STATE OF MICHIGAN

54TH JUDICIAL CIRCUIT COURT (TUSCOLA COUNTY)

PEOPLE OF THE STATE OF MICHIGAN

vs. File No. 17-013994-FH

JOSEPH EDWIN OESTERLING,

Defendant.
_________________________________/

JURY TRIAL - VOLUME IX of XIV - EXCERPT
(Testimony of Dr. Carl W. Christensen, M.D.)

BEFORE THE HONORABLE AMY GRACE GIERHART, CIRCUIT JUDGE

Caro, Michigan - Wednesday, September 27, 2017

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WITNESSES: DEFENDANT

None

EXHIBITS:	IDEN'D	ADM'D
None		

1 Caro, Michigan
2 Wednesday, September 27, 2017
3 (Proceedings commenced at 8:38 a.m., jury not
4 present.)
5 THE COURT: Good morning. Mr. Wanink, are
6 you ready for the jury?
7 MR. WANINK: Yes, Your Honor.
8 THE COURT: Mr. Chapman, ready for the jury?
9 MR. CHAPMAN: Ready, Your Honor.
10 THE COURT: All right. Mr. Oprea?
11 (Jury present at 8:39 a.m.)
12 THE COURT: Good morning, ladies and
13 gentlemen. Welcome back to Circuit Court.
14 Mr. Wanink, if you'd like to proceed.
15 Dr. Christensen, you can retake the stand for
16 me. Sir, I'll just remind you that you're under oath.
17 THE WITNESS: Yes, Your Honor.
18 THE COURT: Good morning.
19 THE WITNESS: Good morning.
20 THE COURT: And watch the tippy chair.
21 CARL W. CHRISTENSEN, M.D.,
22 having been previously duly sworn, at 8:40 a.m.
23 testified further under oath as follows:
24
25

D I R E C T E X A M I N A T I O N C O N T ' D.

BY MR. WANINK:

Q Dr. Christensen, I'm gonna again hand you back Exhibit 90, which is the guidelines. When we wrapped up yesterday, we were talking about a patient by the name of Dennis Marcum. I'm gonna hand you back People's Number 9 which was identified as his chart yesterday, and, Dr. Christensen, if you would look at even the most recent of the office visits which I believe was May or June.

A I have June 23rd.

Q All right. Looking at June 23rd, the diagnosis for pain which supported the Norco prescription, what does that indicate in the medical chart?

THE COURT: And, I'm sorry, not to interrupt but was that 2016? June 23rd, 2016?

THE WITNESS: Yes, Your Honor.

THE COURT: All right. Thank you.

THE WITNESS: On the -- on Page 4 for what I see, assessment and plan is benign prostatic hypertrophy with lower urinary tract symptoms.

BY MR. WANINK:

Q And with regards to the prescription for Norco, what does it indicate is the diagnosis?

A I'm sorry. There's more below. So for the -- at the

1 bottom of the page, bilateral knee pain. Continue
2 Norco 7.5 milligrams four times daily 30 days.
3 Q Thank you. May I see the exhibit?
4 Now, if we go back to the January 14, 2016,
5 medical chart, what does it indicate is the diagnosis
6 for the hy- -- in support of the hydrocodone?
7 A At the bottom of Page 16, it stays lumbago, which is
8 low back pain. Continue Norco.
9 Q And so the diagnosis in support changes?
10 A Yes, it did.
11 Q And looking at that chart, did you notice anything that
12 would cause that diagnosis to change that occurs in the
13 interim of six months?
14 A I did not see any -- let's see. It appears on the
15 initial visit in -- let's see. On the initial visit I
16 have from April 9th, it says that he presented with
17 right knee pain, depression and anxiety, and the
18 initial diagnosis was bilateral knee pain.
19 Q So we go from knee pain to lumbago to knee pain?
20 A It appears so, yes.
21 Q And do you see anything that would cause a change in
22 diagnosis in that medical chart?
23 A So in May he presents with right knee pain. In June --
24 this is 2015 now -- right knee pain. In July, right
25 knee pain. August of 2015, right knee pain. In

1 January of 2016, it states he returns on January 16,
2 2015, with right elbow and right knee pain, depression.
3 And then in February again it says right elbow and
4 right knee pain. Same in March of 2016. Same in
5 April. Same in May and same in June.
6 Q Do you see anything that would have caused the
7 diagnosis to change in those medical records?
8 A Not according to the patient complaint, no.
9 Q As a physician, do you have to have a basis -- a
10 medical diagnosis or basis for issuing an opioid
11 prescription like Norco?
12 A You have to have a legitimate reason, yes.
13 Q And so is there anything concerning there that we're
14 changing the diagnosis back and forth and there seems
15 to be no justification?
16 A It's possible, yes. I don't know if it was a medical
17 error or just put in the chart.
18 Q All right.
19 A But it doesn't fit the patient's complaints.
20 Q And if you look at those medical records for the
21 musculoskeletal exam it says that was done for every
22 one of those visits, what does it indicate?
23 A Full range of motion in all joints. Normal joints and
24 muscles.
25 Q Does that seem consistent with the complaints of pain

1 and knee pain, elbow pain, lumbago?
2 A No.
3 Q So in those records do you see any justification for
4 any of those diagnosis [sic] other than the patient
5 complaint?
6 A The documentation that I see here is patient complaint.
7 Q As a physician, is it a good idea to just take the
8 patient's naked word that they're in pain?
9 A That is not sufficient for a situation where you are
10 considering prescribing opioids, no. You have to have
11 additional information.
12 Q Such as actually doing a physical examination or some
13 sort of testing?
14 A A complete history, a physical examination, lab work,
15 yes.
16 Q And that's required by those guidelines?
17 A Yes.
18 Q Thank you. I'll take Mr. Marcum's chart back.
19 Now I'm gonna hand you People's Exhibit
20 Number 5. It's identified as the patient chart for a
21 patient by the name of Cassie Tappen, correct?
22 A Yes.
23 Q Did you review that chart as well?
24 A Yes.
25 Q I'm gonna start right off by looking at the very first

1 drug screen in that medical chart that's dated
2 December 21st, 2015, if you could locate that for me.
3 A I have it on Page 47.
4 Q Looking at that particular chart, do you recall looking
5 at that before?
6 A Yes.
7 Q And was there anything about that urine toxicology
8 screen from December 21st, 2015, that drew your
9 attention?
10 A Yes.
11 Q What was that?
12 A The urine drug screen is -- the patient was prescribed
13 according to this Klonopin and Norco, and the urine
14 drug screen shows Xanax and methadone and morphine.
15 Q As well as marijuana, true?
16 A Yes.
17 Q And so let's look ahead to January 21st, 2016, patient
18 chart for that office visit.
19 A I have it on Page 14.
20 Q Do you see any discussion listed in that medical chart
21 with regards to that urine toxicology screen?
22 A It says urine drug screen was done today. Doesn't say
23 anything else that I see.
24 Q Does it indicate whether the patient received a Norco
25 prescription?

