug screen didn't show any indication of oxycodone?

A That's correct.

Q But yet oxycodone continued to be prescribed?

A Yes, it is.

Q I would like you to take a look at September 2014 up to December 22 of 2014 at page 88. You had a concern after [191] reviewing the Prescription Drug Monitoring Program after the December 22nd, 2014 visit. What was your concern?

A I did not see any progress notes in the chart indicating any visitings with Dr. Kahn during that time.

Q In your opinion, did Shakeel Kahn appropriately select the pain management therapy?

A No.

Q And was the therapy that he chose high dose opioids?

A He did.

Q All right. And was that outside the usual course of professional practice?

A Yes, it was.

Q Were any of them for a legitimate medical purpose?

A No.

Q Mary Parent was another individual that you reviewed her patient files that Dr. Kahn kept. Do you recall that?

A Yes.

Q Now, I will give you a second to refresh your memory on that.

A Yes. This patient had reported that she had multiple sclerosis, depression, uterine cancer and osteopathic pain. She was 38 years old, and that she had been treated intermittently with oxycodone 30-milligram in the state of Utah. And her, then, medicine at

the time of presentation was only Pregabalin and Aciphex. There were no narcotics that she [192] said that she was on.

Q What therapy was chosen by Shakeel Kahn?

A Narcotics high dose.

Q And did that continue throughout her treatment by Shakeel Kahn?

A Yes.

Q And just for the record, that treatment started March 30 of 2012, and the last progress note was May 18 of 2016; is that right?

A Yes.

Q During the course of the treatment of Mary Parent, did Shakeel Kahn document any reason for the continued treatment of her pain through narcotics?

A No.

Q Did the narcotic prescriptions escalate?

A Yes.

Q Was there any documentation to support why that happened?

A No.

Q In your opinion, Doctor, was the treatment of Mary Parent by Shakeel Kahn outside the usual course of professional practice?

A Yes, it was.

Q Was any of it for a legitimate medical purpose?

A No.

Q Ruth Sunrhodes was another patient. It appears that [193] Ruth Sunrhodes' initial visit was January 27 of 2016. You made some observations, Doctor, in your review of her patient file, which included visits up through November 3, 2016. I would direct you to page 94 of your report.

Before I ask you a question of that, I want to ask you what therapy did Shakeel Kahn choose to treat Ruth Sunrhodes' pain?

A High narcotics.

Q And was there an escalation in the narcotics?

A Yes.

Q And did you make a note that there was a large escalation that caught your attention?

A Yes.

Q What did you note?

A On March 23, I said there was no justification for rapidly increasing the amount of pain medication in such a short time in such a young patient with the listed medical conditions of chronic low back pain and nephrophthisis.

Q Was there any indication that any other type of treatment was considered by Shakeel Kahn?

A No. Specifically, this patient stated that she had osteoarthritis. The recommendation is nonsteroidal antiinflammatory drugs.

Q Interferometries?

A Yes, not oxycodone.

[194] Q What did Shakeel Kahn choose to prescribe to Ruth Sunrhodes?

A Oxycodone.

Q Looks like 180 20-milligram tablets?

A Yes.

Q In your opinion, Dr. Shay, was Shakeel Kahn's treatment of Ruth Sunrhodes outside the usual course of professional practice?

A Yes, it was.

Q Was it for a legitimate medical purpose?

A No.

Q Next looking at Stephen Szabo. It appears that Stephen Szabo began visiting Shakeel Kahn October 31 of 2012.

A Yes.

Q And you had some concern with that initial visit that is listed on page 96 of your report. What was your concern?

A Urine drug screen wasn't tested for oxycodone, and yet, he prescribed 90 milligram of oxycodone per day.

Q 90 milligram?

A Yes.

Q So he gets 30-milligram tablets, 90 of them?

A Yes.

Q Does he also get Xanax?

A Yes.

Q Is there any indication that the 30-milligram tablets were [195] an appropriate therapy for Stephen Szabo?

A No.

Q And is there any indication that he was counseled on the dangers of the combination of oxycodone and Xanax?

A No.

Q So Stephen Szabo was an opioid naive patient that Shakeel Kahn chose to treat with high dose opioids?

A No. He was narcotic naive. Urine drug screen showed some opioids.

Q So –

A But no oxy.

Q All right. I misunderstood. Not oxy, but some opioids?

A Yes.

Q Okay.

A Maybe hydrocodone, maybe some other, but no oxy.

Q In your opinion, was that still a high dose to start off Stephen Szabo?

A Very high dose.

Q Did Stephen Szabo's prescriptions continue to escalate for oxycodone?

A Yes.

Q At some point, were other medications added?

A Let me see where he added –

Q For example, I will direct you to December 21 of 2012.

A December 21, 2012, yes.

[196] Q There was one even before that in November –

A Methadone, and oxy IR20. Yeah, and methadone is added.

Q So at that point he was getting 10-milligrams methadone – 120 of those tablets?

A Yes.

Q 30-milligram of oxycodone, 100 of those?

A Yes.

Q And 1 milligram Xanax tablets, 60 of those?

A Yes.

Q Is there any indication that when that change was made, that he was counseled – he being Stephen Szabo – by Shakeel Kahn?

A No.

Q Was there any EKG ordered?

A No.

Q Was there any indication even in the progress notes that there was any reason to add this new prescription to help Stephen Szabo's pain?

A No.

Q Does this increase in dosage continue throughout Stephen Szabo's treatment by Shakeel Kahn?

A Yes.

Q And in your opinion, was there any medical necessity for those increases?

A No.

[197] Q In fact, at some point – November 25 of 2013, Stephen Szabo starts to get more oxycodone. Do you see that?

A Yes.

Q So he moves from what we have talked about and progresses over time to 30-milligram oxycodone 240 of them now, right?

A Uh-huh. Yes.

Q And 20-milligram oxycodone, 180 of them?

A Yes.

Q And 2-milligram Xanax, 60 of those?

A Yes.

Q And these are now prescribed every two weeks?

A Yes. He started that February of 2013.

Q When he started that – he being Shakeel Kahn – make any notes in the patient file about why that was happening?

A No.

Q So there was no medical necessity for that?

A No.

Q And throughout the time that he kept prescribing those combinations, did he – he being Shakeel

Kahn – make any notes about why they were continuing to be prescribed?

A No.

Q Would that have been outside the usual course of professional practice?

A Yes.

Q Now, those are pretty high doses, right?

[198] A Yes.

Q And if Stephen Szabo were to have that – those really high doses cut in half, what effects would he feel?

A He would have withdrawal symptoms.

Q Like the ones you have described before?

A Yes.

Q Would there be any reason to cut a patient's prescriptions in half from one month to the next month?

A If the patient wanted and you agreed and you properly planned for it.

Q And then what about increasing them back up to where they were before the next month?

A That doesn't make sense.

Q All right. It happened to Stephen Szabo on a couple of occasions, didn't it?

A Yes.

Q And was there any documentation written in the patient file for a reason for that?

A No.

Q In your opinion was treatment by Shakeel Kahn of Stephen Szabo outside the usual course of professional practice?

A Yes, it was.

Q And were the prescriptions he wrote for a legitimate medical purpose?

A No, they were not.

[199] THE COURT: Good time for a break?

MS. SPRECHER: It is, Your Honor. Thank you.

(Recess was taken.)

(Hearing in chambers, outside the presence of the jury.)

THE COURT: Let the record reflect we are meeting in chambers with counsel for the parties at this time. We are in the middle of the testimony of Dr. Shay. I suspect the Government is approaching the end. We have had him on for seven hours at this point of actual testimony. If you take seven hours, we'll be at 10:00 tonight without any break. And I just don't think it is fair because we will be asking the jury to come back at 7:30 in the morning for our Thursday session.

My suggestion is if he cannot – I don't know what he can or can't do. I have no knowledge about this man. I have never run into him. He has never testified in this court before. I checked with Judge Skavdahl. He hasn't seen him either. Maybe he could be cross-examined later on in the trial.

MS. SPRECHER: I am waiting for their answer, before I butt in.

MR. BRINDLEY: Well, Judge, I would like to – it is going to be –

THE COURT: You would like to take a shot at him –

MR. BRINDLEY: I don't have seven hours. I want to [200] get started. I won't go for seven hours. So we would like to get started, but I don't think it is fair to the jurors at all or even to us to – if the Government gets done here in an hour or however long, and then we get started toward the very end of the day, the jurors are going to be blaming me when I don't intend to take nearly as much time. So I don't think that is fair to either the jurors or the defense. I don't really know what –

THE COURT: They are coming in at 7:30 in the morning to start.

MR. BRINDLEY: Right. So I would like to know from the Government what is the witness' issue in terms of scheduling?

MS. SPRECHER: He has a plane leaving in the morning. I don't recall where he is going. I don't know.

THE COURT: Why don't you find out what is going on with him?

MS. SPRECHER: Okay. You want me to come back –

MR. THOMPSON: Availability going forward is necessary.

THE COURT: We have to have fair cross-examination. Plane reservations can be changed, and the Government can afford it.

MS. BOWEN: I will hold you to that when I am asking for some experts down the road.

[201] THE COURT: You are not getting it.

(Off the record.)

MS. SPRECHER: So the doctor said he can make himself available next Tuesday afternoon or next Friday afternoon.

MR. BRINDLEY: What does he mean when he says he is – what is the "afternoon"? I guess what does he mean?

MS. SPRECHER: I assume that means 1:00, Beau.

MR. BRINDLEY: All right.

THE COURT: We will take him for a couple hours.

MS. SPRECHER: We will do some work today, and then we will bring him back Tuesday afternoon. We don't have to wait too long. That is just a couple of days. That should be fine.

THE COURT: Okay.

(Off the record.)

THE COURT: Before the jury comes back in – normally, we have abused you a little bit. We have had you on the witness stand for a long time. We are going to take you for – until Mr. Brindley says he has had enough for the day. We will be bringing the jury back in at 7:30 tomorrow morning. I don't want to wear them out either. We appreciate your willingness to come back and finish this.

All right, let's bring the jury in.

Do you think it is fair to tell the jury what our plans are?

[202] MR. BRINDLEY: Yes, Your Honor. Specifically with respect to tomorrow, I would like to stop so I can get to the airport by 1:45. So if you want to tell them that, that would be my request.

THE COURT: Fair enough. They can make their plans tonight as to what they want to do.

(Jury entered the courtroom.)

THE COURT: Thank you. Please, be seated.

Before the Government – before the Government resumes, I want to spend a moment with you, Ladies and Gentlemen, discussing the schedule because it does affect you, and I think we made some reference to an early release tomorrow for the weekend early on in this case.

We have been pushing you pretty hard today having you come in 8:30 and we will push you even harder tomorrow. I will have you come at 7:30 tomorrow morning. We'll work with breaks, no lunch hour, and we will finish at 1:45. Then with instructions, I will send you home for the weekend tomorrow. Hopefully – I have been looking at the roads. They look like they're dry around here. I think most of you are headed out – will be headed north. The storm, I think, has pretty much passed this area at this point and should be in pretty good shape tomorrow. At any rate, you would be traveling in plenty of daylight. I am not that concerned. I think you will be fine. That's my concern, and I want you to know.

[203] Now the rest of our schedule, it looks like it is a regular Monday through Friday sort of situation, but I am also thinking about just given the time of year it is and the unpredictability that maybe on Friday afternoons, we could – Friday, we come in a little bit earlier and let you go a little bit early on Fridays, if that is okay.

If there is strong objection to it from the jury, let us know, because you are the ones who have to pay

attention to what is happening and listen carefully to the evidence as it comes in. And there is a lot of it that's coming your way. So be patient with us. I am sure when this case is over and both sides have their closing statements, you will have the information you need to be able to sort through it and make your decisions.

Are we ready to proceed?

MS. SPRECHER: Yes, Your Honor.

THE COURT: Ms. Sprecher.

BY MS. SPRECHER:

Q Doctor, I appreciate your patience as we go through these pretty extensively. Before I start on the next patient which is Shawnna Thacker, I would like to ask you a question. If a doctor were to just simply send a prescription into the pharmacy, whether an electronic prescription or somebody comes to the office to pick up a prescription, but doesn't actually see the patient for a visit, would it be appropriate to charge [204] a patient for a visit?

A No.

Q Would it be appropriate to document in the medical file that a person appeared for a visit?

A You have to document who picked up the prescription.

Q But would you necessarily document that the person appeared for a visit, for example, an assessment?

A No.

Q Directing your attention to Shawnna Thacker, she was a patient from 2009 up until 2016. I would like to make sure that your opinion only addresses the behavior of Shakeel Kahn from 2011 – January of 2011 to December of 2016 – actually, November of 2016. With Ms. Thacker during those periods of time that I was referring to, did you see the same pattern of behavior of treatment from Shakeel Kahn?

A The first couple of times March of 2009 –

Q Actually, I would like you to only make this to 2011.

A Oh, 2011.

Q Yes, please.

A So starting in 2011, he again continued with high dose narcotics and multiple medication, benzos and continued with that.

Q And throughout the time that he saw Shawnna Thacker –

A Yes.

Q – was there any indication or documentation in the file [205] that supported the high dose therapies of narcotics?

A No.

Q Or the increased escalation of the dosages?

A No.

Q Was there any indication that he considered other therapies?

A No.

Q During those years that I have talked about, in your opinion was the treatment of Shawnna Thacker and the prescribing of medications outside the usual course of professional practice?

A It was.

Q And were the prescriptions for any legitimate medical purpose?

A No.

Q The prescriptions for Shawnna Thacker, did they also include in addition to opioids, Xanax?

A Yes.

Q And next I would like to direct your attention to Julene Todd. It appears that Julene Todd had her initial office visit with Shawnna Thacker on April 6, page 106 of your report. Did you have an opportunity to review Julene Todd's patient file?

A I did.

Q What did you observe about her treatment from Shakeel Kahn?

[206] A Again, in spite of positive tools COMM and SOAPP, patient started on high dose narcotics.

Q And those high dose narcotics 30-milligram oxycodone?

A Yes.

Q 120 of those?

A Yes.

Q And Soma?

A Yes.

Q All right. Was there any indication that that was a necessary treatment?

A No.

Q Was there counseling on the drug combinations danger?

A No.

Q Throughout the course of Julene Todd's treatment, were those narcotics increased over time?