1 A On the following page, it states that they prescribed
2 Norco 7.5 milligrams three times a day 30 days,
3 Restoril, which is a sleeping medication, a
4 benzodiazepine, and Klonopin.
5 Q Now, did you -- what were your concerns, if any, in
6 regards to the urine test that was done the month
7 before that he would have had in front of him on this
8 particular medical appointment?
9 A The most important concern was that the urine drug
10 screen was positive for methadone. Methadone is a very
11 potent pain medication. It's only 3 percent of the
12 pain medication prescriptions in the United States, but
13 it accounts for 30 percent of the overdose deaths. Or
14 if it's not a prescription pill, it's coming from a
15 methadone clinic, which means the patient's being
16 treated for opioid dependence. And both of those --
17 either one of those possibilities is very concerning
18 because you need to make sure why you're really
19 treating the patient.
20 Q Is it a bad idea to have someone on methadone and Norco
21 at the same time?
22 A It's been done, but it needs to be done very carefully
23 and it should be done in cooperation between the two
24 prescribing doctors so they both know what's going on.
25 Q If there was no prescribing doctor and the patient was

1 abusing methadone, would that be of even more concern?
2 A Yes, because I would call -- I would worry about what
3 the real diagnosis for this patient was. If we are
4 giving the patient opioids and their real diagnosis is
5 opioid dependence, that's dangerous for the patient.
6 Q And so is it a good idea to continue the patient on
7 Norco in light of that drug screen?
8 A You need to immediately address it with the patient to
9 find out what's going on.
10 Q Should Norco have been prescribed to Miss Tappen on
11 January 21st?
12 A Not without an immediate discussion about what -- why
13 the drug screen showed what it did.
14 Q And there appears to be no discussion contained in that
15 report?
16 A Not that I saw.
17 Q Let's look at Miss Tappen's urine sample from
18 February 18, 2016.
19 A I have it on Page 45.
20 Q Anything of concern with that urine drug screen?
21 A So the medications list here -- listed here as being
22 expected to be seen were Norco, which is hydrocodone.
23 There is no hydrocodone and none of the normal
24 breakdown products for hydrocodone, and the drug screen
25 also shows Codeine and THC.

1 Q And is that of some concern?
2 A Again, the prescribed medication's not there and a
3 non-prescribed medication is there, and -- yes.
4 Q All right. Let's look at the March 17, 2016, patient
5 visit.
6 A I have that on Page 8.
7 Q Any discussion in that patient chart with Miss Tappen
8 about the urine result that she had from the previous
9 month?
10 A It says MAPS reviewed and urine drug screen done today.
11 Q So no discussion with her at all about the fact that
12 there's no Norco in her system?
13 A I don't see it.
14 Q And, again, if there's no Norco in your system that's
15 being prescribed to you, what should that be telling
16 you as a physician?
17 A So if a patient's prescribed a narcotic and it does not
18 show up in their urine, there's several possibilities.
19 One is that it's a laboratory error, which is not
20 likely in the situation because this is full drug
21 testing that's sent to a laboratory, it's not a drug
22 screen that's done in your office.
23 It may be a -- a watered-down specimen, but I
24 didn't see any sign of that.
25 The patient may be not taking it, which means

1 they're either hoarding it or diverting it, and both of
2 those are a major concern if somebody is prescribed
3 narcotics.
4 And the final possibility is the patient is
5 abusing it, which means that they are taking all of it
6 right away and then by the time they come back to your
7 office there's nothing left.
8 Q And so in either of those cases should a doctor be
9 concerned?
10 A Yes.
11 Q Under those guidelines, should they address that with
12 the patient?
13 A The guidelines say you need to be diligent about
14 diversion and consider referral for any substance abuse
15 treatment and monitor carefully, yes.
16 Q Do you see that being done in this particular patient
17 visit?
18 A No, sir.
19 Q Does he give her a Norco script still?
20 A So she's continued -- she's continued on the sleeping
21 pill, the Norco, Klonopin and also Adipex, which is a
22 stimulant -- stimulant used for weight loss.
23 Q And so despite that urine result, Norco is continued?
24 A Yes.
25 Q Let's look at the urine sample collected on March 17,

1 2016.
2 A I have that on Page 42.
3 Q Anything about that urine screen?
4 A So it was once again positive for methadone, and the
5 way the lab test reads, it is mostly methadone
6 breakdown product in the body, which means that the
7 urine was not tampered with, there was no methadone
8 added to the urine. It's positive for marijuana, and
9 it is negative for Klonopin, Restoril and hydrocodone.
10 Q So now we're positive again for methadone and negative
11 for the Norco?
12 A Yes.
13 Q Let's look at the April 18, 2016, patient visit.
14 A So I have that on Page 6.
15 Q Do you see any discussion with Miss Tappen that occurs
16 according to that patient chart?
17 A It states urine drug screen was done today.
18 Q No discussion at all with her that's referenced in that
19 chart?
20 A No.
21 Q Just for the sake of argument, I mean if you talk to
22 your patient about those things, is that something that
23 you're gonna document?
24 A You need to document it because you're prescribing
25 opioids, yes. You need to document that you have a

1 legitimate reason for prescribing these medications.
2 Q And so does Miss Tappen receive a Norco prescription on
3 April 18, 2016?
4 A So on Page 7 she's prescribed the sleeping pill
5 Restoril, Norco, Klonopin and Adipex.
6 Q So again receives a Norco prescription in light of
7 those urine results?
8 A Yes.
9 Q Again, now we're three months in with these urinalysis
10 results being abnormal and continuing the patient on
11 Norco. Is this a good method of treatment?
12 A No, because, again, you don't -- there's a major
13 question about what the real diagnosis is, and if the
14 medication is being diverted or abused, it needs to be
15 addressed.
16 Q What does it indicate is the basis for the Norco
17 prescription in the medical chart?
18 A Lumbar spondylosis, which means degeneration of the
19 back.
20 Q All right. Let's look at the urine sample collected
21 April 21st, 2016.
22 A I have it on Page 39.
23 Q And is there anything about that particular urinalysis
24 result?
25 A It's positive for methadone and methadone breakdown

1 products. It's positive for marijuana. It's negative
2 for Klonopin, Restoril and Norco.
3 Q Now, if you're running MAPS and you're not seeing a
4 methadone prescription for someone, is that generally
5 indicative that they're not receiving that as a result
6 of a physician's treatment?
7 A They may be receiving it at a federal methadone clinic
8 which does not report to the MAPS system.
9 Q All right.
10 A There is no way of accessing that. You need to talk to
11 the patient about it.
12 Q And if that was never done, if it was never discussed,
13 and the opioids are continued, is that advisable?
14 A No.
15 Q Why not?
16 A Again, you are calling into question what the real
17 underlying diagnosis is, and if it's either diversion
18 or addiction, you're making things worse. You're
19 violating the ethical principle of first do no harm.
20 Q And so looking at the office visit on May 16, 2016,
21 following that last drug screen on April 21st, do you
22 see any discussion with Miss Tappen on that day about
23 the methadone and the fact that she's negative for the
24 Norco?
25 A April -- which date are you -- I'm sorry.