A Yes.

Q And was there any indication in the patient file there was a need for that?

A No.

Q And in your opinion, was the treatment of Julene Todd by Shakeel Kahn outside the usual course of professional practice?

A It was.

Q And was it for a legitimate medical purpose?

A No.

Q Finally, I want to direct your attention to Jessica Burch. [207] Now, Dr. Shay, you were asked to review Jessica Burch's file after you reviewed the 21 files we have just gone through, right?

A That's correct.

Q Were you made aware of why you were asked to look at this?

A Yes.

Q What was the reason?

A The patient had expired.

Q And did you review her patient file as you had every other patient file that we discussed?

A Yes.

Q And did you find – what did you find?

A The same pattern of high dose narcotics with minimal evaluation and inadequate monitoring, the same pattern as the rest of the patients.

Q And Jessica Burch was how old when she first started seeing Shakeel Kahn on March 20 of 2012?

A March – I don't have page 1.

Q You do not?

A No. It is – let's see.

THE COURT: Is it on your screen?

THE WITNESS: No. If you can give me a copy of it?

MS. SPRECHER: Let me give you – Counsel, do you have it? I can put it on here, and we can't publish it to the jury, and I think that will work for everybody.

[208] BY MS. SPRECHER:

Q All right. This, Doctor, is page 1 of 8.

A Yes.

Q Jessica Burch was how old?

A 21 years old.

Q And the first visit was March?

A 20th of 2012.

Q All right. And the concern you had on her first visit was what?

A There was no documentation of urine drug screen, review of medical records or any additional screening tool.

Q And now her chief complaint was low back pain and a abdominal pain?

A Yes.

Q You said that her treatment pattern was similar to the other ones that you have talked about?

A Yes.

Q Was there a time when she was combined – her prescriptions included a combination of OxyContin, Soma and Xanax?

A Oxycodone, yes.

Q Thank you. And I would direct your attention to January 4, 2013, which is on page 2 of your report, was there any indication that there was any need for that combination?

A No.

Q Was there any explanation for why Soma was added to Xanax?

[209] A No.

Q Did this sort of change in medication continue without appropriate notes to document why that was happening?

A Yes.

Q All right. You also noted that these medical records also were cut and paste versions every time?

A Yes.

Q And you made a note at the bottom of page 2 about documenting that the patient has one child. Do you see that?

A Yes.

Q What did you keep seeing?

A So he has been documenting this since the first visit. So every progress note, he writes patients has one child, age three.

Q That just keeps going on and on and on?

A Yes.

Q At some point Jessica delivers a baby in March of 2013. Are you aware of that?

A Yes.

Q She was in the hospital on March 26 through March 28 of 2013, was she not?

A Yes.

Q I would like to direct your attention to page 213 of Exhibit 3003. Do you see that on your screen?

A Yes.

[210] Q So first, I notice that there is a crooked note here. Is that something that came to you that way?

A Yes.

Q And the date is 3/27/2013?

A Yes.

Q And does it indicate whether or not Jessica Burch appeared in Shakeel Kahn's office for an office visit?

A Yes, follow-up office visit.

Q So it says she was actually physically present?

A I'm sorry?

Q It says she was actually physically present in the office?

A Yes.

Q It also lists her weight at the top of the page?

A Yes.

Q Temperature? Pulse?

A Yes.

Q Would that indicate to you that she was physically in the office?

A Yes.

Q If you were to learn she was actually in the hospital, what would you think about this particular note?

A That is a false record.

Q All right. Is there any indication, Doctor, prior to this visit on 3/27/2013 that Shakeel Kahn noted that Jessica Burch was pregnant?

[211] A No.

Q Were there indications in the notes that he was doing a physical exam?

A Yes.

Q And if he had been doing the physical exam that he said he was doing, should he have noticed that she was pregnant?

A Yes.

Q Is there any danger in prescribing opioids or Xanax to pregnant individuals?

A Yes.

Q What is it?

A You can get the baby addicted to narcotics as well.

Q So when the baby is born, they go through withdrawal?

A Right.

Q And if there was no indication in Shakeel Kahn's notes that she was pregnant, I assume there was no indication he had counseled her on the use of opioids during pregnancy?

A No.

Q All right. There is also continued documentation that changes a little in the patient notes. You note it also repeats. I want to direct you to September to November of 2014.

A One other thing on that previous note that really caught my attention –

Q Yes, sir.

[212] A – was the fact that he documented he listened to the bowel/abdomen and bowel sounds are present, but yet he didn't document that she was pregnant.

Q All right. Along that same line, is it appropriate to continue to prescribe opioids to patients that are complaining of constipation or bowel problems?

A Narcotics can cause constipation. They relax the intestine, so the food does not move, and you get constipated. That is what opioids do. And so if someone comes in complaining of abdominal pain, and they are on narcotics, well, the first thing that goes through your mind, "Are you constipated?" You do not necessarily throw in narcotics, because the patient has abdominal pain. You are causing more constipation and more pain.

Q All right. I misspoke. May we go to February 17th of 2013. Doctor, I will direct you to page 4 of your report. At some point like many other of Shakeel Kahn's patients, is Jessica Burch moved to biweekly appointments?

A Yes.

Q And does it – is the same pattern followed where she is getting the same prescription that she got for 30 days now every 14 days?

A Yes.

Q At the time that that happened, can you tell the Ladies and Gentlemen of the Jury, what prescription she was getting?

[213] A She was getting oxycodone 30-milligram, 180 tablets; oxycodone 15-milligram, 180 tablets; Xanax 2-milligrams, 120 tablets; Soma 315, 100 tablets a month.

Q Does there appear to be any medical necessity for this increase?

A No.

Q What would be your opinion about whether or not they were within the usual course of professional practice?

A They were not.

Q Does there appear to be any legitimate –

THE COURT: Just a minute. We have a screen that is out.

(Off the record.)

BY MS. SPRECHER:

Q Were any of these prescriptions for these 15-day periods for a legitimate medical purpose, Doctor?

A No.

Q I want to refer you to a note that is made in your report on June 9 of 2014. Do you see that on page 5?

A Yes.

Q So read that note, and then describe why you were concerned about what was going on.

A So on June 9, Jessica goes back to Dr. Kahn. And another visit, there is no documentation of her recent visit to Arizona Regional Medical Center, and patient is prescribed the same [214] medication.

Q "Seeking medication"?

A She was prescribed the same medication.

Q Okay.

A So before that patient had gone to the ER complaining of abdominal complaints and saying to the ER doctor that she has cancer, so this had been occurring, and then yet on June 9 when she goes and visits with Dr. Kahn, none of that comes up.

Q And there had been documentation in Shakeel Kahn's note that Jessica Burch indicated that she thought she had cancer, right?

A Yes.

Q Was – did he do anything to follow up on that report by her?

A No.

Q And should a doctor in the usual course of medical practice have done something?

A Yes.

Q What was that?

A Well, if patient has cancer, and she is telling you, then you need to investigate and find out; maybe that is the cause of her abdominal pain.

Q Is it appropriate to continue prescribing oxycodone to treat cancer?

A If it has been properly diagnosed, yes.

[215] Q If you are just treating pain you would have to have a legitimate medical reason to do that also?

A If you are treating pain and it is due to cancer, but you can't prove it, that is not a legitimate medical reason.

Q Okay. Also, looking at September 15 of 2014, I want to draw your attention to another cut and paste that keeps appearing in the records. Do you see your note?

A Yes.

Q About page 5?

A Yes.

Q What note kept now occurring?

A "She will not be able to attend her regular appointment due to her child having to undergo surgery," and that statement keeps appearing every two weeks.

Q All the way up until March 16th of 2015?

A Yes. From September to March, that is like seven months, yes.

Q And her last visit to Shakeel Kahn was March 16 of 2015?

A Yes.

Q Was there – so we are looking at it on the screen. We have another crooked sheet.

A Yes.

Q And is there any indication that Jessica was prescribed any medication on that date?

A On March 16, she was prescribed oxycodone 30-milligram, 180 [216] and 15-milligram oxycodone, another 180 tablets.

Q All right. Doctor, I would like to move on. Let me first ask you: Looking at the medical records of Jessica Burch for the dates from beginning to end, what is your opinion about whether Shakeel Kahn's treatment of Jessica Burch was within the usual course of professional practice?

A So he wrote large amounts of potent narcotics for no legitimate medical reasons and outside the usual course of practice.

Q Thank you. Prior to coming to court today, did you have an opportunity to review a conversation that occurred between Shakeel Kahn and Paul Beland?

A Yes.

Q I would like to at this time have you listen to Exhibit 1040 that, Your Honor, has been accepted into evidence 1040 A and B have been accepted. We would offer C, which is the rolling Powerpoint.

Doctor, this is a call that occurs on October 31 of 2016. Do you see that before you?

A Yes.

MS. SPRECHER: May we play it, Your Honor?

THE COURT: You may play it.

(Audio was played, not reported.)

BY MS. SPRECHER:

Q Doctor, is there anything that concerns you about the [217] content of that call?

MR. BRINDLEY: Objection; may we be heard at sidebar? (At sidebar.)

MR. BRINDLEY: Your Honor, based on the expert disclosure with respect to this witness, he has been provided patient files. He is going to opine as he has been on the patient files. There is nothing in the report that was submitted about him opining about conversations – regarding conversations that the doctor had with Mr. Beland. I think it is outside the expert designation that has been given by the Government. I don't think he should be able to opine on the phone call. All the patient files is what they told us about, and that is appropriate. We think this is beyond the expert disclosure, and he shouldn't be permitted to do it.

MS. SPRECHER: I don't think it is in his reports, Your Honor. I can ask hypothetical questions.

THE COURT: I will sustain the objection.

MR. BRINDLEY: Thank you.

(End of bench conference.)

(Proceedings resumed in open court.)

BY MS. SPRECHER:

Q Doctor, let me ask you a question. Would it be appropriate to prescribe to a person or agree to prescribe a person that you have not seen as a patient a certain regimen of medicine of oxycodone?

[218] A No.

Q Would it be appropriate to charge a person based on the amount of prescriptions that you were providing to that person or that person's friends?

A No.

Q Doctor, having reviewed all of Shakeel Kahn's medical files that we spoke about, what is your opinion about whether or not the prescriptions of hydromorphone, carisoprodol, alprazolam and oxycodone were made or written inside – if they were outside the usual course of professional practice?

A They were outside.

Q And were any of them for a legitimate medical purpose?

A No.

Q Why do you say that overall?

A Because he did not establish with his medical records a legitimate medical reason for which you can prescribe pain medication or controlled substances, and then he prescribed those substances when the patients were not present, and he documented that they were, and that is outside the usual course of practice.

Q And so what is your opinion about Shakeel Kahn's practice?

A Unacceptable.

Q Even though he was documenting those things, are you saying there was a different purpose for that?

A It was not to treat the patient.

[219] Q You had stated previously that he was giving the illusion of practicing medicine. Why do you say that?

A Throughout the review of these 22 charts, I saw Dr. Kahn understanding what he needs to do. He knows that he needs to start slow. He knows that he should consider non steroidal antiinflammatory drugs –

MR. BRINDLEY: Your Honor, I would object to the witness testifying as to what Dr. Kahn knows. He can testify about what he should know, but he

cannot testify to the jury about what Dr. Kahn knows about any particular thing.

MS. SPRECHER: I can follow-up with that, Your Honor.

THE COURT: You may.

BY MS. SPRECHER:

Q When you say that "he knows," were there indications that – in the charts that you reviewed that Dr. Kahn knew what he should be doing?

A Yes, it was.

Q For example, what?

A He had documented he was going to consider nonsteroidal antiinflammatory medications, yet he never did and kept adding oxy, so he knew.

Q Did he also indicate in some instances prescribing gabapentin?

A Yes, he did.

Q Were there occasions where he would say or actually tell [220] people to go get an X-ray?

A Yes.

Q Or an MRI?

A Yes.

Q Was anything done when they didn't follow up?

A No.

Q But it indicated to you that he knew those things should be done?

A Yes.

Q Okay. What else did you notice?

A He recommended neurology follow up. He never followed up with that. He gives an illusion of practicing medicine, but it is just an illusion.

MS. SPRECHER: Thank you, Doctor. I don't have any further questions.

THE WITNESS: Thank you.

CROSS-EXAMINATION

BY MR. BRINDLEY:

Q Dr. Shay, I would like to talk first about your background for a bit, if we could. You said that you are board certified in pain management, correct?

A Yes, pain medicine.

Q "Pain medicine," that is the right term?

A Yes.

Q And when did you get board certified in pain medicine?

[221] A American Board of Pain Medicine is an organization that you can participate and pass examinations and become board certified in pain medicine.

Q When did you become board certified in pain medicine is the question?

A In 2011.

Q And you said, if I heard you correctly on direct examination with the Government, you said that you started doing pain management back in 1995; is that right?

A Yes.

Q And you have been doing pain management ever since, right?

A Yes.

Q Okay. Now, you said that – I think you said it had been a long time ago, but I think you said that you worked as an expert for the State of Wyoming in certain circumstances, am I right?

A I am working for the State of Wyoming.

Q And when you work for the State of Wyoming, you are giving your opinion about what?

A How impaired a patient is after injuries at work.

Q So these are – the State of Wyoming has you reviewing workmen's compensation cases?

A Yes.

Q Right. So those are not criminal cases for the State of Wyoming that you are usually engaged in an expert for, am I [222] right?

A No.

Q When you say no, you are agreeing with me, you are not usually –

A They are not criminal cases.

Q And obviously you understand that there is a difference between workmen's compensation cases or a medical malpractice case and a criminal case, you understand that, right?

A Yes.

Q Have you been engaged as an expert to give opinions in medical malpractice cases in the past?

A No.

Q Never?

A No.

Q And how many times before this have you been engaged as an expert in pain medicine to testify in a criminal case?

A None.

Q So this is the first time that you have testified in any criminal matter regarding any doctor's conduct, right?

A Yes.

Q All right. Now you were engaged to review some of Dr. Kahn's work by the United States Government, right?

A Correct.

Q The Government is paying you for your work here, right?

A They are.

[223] Q And can you tell us, if you would, how much you are being paid?

A $250 an hour.

Q All right. And how many hours – well, I will start this – it appears to me, and you correct me if I am wrong, based on the breadth of your report and the detail that you provided today, you spent a very long time working on this case?