1 Q May of 2016.
2 A So I have that on Page 3, and it says urine drug screen
3 performed today.
4 Q No discussion again about these abnormal test results?
5 A Not that I see.
6 Q Is the patient continued on Norco again?
7 A She's continued on Klonopin, Norco, Restoril and
8 Adipex.
9 Q And so we have now gone several months with abnormal
10 results beginning with January 21st, 2016, and in all
11 of those cases was a Norco prescription justified based
12 on what's in the medical chart in light of the
13 guidelines?
14 A Not in my opinion, no.
15 Q And when Miss Tappen despite the -- what did you say
16 the diagnosis was? I don't want to butcher it.
17 A Lumbar spondylosis.
18 Q Despite that diagnosis, what does it indicate with
19 regard to her musculoskeletal examination in those
20 charts?
21 A So the final musculoskeletal -- musculoskeletal exam on
22 Page 4 again says full range of motion in all joints,
23 normal joints and muscles.
24 Q Is that consistent with somebody with that diagnosis?
25 A No.

1 Q Do you see any records contained in that medical chart
2 that support that diagnosis other than the patient's
3 complaint?
4 A No, I do not.
5 Q And so is it again important as a physician to put such
6 a justification for such an opioid prescription as
7 Norco in the chart?
8 A Yes.
9 Q Should you have something in there to back up that
10 diagnosis?
11 A The diagnosis should be documented and discussion about
12 follow-up and monitoring should be documented.
13 Q Looking at those guidelines again, doesn't it basically
14 indicate that every once in a while you should revisit
15 the treatment plan rather than continuing the patient
16 on Norco month after month after month?
17 A Yes.
18 Q And do you see any of that being done?
19 A No, sir.
20 Q In fact, it is Norco month after month after month for
21 Miss Tappen?
22 A Yes.
23 Q I'll take that patient chart from you. Thank you.
24 Final patient I want to discuss with you.
25 Hand you People's Exhibit Number 8. It's been

1 identified as the medical chart for a Juanita Huizar.
2 Is that accurate?
3 A Yes.
4 Q Did you review that medical chart as well?
5 A Yes.
6 Q Let's look at the only real record we have for
7 Miss Huizar, and that is October 20th, 2016. Does it
8 indicate whether any medical -- prior medical records
9 were received?
10 A It states on Page 3 please see previous medical records
11 for further details.
12 Q Do you see any prior medical records scanned into this
13 patient's chart?
14 A No, sir.
15 Q Is it important for a physician who is considering
16 prescribing an opioid medication to have prior medical
17 charts for the patient?
18 A If a patient comes to you and they are already on
19 prescribed controlled substances, that is a concern
20 because, number one, you want to know why is the
21 patient coming to me, why did she leave her previous
22 provider, what was the previous provider's diagnosis,
23 what was the patient's progress under the previous
24 provider and were there any signs of addiction or abuse
25 and is there a legitimate diagnosis with the previous

1 provider, yes.

2 Q And so you don't have that at all here?

3 A I don't see it, no.

4 Q What is -- is there a prescription for Norco issued

5 that day?

6 A She's prescribed Norco 7.5 milligrams twice daily 30

7 days, Ultram 50 milligrams twice daily 30 days, and

8 Neurontin, which is gabapentin, 800 milligrams three

9 times a day 30 days.

10 Q Are you familiar with Ultram?

11 A Yes, sir.

12 Q Ultram and Norco, do they go well together?

13 A They're both short-acting opioids. And typically if

14 you're gonna use two opioids together, one would be a

15 longer acting one, one would be a shorter acting one,

16 but you normally wouldn't prescribe two short-acting

17 opioids together.

18 Q That's not advisable?

19 A Not normally, no. Not without investigation or

20 justification.

21 Q Do you see any investigation or justification in that

22 medical chart?

23 A No, sir.

24 Q And what does it indicate for the diagnosis in support

25 of that prescription?

1 A Chronic lower back pain, which is lumbago.
2 Q Do you see anything in that chart -- I know it's pretty
3 limited -- other than the patient's complaint of pain
4 in support of that diagnosis?
5 A The musculoskeletal exam says general movements, full
6 range of motion in all joints; joints and muscles,
7 normal joints and muscles. Posture, which is how you
8 stand, is normal. Gait, which is how you walk, is
9 normal.
10 Q So any justification for the diagnosis?
11 A Not according to the examination listed in the chart.
12 Q If no physical exams were actually done on this patient
13 in order to obtain that -- that diagnosis and that
14 prescription, is that of any concern?
15 A Yes.
16 Q Why?
17 A Again, you don't have a legitimate diagnosis for
18 prescribing opioids to this patient.
19 Q Same thing with Miss Tappen and Mr. Marcum. If those
20 physical exams delineated in those patient charts
21 weren't actually done, is that of concern with regards
22 to those two patients?
23 A Yes.
24 Q Same reason?
25 A Yes, sir.

1 Q So I'm gonna hand you what has been admitted as
2 Defendant's Exhibit Number 10. This has been
3 identified as additional medical records that are
4 obtained and come after our October 25th, 2016, raid.
5 In particular, can you find the -- well, here, I'll
6 help you find it. If I could see the exhibit, sir?
7 First of all, we have a radiological
8 examination that appears to have occurred on
9 October 30th, correct?
10 A Yes.
11 Q Of 2016?
12 A Yes.
13 Q It indicates presence of cocaine abuse, correct?
14 A That's listed there, yes.
15 Q Now we have a urine toxicology test from a date of --
16 looks like a collection date of October 31st, 2016,
17 true? Let me find the page of it for you.
18 A Yes.
19 Q When does it indicate it was received by
20 Dr. Oesterling?
21 A It says it was reported on -- to Dr. Oesterling on
22 November 10th, 2016.
23 Q All right. And are there any concerns with this
24 particular urine toxicology screen?
25 A So it is positive for the EtG test again which shows

1 that the patient has been consuming alcohol. It's
2 positive for the EtS test, which is a second test that
3 we do to confirm that it's not accidental from
4 something like a hand sanitizer. It's positive for
5 amphetamines, it's positive for Klonopin, and it's
6 positive for breakdown product of cocaine.
7 Q So we have no urine toxicology with regards to
8 October 20th but we do have one from October 31st,
9 right?
10 A Yes.
11 Q So let's look at the November 3rd chart here.
12 THE COURT: Which patient is this?
13 MR. WANINK: This is Juanita Huizar. I'm
14 sorry, Your Honor.
15 THE COURT: Okay.
16 MR. WANINK: This is still Defendant's
17 Exhibit Number 10.
18 BY MR. WANINK:
19 Q Now we're looking at November -- find it. This is a
20 little -- little bit disorganized. Ah, here we go.
21 All right. It indicates on November 3rd prescriptions
22 were provided including Ultram and Norco again,
23 correct?
24 A Yes.
25 Q And it says 7.5's 60 dosage units for 30 days?