A Yes.

Q Do you know how many hours?

A About 80.

Q Now – and this is the first time that the federal government has ever called on you to be an expert; is that right?

A That's correct.

Q The federal government agents made the decision about what files from Dr. Kahn you would receive, didn't they?

A They did.

Q And you do not know how many patients overall total Dr. Kahn saw, do you?

A No, I don't.

Q You received 22 handpicked patient charts to look at, right?

A Yes.

Q Plus – maybe it is 22 plus Jessica Burch – 21 plus [224] Jessica Burch?

A Twenty-one plus.

Q So 22 is the right number. So you only got what the Government wanted you to see? Fair to say?

A Yes.

Q Now, you have never met Dr. Shakeel Kahn, have you?

A No.

Q And you have never spoken with Dr. Shakeel Kahn?

A No.

Q You – therefore, you do not know what Dr. Kahn's particular opinions are about the use of high dose opiates, do you?

A No.

Q And you do not know what Dr. Kahn's particular opinions are about why he uses certain drugs in combination, or why he thinks it is a good idea, right?

A No.

Q And you do not know what Dr. Kahn's view was or his opinion was about the impact of the various pain contracts and documents that his patients used inside?

A No.

Q Okay. Now, you talked early on today about the various guidelines, right?

A Yes.

Q Okay. And one of those was the CDC guidelines?

[225] A Yes.

Q And you would agree, and I think you may have even said as much, that the CDC guidelines are not mandatory rules for doctors.

A They are not.

Q And, in fact, I believe you said the medical board is even specifically indicated that these guidelines are recommendations and are not mandatory, right?

A They are not mandatory.

Q And, in fact, the problem has been created with some medical providers due to opioids, because they treated the guidelines as mandatory, when they are not?

A That is correct.

Q You showed the jury certain forms that you utilize in your practice, right?

A That is correct.

Q And from what I understood, you found that through the course of your practice, these do a good job of trying to get you to do your best for your patients?

A Correct.

Q And but these forms that you used and that you suggest, it is not mandatory that medical practitioners use those particular forms, is it?

A No.

Q In fact, it is not mandatory – there are no mandatory [226] forms –

A No.

Q – that they have to use?

A No.

Q Okay. There are no mandatory rules about how long a doctor can take before he finishes entering patient information into a chart, are there?

A No.

Q There is no mandatory rule that the content of forms that are read and signed by patients have to be read aloud to the patients, are there?

A Not the forms.

Q Drug screening tests are not mandatory, are they?

A They are not.

Q And there is no mandatory rule about what particular kind of urine drug screening analysis has to be done, right?

A No.

Q There are different kinds, right?

A Yes.

Q Some certify with more particularity or specificity what substances may be found in the urine, right?

A Correct.

Q For example, you were saying there is some urine testing that will specifically identify oxycodone in particular, right?

A Correct.

[227] Q While others will only identify opioids or opiates generally, right?

A Yes.

Q And there is no mandatory rule that any doctor has to use a urinalysis test that identified oxycodone in specific, right?

A Correct.

Q And oxycodone is indeed an opioid or opioid medication, right?

A It is a semi-synthetic opioid.

Q Okay. Is there – when I am saying "opiate" or "opioid," are they synonymous, or are they different? I don't want to get it wrong.

A To the public, they are all the same.

Q Okay.

A To the physicians, they are not.

Q Okay. What is the difference?

A Opioids to public includes fentanyl, Morphine, methadone, hydromorphone – all of those to the public is opioids.

Q Okay.

A But if a doctor tells me his patient is on opioids, I am not going to assume that patient is on oxycodone, methadone or fentanyl. I'm going to assume that patient is oxycodone and is not on any other opioid.

Q Okay. Now, there is no mandatory rule about the number of urine drug screens a doctor has to use with each patient, is [228] there?

A No.

Q It is up to the discretion of the doctor, right?

A Yes.

Q And practitioners have different ideas about how effective urinalysis is, don't they?

A Yes.

Q Some people find it very effective, and some people disagree. That's true?

A A lot of people find it very effective. A few people think that they are not effective.

Q Okay. And in terms of the dosage, there is – just like the CDC guidelines are not mandatory, there is no mandatory rule that sets an upper boundary on how much oxycodone can be prescribed to any given patient, right?

A No.

Q That is to be determined by the doctor based upon his own analysis and theory of what he believes, right?

A Yes.

Q There is no mandatory prohibition on the combination on Suboxone and oxycodone, is there?

A No.

Q And there is no mandatory prohibition on the combination two different strengths of oxycodone at

the same time; say, 20-milligram – 15-milligram and 30-milligram?

[229] A No.

Q So there is no mandatory prohibition on that?

A No.

Q And there is no mandatory prohibition on the combination of oxycodone, Xanax and Soma, is there?

A No.

Q All of that in terms of what combinations to use is left to the discretion of the doctor, the medical professional, right?

A Yes.

Q And that doctor's view and his opinion may be shaped by whatever theories and literature he subscribes to, right?

A Yes.

Q And sometimes a doctor might subscribe to some theory or literature that turns out to be wrong, right?

A Yes.

Q And sometimes a doctor who is believing in the wrong theory could make a bad mistake, right?

A Yes.

Q It is not mandatory that a doctor has to request a police report in the event of lost medication, is it?

A It is not mandatory.

Q It is a – there is no mandatory prohibition on seeing a patient with somebody else in the room at the same time, right?

A No, there is not.

Q And, in fact, you said that in some circumstances when it [230] is a fiance and her intendant for lack of a better term, or a husband and wife, it can be helpful?

A Yes.

Q Okay. But ultimately it is up to the patient I understood you to say whether they want somebody else in there, right?

A Patient and the doctor.

Q Right. And you might say, "Hey, I would rather meet with you by myself," and the patient says, "No. No. I really want this person in here, Doc," and you would take that into account?

A Yes.

Q Now there is also no mandatory rule about what a doctor can charge for his service, is there?

A No.

Q That varies depending on who it is and what they are doing, right?

A Yes.

Q Higher dose opiate patients may be more demanding than others, right?

A Yes.

Q And they pose greater risks, right?

A Yes.

Q They might have a greater need for access to the doctor, right?

A Yes.

[231] Q And so if you are dealing with a high dose opiate patient, it might be more work for you overall than one who is not, right?

A Not necessarily.

Q It may be is my question.

A Yes.

Q Okay. There are no mandatory rules about how doctors interact with or chose what pharmacies to recommend, are there?

A No.

Q You did say during your testimony earlier that some pharmacists based on current climate, I will say,

are hesitant to fill narcotic prescriptions even for people who need them, right?

A Yes.

Q So sometimes a patient may go to a pharmacy and try to get his legitimate pain medication, and then you find out they couldn't get it from the pharmacy, right?

A That's correct.

Q And then you might have to recommend another pharmacy that you know is more reliable, right?

A Yes.

Q And that is not because there is anything wrong with your prescription in every case, it is often because the pharmacies just don't want to deal with the narcotics, right?

A That is correct.

[232] Q Because over time, and particularly now, pharmacies are becoming less and less cooperative with doctors who are trying to use pain medicine, isn't that true?

A Yes. It is true.

Q And it makes it harder for you, doesn't it?