1 A Yes.
2 Q That's November 3rd of 2016, correct?
3 A Yes.
4 Q So at this point you have a patient who received a
5 month's supply of Norco probably less than two weeks
6 prior, correct?
7 A Yes.
8 Q Received that without any medical charts, without any
9 urine toxicology screening whatsoever, and now here we
10 are two weeks later handing out another month's supply.
11 Is that normal?
12 A No.
13 Q And why not?
14 A Again, it's desirable to try and make the diagnosis.
15 Again, the bottom line is the Controlled Substance
16 [sic] Act before you prescribe opioids, and that would
17 typically involve getting a drug screen first, getting
18 records first before you make a diagnosis of pain
19 without addiction, and --
20 Q Now -- now we have two prescriptions for Norco and we
21 don't even have the results of any kind of urological
22 testing on this person until November 10. Would
23 agree --
24 MR. CHAPMAN: Your Honor, I'm going to object
25 to counsel continuing to testify. There's been a

1 series of leading questions here.
2 MR. WANINK: All right. I'll rephrase.
3 THE COURT: Thank you.
4 BY MR. WANINK:
5 Q Do you see any urine toxicology screen that predates
6 either of the October 20th or November 3rd
7 prescriptions?
8 A No, I didn't.
9 Q Is it a good idea to prescribe Norco to a patient twice
10 in a row without any kind of urine toxicology screen?
11 A No, because you haven't established the true diagnosis.
12 Q And if you're confronted with a diagnosis of cocaine
13 dependence, is that something that should be I guess
14 noted or of concern to the physician?
15 A There's a positive drug screen for cocaine, which is a
16 major concern because it raises the doubt as to the
17 true diagnosis. I don't know that that patient has a
18 diagnosis of cocaine dependence.
19 Q All right.
20 A But the presence of cocaine is very concerning.
21 Q You saw that the prescription here was for 60 pills for
22 30 days. I'm now gonna show you what's been admitted
23 as People's Exhibit 108. These are the -- are these
24 the written prescriptions for the November 3rd date?
25 A Yes.

1 Q And what does it indicate with regards to the Norco
2 prescribed in the actual prescription?
3 A It says Norco 7.5 milligrams, one pill four times a
4 day, number 120.
5 Q That's different than what was actually charted?
6 A Yes.
7 Q Can you think of any reason why a physician would chart
8 one amount but yet write a prescription for another?
9 MR. CHAPMAN: Objection. Calls for
10 speculation, Your Honor.
11 THE COURT: Your response, Mr. Wanink?
12 MR. WANINK: Well, let me ask him if he even
13 can answer the question without comment.
14 THE COURT: All right.
15 THE WITNESS: It may be either a medical
16 error or it may --
17 THE COURT: Well, you have to answer whether
18 or not --
19 THE WITNESS: I'm sorry.
20 THE COURT: Whether or not you can answer
21 that question.
22 BY MR. WANINK:
23 Q Can you -- can you answer the question yes or no?
24 THE COURT: Within your expertise.
25 THE WITNESS: I believe it's in my expertise,

1 yes.

2 MR. WANINK: Okay.

3 THE COURT: All right. Objection's

4 overruled.

5 BY MR. WANINK:

6 Q Go ahead.

7 A So the reason may be either medical error or it may

8 have been done intentionally.

9 Q Is it a good idea if you're going to up the patient's

10 prescription like that to document it?

11 A Yes.

12 Q And why is it important to document the correct amount

13 you actually gave the patient?

14 A Again, when you're -- when you're doing periodic visits

15 for prescribing opioids for chronic pain and you assess

16 the patient and make adjustments, it's always important

17 to diagnose -- I'm sorry. Document what you did and

18 why you did it.

19 Q Given what you've seen between the medical charts that

20 I provided you from October 20th, the medical charts

21 the defense has provided from November 3rd, the actual

22 prescription on November 3rd, 2016, do you see any

23 justification for this particular prescription?

24 A No, I don't.

25 Q And why is that?

1 A We have not established a legitimate diagnosis and the
2 actual diagnosis is in doubt, and I would be concerned
3 about a diagnosis of chemical dependence, which would
4 make this prescription contraindicated.
5 Q Now, what if Miss Huizar presented documentation as
6 indicated in Defense Exhibit Number 10 in the form of
7 medical testing done at St. Mary's showing bulging
8 discs in her back?
9 THE COURT: This is Defendant's 10?
10 MR. WANINK: Yes.
11 THE COURT: Okay. Thank you.
12 BY MR. WANINK:
13 Q And I'll give you a minute to process that because I
14 know you're probably seeing it for the first time.
15 A So this CAT scan is abnormal. The main finding that
16 they talk about here -- this is the October 31st one.
17 Q Okay.
18 A The main finding they talk about here is the right
19 psoas muscle, which is the muscle on the back of the
20 abdomen in front of the spine, in front of the back, is
21 enlarged compared to the other one, and there may be a
22 blood clot or an infection, and they recommend an MRI,
23 and they also note bulging -- varying degrees of
24 bulging discs but they don't give any additional
25 information that I see.

1 Q In light of being provided with that information, is
2 now the November 3rd, 2016, prescription for Norco
3 justified?
4 A Not -- not this by itself, no. You still need to -- we
5 need to establish a diagnosis. In the presence of a
6 urine drug screen that shows cocaine, we need to
7 establish the true diagnosis.
8 Q But if we didn't have that 'til November 10, is that a
9 problem?
10 A Ideally you wait before prescribing opioids until you
11 have that kind of information back.
12 Q And still wouldn't you want to di- -- or chart the
13 correct amount that you prescribed?
14 A Yes.
15 Q And in light of the fact that the original Norco
16 prescription was provided without any medical support,
17 is that of some concern still?
18 A Again, for the same reasons. There's no established
19 diagnosis.
20 Q All right. So this -- this radiological evidence from
21 St. Mary's I guess still doesn't make the prescription
22 on November 3rd justified?
23 MR. CHAPMAN: Again, Your Honor, leading.
24 THE COURT: Mr. Wanink, your response?
25 MR. WANINK: I'll rephrase the question.

1 BY MR. WANINK:
2 Q Does the presence and existence of this radiological
3 data that was provided to Dr. Oesterling justify the
4 November 3rd, 2016, prescription?
5 A It is one piece of information, but a complete history
6 is lacking, a physical examination is lacking, the
7 urine drug team -- urine drug test results were
8 lacking. So in my opinion, no.
9 Q What if the patient says, well, jeez, doc, I'm really
10 in pain here? I mean does that raise the bar for the
11 patient? Does that make it justified --
12 A If a patient comes to you for a first visit and you
13 don't have an established relationship and the patient
14 appears to be in extreme pain, which we consider pain
15 scores of 8 to 10, then that patient should be referred
16 to the emergency department where they can do an
17 immediate evaluation because there are a lot of
18 potentially lethal conditions that could be causing
19 that pain and you haven't established the relationship
20 with the patient.
21 Q What if the patient's a -- a really good actor, you
22 know, comes in and -- and really lays it on thick of
23 how -- how much they're in pain? What should a
24 physician do then?
25 A For a new patient?

1 Q Yes.
2 A For a new patient, if they come in with that type of
3 severe pain, they should be referred to the emergency
4 department.
5 Q What if they're an established patient?
6 A It depends on their past history, what you've
7 established as the diagnosis. Again, there are
8 patients who come in with flares of their pain and the
9 actual reason is something quite serious. Could be
10 cancer. Could be a collapsed disc. Could be a
11 compressed spinal cord. And, again, if someone comes
12 in and their pain is suddenly out of control, you need
13 to ask yourself why and not simply prescribe opioids.
14 Q So you should investigate as the guidelines recommend?
15 A Yes, sir.
16 MR. CHAPMAN: Again, leading, Your Honor.
17 THE COURT: Mr. Wanink?
18 BY MR. WANINK:
19 Q Should you investigate as the guidelines recommend?
20 A Yes, sir.
21 Q And why is it you want to do that? Why do you want to
22 justify a patient's naked word that they're in pain?
23 A Well, number one, you -- again, you need to establish a
24 diagnosis for patient safety. The ethics of medicine
25 say that we should first do no harm and do the best

1 thing for the patient. So we need to find out what the
2 true problem is underlying the patient's pain
3 complaint. It may be chronic musculoskeletal pain, it
4 may be psychological disorder, it may be addiction, it
5 may be cancer and it may be a combination of any -- any
6 combination of those, and each one of those is treated
7 differently. But for all of those diagnoses, the
8 treatment is not just prescribing opioids.
9 Q And with regards to the urine toxicology screens that
10 we see in these patients, the fact that they're scanned
11 into the charts but yet Norco prescriptions are still
12 being provided, I mean what -- what does that -- what's
13 going through a physician's mind there, I guess? Why
14 would a physician do that in spite of those results?
15 A If a test is ordered, in my medical experience, the
16 person who ordered the test is responsible for checking
17 the results.
18 Q I mean is it okay to either ignore or disregard a urine
19 toxicology result and still prescribe Norco?
20 A Not unless you've assessed it and believe that it's a
21 laboratory error, which should be -- if you do believe
22 that, that should be documented.
23 Q And do you see that in any of the documentation done by
24 Dr. Oesterling?
25 A I did not.

1 Q And in light of any laboratory error, would it be a
2 good idea to continue patients on Norco in spite of
3 those laboratory results?
4 MR. CHAPMAN: Objection. Leading, Your
5 Honor.
6 THE COURT: Mr. Wanink, it's leading.
7 BY MR. WANINK:
8 Q Is it a good idea in light of those facts?
9 A I'm sorry?
10 Q Is it a good idea in light of those facts?
11 A Of the drug screen tests?
12 Q Yes.
13 A No, sir.
14 Q Thank you, Dr. Christensen. I don't have any further
15 questions.
16 THE COURT: Mr. Chapman, cross-examination,
17 sir.
18 MR. CHAPMAN: Thank you, Your Honor.
19 Your Honor, if I could just have one moment,
20 I need to get a few documents.
21 THE COURT: Sure.
22 MR. CHAPMAN: Thank you.
23 C R O S S - E X A M I N A T I O N
24 BY MR. CHAPMAN:
25 Q Good morning, Dr. Christensen.

1 A Good morning.
2 Q I know we've met quite a few times before.
3 A Yes, sir.
4 Q I'm gonna ask you a few questions, okay?
5 A Yes, sir.
6 Q All right. First, Mr. Wanink used the question or --
7 or -- or said many times is it okay for a doctor to do
8 X, Y, Z. Do you recall him saying that?
9 A Yes.
10 Q Okay. And when he says that, what's going through your
11 mind is is -- is this within a medical standard, right?
12 Is this practice within a medical standard?
13 A Is it within the medical standard and is it safe.
14 Q Okay. And so just to be clear, there are many types of
15 medical standards that apply to a physician's practice,
16 correct?
17 A Yes.
18 Q There's the civil standard. Are you familiar with the
19 civil standard?
20 A Malpractice?
21 Q Malpractice, yes.
22 A Yes, sir.
23 Q That's a negligence standard, right?
24 A Yes.
25 Q So if a physician commits an act which is below the

1 standard in his profession, he could be -- he or she
2 could be guilty of negligence and sued, right?
3 A Yes.
4 Q And sued for money damages, right?
5 A Yes.
6 Q Then there's the -- the administrative standard or the
7 licensing standard. You're familiar with that?
8 A Yes.
9 Q You've testified in licensing cases before?
10 A Yes.
11 Q And if a physician -- if a physician's conduct departs
12 below the minimum standard in the profession, they can
13 face some sort of licensing action, is that right?
14 A Yes.
15 Q They could have their license taken away?
16 A Yes.
17 Q Okay. And the civil standard, you violate the civil
18 standard, that's not something that -- that's the same
19 as the standard to criminally prosecute somebody,
20 right?
21 MR. WANINK: Objection. I believe this is
22 outside the scope of this witness. He's asking him a
23 legal question at this point. I think that's outside
24 the scope of the qualification. MRE 602, lack of
25 foundation.

1 MR. CHAPMAN: Your Honor, he needs -- he
2 needs to testify as an expert in this case to
3 understand the standard that applies to the case. Of
4 course, the standard comes out of statute, but that
5 also is a standard that guides physicians in the
6 practice of medicine and he would know about that.
7 THE COURT: Objection's overruled.
8 You can answer the question, or would you
9 like it repeated?
10 THE WITNESS: Could you repeat it, please?
11 BY MR. CHAPMAN:
12 Q Sure. I'll rephrase it in a different way. So the
13 civil standard is different than a criminal standard,
14 right?
15 A Yes.
16 Q Okay. If you violate the civil standard, you don't
17 necessarily get prosecuted?
18 A Yes.
19 Q But you could if you violated it enough where you
20 committed conduct that could be criminally prosecuted,
21 right?
22 A That I -- I'm not --
23 Q Not sure about?
24 A -- sure of your intent. I'm not sure what you meant,
25 sir.