A It can, yes.

THE COURT: Are pharmacies targets for robberies?

THE WITNESS: They are.

THE COURT: For drugs?

THE WITNESS: Yes.

BY MR. BRINDLEY:

Q There is no mandatory time frame on how often patients have to come in to see their pain management doctor, is there?

A No.

Q Now, you said earlier, I think, something like this – I want to make sure I have it right. If you had a long-time patient who had been a good patient for a long time, and that person was in prison, and the family member came in to pick up their medication and misled you about the situation, you said that in that circumstance, it would be possible that even though you have good intentions, you might be prescribing incorrectly?

A Yes.

Q Now, you were not given access to all of Shakeel Kahn's interactions with the Arizona Medical Board, I don't think, [233] were you?

A No.

Q So you do not know if Dr. Kahn had prior prescriptions evaluated by the Arizona Medical Board and found to have been proper, do you?

A Actually, I have been informed of his situation with medical – Arizona Medical Board.

Q You have been informed that his license was suspended?

A Yes.

Q But do you know about all of his prior interactions with them before that?

A I have some idea. I have some information that there was a complaint about him.

Q That led to the suspension?

A Yes, and that he responded. He had an expert witness.

Q Yes.

A And that he responded to that.

Q With respect – before the suspension issue came up, before that complaint, do you know if Shakeel Kahn had responded to other complaints?

A No, I don't know.

Q Do you know if the Arizona Medical Board had previously found with respect to other complaints that Shakeel Kahn acted properly?

A I don't know about that.

[234] Q You would agree with me if a doctor was engaging in prescribing practices and had one of his practices challenges to a medical board, then the

medical board said, "You didn't do anything wrong," you would agree with me that that could lead the practitioner to believe he was doing the right thing, right, or that there was nothing wrong with his practice?

A He could think that, yeah.

Q Okay. Could it turn out that he was wrong, but in good faith believe it, right?

A Yes.

Q It is also true, Dr. Shay, that doctors in general have to have concerns about potential liability for things that happen with their patients, right?

A We are always liable for the treatment that we provide to our patient.

Q There is malpractice concerns that you have to keep in mind, right?

A Yes.

Q There are no mandatory rules about what kind of financial releases doctors can use, are there?

A No.

Q You talked about an addiction statement that Dr. Kahn uses in the files that you reviewed, correct?

A Yes.

Q And in those addiction statements that the patients filled [235] out, each patient had to indicate that

they were not suffering from the effects of addiction, right?

A Yes.

Q And they had to indicate that they were in pain for a pain condition – chronic pain condition?

A Correct.

Q They had to indicate that they were not sharing, selling or abusing their prescription pain medication, right?

A We do not ask them every time if they're selling or sharing, but we monitor for those.

Q You are speaking of "we," but Dr. Kahn's particular form had that listed; that they were not selling their pills, right?

A I don't specifically recall in his specific progress notes as they occurred that he had talked to them, and they had told him that they were not selling their drugs, that was –

Q You don't remember that?

A Not in a progress note, I don't.

Q Maybe we are talking about two different things. I not talking about progress notes. I am talking about each time that Shakeel Kahn had a visit with one of his patients, you saw that they had to fill out a statement indicating they were not addicted, that they weren't abusing their pills, et cetera, right?

A Yes.

Q Okay. In that statement it included that they weren't [236] selling or sharing their pills?

A I'm not quite sure if they were doing that every single time.

Q Okay. But you saw in the records it was frequent?

A Yes, it was.

Q There is no mandatory rule prohibiting husbands and wives from going to the same pain management doctor and receiving medication, is there?

A No.

Q When a husband and wife are both going to the same doctor for pain management, then that doctor has access to information about what drugs both of them are on, right?

A Yes.

Q Now, if they had different doctors – each of the separate doctors for the husband and wife, they would actually have less information about what drugs the spouse was taking, right?

A Yes.

Q And they would then therefore have less information about what drugs their patient might have access to that weren't his own?

A Correct.

Q You talked a lot about Dr. Kahn's patient files including cut and pasted or what appears to be on its face – obviously, cut and pasted summaries of interaction with patients?

A Uh-huh.

[237] Q Did you say "Yes" just for the court reporter?

A Yes.

Q And that was obvious as you looked at the patient files that Dr. Kahn was using cut and paste in the files?

A Yes.

Q Now, somebody who was intentionally trying to falsely give the impression of good records, they wouldn't want the record to be copy and paste every time, would they?

A No.

Q But somebody who is copying and pasting all the time that maybe an indication of a doctor who is a little lazy, right?

A Yes. Yes.

Q Maybe overworked and overwhelmed and letting his practice get too big, possible, right?

A Possible.

Q You would agree with me that a doctor can intend to act within the acceptable norms for the medical profession and still fall short, right?

A A doctor can intend and fall short, that is correct.

Q And a doctor can intend to act within the acceptable norms for the medical profession, but still end up making recordkeeping errors, right?

A Yes.

Q And some doctors keep sloppier records than others; that is just a fact, isn't it?

[238] A Yes.

Q Everybody should do a better job. Everybody should do a good job. Some doctors don't do as good a job as they should?

A Yes.

Q Then they ought to, right?

A Yes.

Q Even though they intend to be doing a good job, a doctor might still keep sloppy records, right?

A Yes.

Q Now, doctors who act within the acceptable – let me rephrase.

Doctors who intend to act within acceptable norms for medical professionals can still end up creating

unsafe situations for patients in certain circumstances, can't they?

A Yes.

Q And doctors who intend to act within the acceptable norms for medical professionals can still end up committing malpractice, can't they.

A Yes.

Q And doctors who intend to act within acceptable norms for medical professionals can still get disciplined by medical boards, can't they?

A Yes.

Q Even when their intentions are good, and they are trying, it happens, doesn't it?

[239] A Yes.

Q Now, you have indicated that you have been engaged by the United States to give your opinion as an expert in pain management about Shakeel Kahn, right?

A Yes.

Q And you have throughout the course of the day criticized Shakeel Kahn for practices that you said put patients at risk, right?

A Yes.

Q And you have cited your own vast experience with pain management as the basis for your critique, right?

A Yes.

Q Okay. And as a pain management doctor the entire time you have been acting as pain management doctor you have always intended to act within the acceptable norms for medical professionals, haven't you?

A Yes.

Q And you have always acted in good faith to the best of your ability trying to treat your patients, haven't you?

A Yes.

Q Okay. Now, you are presently licensed in the State of Wyoming, right?

A Yes.

Q You are licensed in other states too, aren't you?

A Yes.

[240] Q You are licensed in the state of Texas?

A No.

Q You were licensed in the state of Texas?

A I was.

Q And you are licensed in the state of California?

A I am.

Q Okay. Now, when you were licensed as a doctor in the state of Texas, you practiced pain management, didn't you?

A Yes.

Q During the entire time when you were practicing pain management in Texas, you intended to act within the accepted norms for medical practice, right?

A Yes.

Q But, Dr. Shay, you were disciplined?

A Yes.

Q By the medical board of Texas, weren't you?

A Yes.

Q And you were disciplined specifically for engaging in behavior that put a pain management patient in danger, right?

A Yes. I pre-signed a prescription, left it with my physician assist, and asked her to fill out the prescription – something that would be permissible today in Wyoming and Texas and California –

Q Doctor –

A – but it wasn't then.