1 Q Okay. Then there's the administrative standard. If
2 you violate the administrative standard, that doesn't
3 necessarily mean you get prosecuted or -- or you've
4 committed a crime, I should say?
5 A In my experience with the administrative law judges,
6 all the participants that I evaluated had also been
7 accused of committing a crime. I don't know if that's
8 universal or not.
9 Q Well, let me ask you this: If a physician commits a
10 medical error, it is true that they could face
11 licensing action?
12 A If it was extreme -- my understanding is that if they
13 make a mistake, that may be malpractice. If they are
14 in wanton disregard, then that is below the minimum
15 standard of practice and they may face prosecution
16 and/or loss of their license.
17 Q Okay. So is it your testimony that the administrative
18 standard is the same as the criminal standard?
19 A No, it's not.
20 Q Okay. So the criminal standard requires more severe
21 conduct?
22 A I -- I do not know.
23 Q Well, you evaluated this case to determine whether or
24 not Dr. Oesterling's conduct departed below the
25 criminal standard, did you not?

1 A It was below the minimal medical standard of care in
2 the state of Michigan in my medical opinion.
3 Q So that's all you analyzed this case for, to see if he
4 departed from the standard of care, is that correct?
5 A No.
6 Q Departed from the minimal standard of care, is that
7 correct?
8 A I was asked to evaluate the charts for the apparent
9 reasons and his prescribing practices of narcotics and
10 whether or not they were prescribed for a legitimate
11 purpose.
12 Q Okay. And so it's your belief -- well, I'm sorry. The
13 standard you applied was whether or not prescriptions
14 were issued for a legitimate medical purpose?
15 A Yes.
16 Q All right.
17 A That is the -- the bottom -- the minimum standard for
18 me.
19 Q That's the standard for you or the standard for
20 physicians in Michigan?
21 A I believe it's the standard for a physician in Michigan
22 who prescribes controlled substances.
23 Q Okay. Now, did you look at the case to determine
24 whether or not there was a medical purpose behind the
25 prescriptions? When you were evaluating the case, did

1 you look to see if there was a medical purpose or good
2 faith?
3 A Could you -- I'm not sure what you're --
4 Q Well, let me ask you this. There's a statute which
5 defines when a physician can prescribe a controlled
6 substance in the state of Michigan. Are you familiar
7 with that statute?
8 A I believe so.
9 Q And that statute says that a doctor shall write a
10 prescription for good faith and for a medical purpose,
11 correct?
12 A Yes.
13 Q Okay. And so you would agree that if a prescription is
14 written for a medical purpose that a physician can't be
15 prosecuted for that, right?
16 A No. I believe it has to also be written in good faith,
17 which means for the correct -- my understanding is
18 it's -- good faith means for the correct reason.
19 Q So -- so you believe the statute requires both as
20 opposed to one or the other?
21 A I believe so, yes.
22 Q All right. And did you look in this case to see
23 whether or not Dr. Oesterling was prescribing for good
24 faith?
25 A I believe that's what we were addressing in all the

1 chart reviews.

2 Q So you believe a physician is only prescribing in good

3 faith if they comply with the medical standards that

4 you've applied?

5 A Which standards are you referring to?

6 Q The standard of care.

7 A So the prescription -- the issuing of a prescription

8 for a controlled substance needs to be for a legitimate

9 medical purpose, which to me means that you need to

10 have a legitimate diagnosis, which implies everything

11 else that we've been talking about.

12 Q I understand that you're saying that, but we've

13 discussed now good faith and medical purpose, the two

14 requirements of the Michigan statute, right?

15 A My understanding is that good faith means that it's

16 prescribed for the correct reason.

17 Q And -- and where are you taking that from?

18 A That's my understanding.

19 Q You don't have any evidence to support it? It's just

20 what you believe?

21 A No.

22 Q You don't have any statute that you can direct us to?

23 A I don't have any statute on me, no.

24 Q All right. And so based on what you mentioned earlier,

25 you do agree that if a physician makes a mistake,

1 that's not necessarily a prescription lacking in good
2 faith and lacking a medical purpose?
3 A It would depend upon the situation. Could you be more
4 specific?
5 Q Well, I think your answer is yes, right? It is
6 possible that a physician can make a medical error and
7 the prescription is still written for good faith and
8 for a medical purpose?
9 A I'm sorry. Could you be more specific about what
10 you --
11 Q I --
12 A -- define as a mistake?
13 Q I have to ask you the questions. You can't ask me the
14 questions, okay?
15 A I --
16 Q If you can't answer my question, you can say I -- I
17 can't answer that.
18 A I can't answer that.
19 Q Okay. You -- you mentioned earlier that there are
20 licensing cases where if a physician makes a mistake,
21 they're not necessarily targeted by the licensing
22 board?
23 A That would be in the situation -- my understanding is
24 that would be in the situation of malpractice, yes.
25 Q Okay. And that's not criminal, right?

1 A Not necessarily.
2 Q Not necessarily. All right.
3 So let's talk briefly about the Michigan
4 Guidelines for the Use of Controlled Substances to
5 Treat Pain [sic]. It's your testimony that that is the
6 standard in Michigan that a physician should use,
7 right?
8 A That's what was put into evidence yesterday.
9 Q I'm asking what your testimony is. It's your standard
10 that that's what a physician should use in Michigan?
11 A I believe the physicians in Michigan should use the
12 Federation of State Medical Board [sic] guidelines
13 which were not admitted into evidence.
14 Q And -- and the state didn't adopt those guidelines,
15 right?
16 A Not completely, no.
17 Q Okay. You think they adopted them in part?
18 A Yes.
19 Q And if they adopted them in part, they'd put them in
20 this document?
21 A Yes.
22 Q Okay. So this is the document that should be applied
23 in the state of Michigan according to the Michigan
24 licensing board?
25 A That's the document issued by the medical licensing

1 board.
2 Q All right. And this was intended to be guidance for
3 physicians like Dr. Oesterling on how to prescribe?
4 A Yes.
5 Q Okay. Now, this guidance is put out by the licensing
6 board, right? So they're discussing the administrative
7 standards?
8 A I don't know.
9 Q Okay. Despite that, you've applied this to
10 Dr. Oesterling's case?
11 A Yes.
12 Q All right. Now, isn't it true that in these guidelines
13 they say that physicians can deviate from these
14 guidelines?
15 A Yes.
16 Q Because they're called guidelines, not rules, right?
17 A It says, "...if good cause is shown for such
18 deviation."
19 Q In fact, it says, Doctor, "The board will not take
20 disciplinary action against a physician for failing
21 to..." strictly adhere "...to the provisions of these
22 guidelines, if good cause is shown for such..." a
23 "...deviation?"
24 A Yes.
25 Q So you've held Dr. Oesterling to this standard but even

1 the board says you can deviate from this standard,
2 right?
3 A If good cause is shown for such deviation.
4 Q Okay. If good cause is shown. It also says that a
5 "...physician's conduct will be evaluated ... by the
6 treatment outcome... ," is that right?
7 A Yes.
8 Q Okay. So the board is saying when we look at the
9 conduct of a physician, we need to look at the ultimate
10 outcome of what happens to the patient, right?
11 A Yes.
12 Q And you're not aware of any negative treatment outcomes
13 in this case?
14 A I am not aware of any successful treatment for possible
15 addiction, no.
16 Q You're not aware of any negative treatment outcomes?
17 Let me rephrase. Of the patients that you've testified
18 to on the stand, there has been no indication that any
19 of them have overdosed?
20 A Not the patients we've discussed here, no.
21 Q Okay. There's no evidence that any of them have had an
22 emergency room admittance because of the use of the
23 substances that Dr. Oesterling prescribed?
24 A Not that I've seen.
25 Q There's no evidence to suggest that any of them have

1 had negative outcomes from the abuse of -- of drugs
2 that might have shown up in their urine drug screen?
3 A I consider abuse of drugs to be a negative outcome.
4 Q Okay. But -- but there's no harm to the patient? You
5 haven't seen --
6 A I don't agree with that.
7 Q Okay. That's fine.
8 The board also says that they must take
9 "...into account whether the drug ... is medically and
10 ... pharmacologically recognized to be appropriate for
11 the diagnosis... ," right?
12 A Yes.
13 Q So one of the things the board asks us to do here for
14 this administrative standard is to look at the
15 diagnosis and whether or not the drug is appropriate?
16 A Yes.
17 Q Now let's talk about a diagnosis of spondyleosis [sic].
18 Did I pronounce that correctly?
19 A Spondylosis.
20 Q Spondylosis. Okay. Spondylosis is something that can
21 cause pain?
22 A Yes.
23 Q Spondylosis is something that can cause moderate pain?
24 A Yes.
25 Q Spondylosis is something that can cause severe pain?

1 A Yes.

2 Q Okay. Spondylosis is something -- well, hydrocodone is
3 a drug that has been proved to treat moderate to severe
4 pain?

5 A Yes.

6 Q Okay. So a physician using hydrocodone to treat
7 spondylosis could be using an appropriate drug to treat
8 an appropriate condition or diagnosis?

9 A If that was an appropriate diagnosis.

10 Q Okay. So if -- if you could confirm the diagnosis of
11 spondylosis, using hydrocodone could be appropriate?

12 A If there were no con- -- if there was no
13 contraindication to prescribing the hydrocodone.

14 Q So the board asks us to compare the drug with the
15 diagnosis, and hydrocodone matches spondylosis
16 according to the board, right?

17 A Yes.

18 Q All right. The boards also say in this document here,
19 the document that you have used for your standard, that
20 they won't use "...the quantity and chronicity of
21 prescribing" to evaluate a physician's treatment, is
22 that right?

23 A It says, "The Boards will judge the validity of
24 prescribing based on the..." patient's "...treatment of
25 the patient and on available documentation, rather than

1 on the quantity and chronicity of prescribing," yes.
2 Q Okay. So -- so the board is basically assuring doctors
3 or reassuring them that we don't just look at how much
4 you prescribe, we look at what you prescribe it for,
5 right?
6 A Yes.
7 Q You could be the number one prescriber of hydrocodone
8 in the state of Michigan and based on that fact alone
9 the board doesn't care?
10 A If the prescriptions were legitimate.
11 Q Based on the documentation and the treatment, if they
12 were legitimate, you're safe with us, right?
13 A If there was no contraindication to the prescriptions.
14 Q Sure. Sure. So we really shouldn't use statistics to
15 evaluate a physician's care, right?
16 A Not by themselves, no.
17 Q All right. Because you -- you would agree that -- that
18 broad-based treatment of -- of patients is
19 inappropriate, you need to treat patients on a
20 case-by-case basis?
21 A Statistics are one part of identifying prescribers.
22 Just one part.
23 Q One part. May be a way to decide whether or not you --
24 you want to look further?
25 A Yes.

1 Q Okay. The board also provides their own definition of
2 chronic pain in this document, correct? I would give
3 you a page number but they're not numbered.
4 A Yes.
5 Q All right. And chronic pain is, "A pain state which is
6 persistent ... in which the cause of the pain cannot be
7 removed or otherwise treated." It "...may be
8 associated with a long-term incurable or intractable
9 medical condition or disease," right?
10 A That's what it states, yes.
11 Q Okay. And so when somebody is suffering from chronic
12 pain, that would mean that there's -- there's nothing
13 you can do to cure the cause of the pain, is that
14 right, according to the board?
15 A The board states that it's incurable -- may be
16 associated with being incurable or intractable.
17 Q All right. So there are some patients that are in this
18 incurable, chronic pain where pain relief by medication
19 is the only available treatment option?
20 A Which medications are you referring to?
21 Q Pain medication in general. If -- if -- let me
22 rephrase. If somebody has pain that the source of it
23 cannot be removed, our only option then is to treat the
24 pain as opposed to the cause?
25 A Treat the symptom, yes.

1 Q Treatment the symptom?
2 A Yes.
3 Q And the symptom would mean treating the pain?
4 A Yes.
5 Q And treating the pain, one option is to provide pain
6 medication?
7 A So if you mean -- when you say pain medication, sir,
8 could you be more -- be more specific?
9 Q Opiates.
10 A So, number one, we know and we've known for quite some
11 time that opioids are not effective for chronic pain,
12 that they have adverse effects.
13 Q Well --
14 A That they're associated with addiction.
15 Q Let me ask you this. You say we know and we've known
16 for quite some time. Did we know this when we put out
17 these guidelines?
18 A The guidelines came out from the American Pain
19 Society --
20 Q Did -- sir, did we know these -- did we know this when
21 we put out these guidelines, the Michigan guidelines?
22 A I believe so, yes.
23 Q Okay. Where in the Michigan guidelines does it say
24 that pain medication is not an effective treatment for
25 pain?