[241] Q Doctor –

A That is why I was – I paid a fine.

Q Doctor, wait a minute. Wait a minute. I need you to answer the question that I am asking. We will get to all the details. Don't worry.

A Yeah.

Q But here is the bottom line. You had a pain management patient that the Texas Medical Board said was endangered by something that happened at your office, right?

A Yes.

Q Okay. And what happened was you signed a prescription that hadn't been filled out yet, right?

A Yes.

Q And you permitted the physician's assistant to fill out the prescription, right?

A That is correct.

Q And in that instance, you had a patient who was supposed to be receiving 40 milligrams per day of methadone?

A Yes.

Q And the physician's assistant signed a prescription increasing 40 milligrams a day to 160, right?

A Patient did that.

Q Okay. The – the prescription –

A The prescription said that, but the patient forged it.

Q Wait a minute.

[242] A I was responsible for it.

Q Hold on a minute. In the order determined by the Texas Medical Board, it doesn't say anything about the patient forging the prescription, did it?

A Because we couldn't prove it.

Q Okay. So the answer to my question, Dr. Shay, is it in the order from the Texas Medical Board – doesn't say anything about a patient forging the prescription, does it?

A No, it doesn't.

Q In fact, in the order from the Texas Medical Board, it says that your physician's assistant prescribed 160 milligrams per day when the patient had been taking 40; that's what is says in the order?

A That's right.

Q At the end of the order, you signed your name, and you said that you have read and understand the agreed order – you agreed to it, right?

A Yes, I did.

Q And part of what you agreed to was your physician's assistant had prescribed 160 milligrams to somebody that was supposed to be getting 40, right?

A That's correct.

Q And what you are saying now is that the truth of the matter was the patient even though that is what the medical board decided and that is what you signed, the truth of the matter is [243] the patient forged the signature, right?

A That is correct.

Q The patient went behind your back, right?

A That is correct.

Q The patient engaged in dishonesty, right?

A Uh-huh.

Q And as a result, you got in trouble, right?

A It was my responsibility, and I should have not signed it.

Q Okay. And so the patient in that instance you learned that patients – pain patients can be dishonest with the doctor and deceptive?

A That's correct.

Q And the Texas Medical Board found your physician's assistant wrote and you signed – Texas Medical Board found that caused that patient to suffer unconsciousness, right?

A Yes.

Q To suffer vomiting, right?

A Yes.

Q Choking, right?

A Yes.

Q Three days in intensive care, right?

A Yes.

Q And six days in the hospital, right?

A Yes.

Q You agreed to all of those findings?

[244] A Yes, I signed it.

Q The prescription, you mean?

A And the order.

Q And the order. That is what I was concerned with. You signed the order as well? You agreed with all the findings?

A Yes.

Q Okay. You had to pay a $5,000 fine, didn't you?

A Yes.

Q But in the order of the Texas Medical Board, Dr. Shay, also indicated that you had ceased your pain management practice, didn't it?

A You know when something happens to your patient, you stop and take a break, and you analyze your office and see what happened, and that is what I did.

Q So the answer to the question – I'm sorry. But the answer to the question is that the Texas Medical Board's order indicated that you ceased your pain management practice, right?

A I told them, "I am not going to practice until I get my office together."

Q Okay.

A That is the meaning of ceasing.

Q Okay. So you stopped practicing pain management for a period of time?

A Yes.

Q Okay. This morning when you were giving your credentials [245] and again when I gave you the opportunity here this afternoon and I asked you whether you had been pain management continuously since 1995, you said you had, correct?

A Yes. I stopped for two or three months.

Q Okay.

A In – from 2003 until 2019, 16 years ago, two/three months, yes. I stopped practicing. I think every doctor who gets in trouble –

MR. BRINDLEY: Judge –

A – should stop.

MR. BRINDLEY: – I would ask that the witness be responsive to the question. He can't be opining when there is no question posed.

THE COURT: Sustained.

Listen to the questions.

BY MR. BRINDLEY:

Q All right. So –

THE COURT: I think he has been very responsive.

MR. BRINDLEY: Thus far, yes. Thus far, I would agree.

BY MR. BRINDLEY:

Q Now, Dr. Shay, here – so there was a period of time where you stopped pain management. That was in 2004?

A Yes.

Q All right. And that was in the state of Texas where you [246] had been practicing in 2004, right?

A Yes.

Q And after the issue with the medical board, you left Texas, didn't you?

A Yes, I did.

Q And you started a pain management practice in California?

A Yes.

Q So the situation was there had been a problem with a dishonest patient that led to a medical board fine in Texas, and then you moved on to another state, right?

A Yes.

Q Okay. And do you know that after he had a problem with the medical board in Arizona, Shakeel Kahn moved to Wyoming? Do you know that?

A Yes.

Q Okay. Now, in 2005, in California, you also got – I think you are going to – I think I have this right. You got a letter of reprimand from the medical board of California. I think it was for this same whole incident?

A Yes. So when you go from one state to another state what you have done in the other state gets reflected in the other state.

Q So you got a letter of reprimand in California too?

A Yes.

Q Dr. Shay, in preparation for your testimony, extensive [247] testimony here today, obviously you had some lengthy meetings with the United States Attorney's Office?

A Yes.

Q Did you advise the United States Attorney's Office about this finding from Texas Medical Board about prescription practices that put a patient in danger?

A Yes.

Q You did.

MR. BRINDLEY: Judge, may we be heard at the sidebar?

(At sidebar.)

MR. BRINDLEY: Your Honor, if, in fact – I did not think that he advised the United States Attorney's Office. If he did, then that meant the United States was in possession of this obviously *Giglio* material regarding their expert witness and that was not disclosed. I bring the Court's attention to that, because that is a violation of *Giglio*, and I – I wanted to bring it to the Court's attention. I don't know what I am going to ask for as a result. I want to question him a little bit further, but I want to make complete for the court.

THE COURT: Thank you.

(End of bench conference.)

(Proceedings resumed in open court.)

BY MR. BRINDLEY:

Q All right. Now, in light of your experience with the Texas Medical Board – Texas Medical Board, I think you can agree [248] with me that when your

prescribing practices ultimately ended up in harm to a patient, it was still true that you intended to act within the acceptable norms for medical professionals, right?

A It has always been my intention.

Q Okay. So you know that doctors' prescribing practices can put patients at risk even when the doctor intends to act within the acceptable norms for the medical profession, right?

A It can happen, yes.

Q And even though with the Texas Medical Board you admitted to improper prescribing practice that put a patient in danger, you do not believe that you were guilty of a crime, do you?

A No.

Q And the reason you don't believe so – in fact the reason you know that you were not is because you were intending to act within the norms for the medical profession, right?

A Yes.

Q Even though you admitted that in this instance there was a problem with your prescribing practices that led to a patient being in danger, even though you admitted that with the Texas Medical Board, it was not your intention when you did that – it was not your intention when you were dealing with that patient to act outside the usual course of practice for doctors, was it?

A No.

[249] Q Okay. So you would agree with me, then, that you know that one can engage in improper prescribing practices that put patients in danger and do so while not at all intending to act outside the usual course of practice for doctors, you agree?

A You said, "improper practices." It was one incident of practice.

Q All right. I will rephrase from the plural to the singular. So let me put it to you another way, then. So you agree that even though in the one instance – I don't mean to suggest there is more. There is one thing you had that was your problem. It was only one. I don't want to suggest anything else.

But even though you admitted that in that instance your prescribing practice was improper, you still did not intend to act outside the usual course of practice for doctors, did you?

A No.

Q And even though in that one instance your prescribing practice was improper, you still intended to act in good faith and tried to do so, didn't you?

A Yes.

Q Okay. So then more generally, you know from your own experience that when a prescribing practice turns out to be dangerous and mistaken, a doctor could still be acting in good faith, right?

[250] A Yes.

Q And you know that when a doctor's prescribing practice might lead to an injury or even a death of a patient, that doctor can still be intending to act within the norms of the medical profession and get it wrong, right?

A Yes.

Q And when a doctor's prescription leads to an injury or death, you know that that doctor can still be acting in good faith, even though they got it wrong?

A Yes.

Q Okay. Now, you talked about at some point with the government I think risks of what everybody in your industry – your business calls "diversion," right?

A Yes.

Q Diversion means basically taking my pills that you give to me legitimately, and going to sell somebody like the prosecutor, or whoever I might sell them to, right?

A Yes.

Q And you know that in your own experience, patients can go out of their way to lie to their doctors and hide the facts they are diverting, right?

A They can.

Q And you have – although you have never intended to allow it to happen, there has been circumstances where you have dealt with patients that turned out to be diverting medications?

[251] A Yes.

Q And you didn't know it when it was happening, right?

A Yes.

Q You were surprised when you found out that it happened, right?

A Yes.

Q You were angry the patient had misled you and deceived you, right?

A A few times in my career that has happened, yes. We have the tools to detect those patients.

Q True. It is true that there are tools that you say can help detect diversion, right?

A Yes.

Q There are tools that you say can help detect addiction, right?

A No.

Q But there is no mandatory rule that those tools have to be used by every professional, is there?

A No.

Q Okay.

A But you got to show good faith in your medical records required by Wyoming Medical Boards.

Q So back to the original question I asked that was: There is no mandatory rule that you have to use any particular tool, right?

[252] A No. That's right.

Q And then with respect to – and then you talked about the medical records, and you need to show good faith in the medical records, right?

A Yes.

Q Now, a doctor can be intending to do a good job, you agree, but still keep lousy, sloppy medical records, right?

A Yes.

Q Okay. And you agreed that – and you said it happened to you a few times, and you tried to use the tools to prevent it –

A Let me explain. A doctor can intend to do a good job and – but if he keeps poor medical records, he is not going to help his patient.

Q Right.

A So if the doctor sees that there is poor medical records or a doctor like me sees, "Hey, I shouldn't have signed that prescription in Texas," the doctor needs to go back and evaluate his work.

Q Okay.

A That is what a doctor asks.

Q Sure. So – and that is what you did. And in your instance, you realized that the practice you used on that occasion was wrong, right?

A Yes.

[253] Q You went back and reevaluated, right?

A Yes.

Q After you had the issue with the medical board, right?

A Yes.

Q And going back to the talk about the medical records, it is possible a doctor can intend to be within the boundaries for what medical professionals can do and still keep inadequate records, you agree with me on that?

A Yes.

Q Okay. It may be the case that the doctor should reevaluate, but it is also true that even if he is keeping bad records or sloppy records, he might still intend to be doing a good job?

A Yes.

Q Now, you also agreed with me a little while ago – and I want to follow up a little bit on this before we

stop for today – that doctors can be influenced by theories and literature that turn out to be wrong, right?

A They can be influenced, yes.

Q And doctors who intend to act within the acceptable norms for medical practice, could make poor decisions due to reliance on ideas or theories that turn out to be just not right, correct?

A Yes.

Q All right. Now, you have been in the pain management [254] practice for a lot of years, right?

A Yes.

Q And throughout the course of your experience, you know that there has been significant disagreement at various times by various medical professionals about the use and the utility of high dose opiate treatment, right?

A Yes.

Q There are – and now in the present day, the current majority of thought is that some of the higher doses that were being given in years past that might not have been a very good idea, right?

A Yes.

Q Okay. But in the past, in years past there was a school of thought regarding high dose opiate treatment that you could just keep increasing opiates until

the person achieved functionality as long as the side effects weren't too bad, right?

A Yes.

Q There was a number of – there's a whole group of medical professionals in pain management that was the right way to go –

A Yes.

Q – correct?

Now, over time I think it is your opinion that that theory that people were using has proved to be inaccurate and [255] dangerous?

A Yes.

Q Okay. That theory of ultra high dose opiate use – that particular term – ultra high dose opiate treatment, are you familiar with the theory that was advocated by Dr. Forrest Tenant?

A No.

Q You are not. Okay. Are you familiar with high dose opiate theory advocated by Dr. Lynn Webster?

A Yes.

Q Okay. Are you familiar with high dose opiate theories advocated by Dr. Thomas Cline?

A No.

Q Are you familiar with high dose opioid treatment theories advocated by Dr. Steven Passik?

A Yes.

Q And you know that in certain instances doctors that espouse or advocate certain theories about pain management or any subject, they hold these symposiums, right?

A Yes.

Q And then a whole bunch of doctors can come out and listen to them and give their opinions about how you should practice pain management, for example, right?

A Yes.

Q And you know that there in the past there was a whole [256] series of these kinds of lectures where people advocated this high ever-increasing high dose of opiates, right?

A Yes.

Q And the doctors who attended those lectures, they could be influenced by that, right?

A I did attend those conferences, but I wasn't influenced by it.

Q You were not, but other people could be, right?

A A few of my peers were.

Q Okay. And doctors who are intending to act in good faith could adopt that philosophy even though it is wrong, right?

A Yes.

Q Doctors who are intending to act in good faith could practice that philosophy, even if it turns out to be a terrible idea?

A Yes.

Q And doctors who are intending to act from good faith could misinterpret what was being advocated by these lectures? That could happen, too, right?

A We are doctors. We are all – we have a high standard for ourselves and what the society wants, but anything that you say can happen.

Q Yes.

A Anything that you can say, can happen, but we are doctors to not let those things happen.

[257] Q I understand you don't want to let them happen, but you would agree with me that doctors, they can misinterpret things and make mistakes about what they ought to do based on what they hear and read, can't they?

A Yes. They can be influenced, but there is a lot of reading. If you just concentrate on what – the area you want to hear, then you are going to make mistakes.

Q Sure. A doctor could be acting in good faith and mistakenly latch on to one particular theory and only listen to that, right?

A Unfortunately.

Q And as a result a doctor who is acting in good faith could engage in all kinds of mistaken and improper practices, couldn't he?

A Yes.

MR. BRINDLEY: Judge, it is 5:00. We had a long day. This is a perfect place to stop if we could.

THE COURT: Makes good sense.

Ladies and Gentlemen, we will get started promptly at 7:30 tomorrow morning. I want to tell you this isn't the first time that this has been done in the United States of America. There are judges I know who start routinely at 6:30 in the morning with their juries, but I'm not one of them. I will still be standing in the shower about 6:30, but I hope all of you are able to survive this early day – that early day

---