1 A The one they may be referring here is the clinical
2 path- -- Clinical Practice Guideline Number 9, but they
3 do not state in here whether or not opioids are
4 effective or not.
5 Q In fact, they actually say -- they define chronic pain,
6 which is an incurable or intractable type of pain, and
7 then throughout the document they tell you what you
8 should do in order to prescribe for chronic pain,
9 right?
10 A They say, "The medical management of pain should be
11 based..." on "...current knowledge and research and..."
12 include "...the use of both pharmacologic and
13 non-pharmacologic modalities."
14 Q All right. So this allows physicians -- the medical
15 board allows physicians to prescribe pain medication or
16 opiates for chronic pain?
17 A If they are not contraindicated, yes.
18 Q Okay. Now let's talk about -- a little bit about
19 physical dependence and tolerance. You would agree
20 that tolerance is a normal condition -- we could still
21 talk about the guidelines, but tolerance is a normal
22 condition for somebody receiving opiate medications?
23 A Yes.
24 Q When you take opiate medications for a long period of
25 time, naturally you will become more tolerant to those

1 medications?

2 A Yes.

3 Q All right. Sometimes that would require a physician to

4 prescribe more and sometimes you may want to try

5 another drug or another therapy?

6 A First you need to establish that the patient has

7 tolerance.

8 Q Okay. So when a physician prescribes more for a

9 patient -- and I'm just talking in the general here.

10 When a physician prescribes medication for a patient,

11 over time we can expect that that patient would become

12 tolerant to the medication?

13 A Very often.

14 Q Very often. And we can expect that the physician

15 should look for prescribing more medication or changing

16 the treatment?

17 A That's one possibility, yes.

18 Q And because of this tolerance, you've noticed in your

19 profession that patients tend to need more and more

20 medication to treat their pain --

21 A Yes.

22 Q -- right? You see this quite often where somebody is

23 prescribed hydrocodone, they take it for six months,

24 they start using it faster than they really should,

25 than their prescription says they should? That happens

1 quite often?
2 A And my response is to investigate the cause.
3 Q Of course. Yes. But it happens quite often?
4 A The patients lose control of their medications?
5 Q I'm -- I'm talking about patients escalating their use
6 because of tolerance.
7 A Without discussing it with the physician? I'm sorry,
8 sir, that's --
9 Q I'm --
10 A My answer is I can't answer that.
11 Q I'm not talking about a conversation with a physician.
12 I'm not talking about treatment. I'm talking about
13 what patients do. It's true that patients often
14 escalate their use because of tolerance.
15 A Not without discussing it with the physician, no. I'm
16 sorry.
17 Q So the patient if they're getting tolerant, you're
18 saying that all of them should go to the physician and
19 say, hey, doc, I'm getting tolerant, I'm -- I'm
20 escalating your use? Is that how it always works?
21 A The patient will complain of lack of analgesia --
22 Q Okay.
23 A -- decrease in functioning. They'll complain that the
24 medication is wearing off too soon. And if that is the
25 situation, then you investigate what is happening, you

1 document it and you make adjustments.
2 Q We're not -- I appreciate the answer. We're not to the
3 standard. I'd like you to keep your answers confined
4 to my questions. My only question was do patients
5 escalate use because of tolerance, and the answer
6 appears to be yes.
7 A I can't answer the question the way it's worded.
8 Sorry.
9 Q Okay. We can move on.
10 Physical dependence is also a normal
11 consequence of opiate treatment?
12 A It's two sides of the same coin, yes.
13 Q Okay. Physical dependence means that a patient would
14 have physical symptoms if they cease taking their
15 medications?
16 A Yes.
17 Q The existence of physical dependence doesn't mean that
18 somebody doesn't need the medication, right? And I
19 apologize for the double negative.
20 A I'm sorry. Say that again.
21 Q The existence of physical dependence doesn't mean that
22 a patient doesn't need their medication.
23 A I agree with that statement.
24 Q Okay. Thank you. It doesn't mean that the patient is
25 an addict and should automatically be referred to

1 addiction treatment?
2 A It does not.
3 Q And the physical dependence can be quite severe for
4 patients who are on long-term opiate treatment?
5 A It can be.
6 Q And the board in their guidelines say that that is
7 expected? I think that's on the first page, right?
8 Maybe it's not on the first page, but it's somewhere in
9 there, right?
10 A I see it. Yes.
11 Q Okay. Now, you mentioned that when a physician doesn't
12 have a patient's documentation, they should wait to
13 prescribe to the patient until they have the
14 documentation. Is that what you said?
15 A The -- what I was saying was the physician needs to
16 make a correct diagnosis. If there is a patient who
17 comes to you who is already on opioid and controlled
18 substances such as benzodiazepines and they're coming
19 to you saying I want you to be my doctor now, it's your
20 responsibility to find out why.
21 Q All right. Let's go back to -- to my question, though.
22 Did -- did you say during your testimony that a
23 physician should wait to prescribe if they don't have a
24 patient's medical records when the patient first comes
25 in for treatment?

1 A Not necessarily.
2 Q All right.
3 A You need to have enough information to make a
4 diagnosis.
5 Q So you can prescribe -- it is possible for a physician
6 to prescribe on the first visit seeing a patient
7 without having their complete medical records from
8 their other provider?
9 A I don't know of any way to make a diagnosis on the
10 first visit without records and without a urine drug
11 screen.
12 Q Okay. So it's not possible for a physician to
13 prescribe without the patient records?
14 A Not for a legitimate purpose, no.
15 Q All right. So you always need to have a patient's
16 prior records prior to prescribing medication to a
17 patient?
18 A You need to have enough information to make a
19 diagnosis.
20 Q And you can gain that information during the first
21 visit, isn't that right?
22 A No.
23 Q It's not possible. All right. Well, doesn't the board
24 tell us that, "Fears of investigation or sanction by
25 federal, state and local regulatory agencies may ...

1 result in inappropriate or inadequate treatment of
2 chronic pain patients?"
3 A Second --
4 Q First page.
5 A Yeah.
6 Q Second paragraph.
7 A Yes.
8 Q All right. And "...these guidelines have been
9 developed to clarify the Boards' position on pain
10 control ... to alleviate physician uncertainty and to
11 encourage better pain management." Is that what the
12 guidelines tell us?
13 A That's the statement there, yes.
14 Q Okay. Wouldn't you agree that telling a patient, no, I
15 can't treat you because I don't have your prior
16 records, you have to stay in pain for another month
17 while I get them, would be not appropriately
18 alleviating a patient's pain?
19 A There's virtually no situation where it would take a
20 month, sir.
21 Q Okay. How long does it typically take?
22 A Same day.
23 Q You -- you believe that you can get records from an
24 out-of-state physician like in the case of Dawn Rise,
25 Arizona, same day?

1 A Yes.
2 Q All right. Especially when the patient doesn't even
3 know the name of their prior physician?
4 A That's concerning.
5 Q Okay. But you would agree that it's not appropriate to
6 turn a patient away simply because you don't have prior
7 records?
8 A I'm not turning -- I -- in that situation, the
9 physician would not be turning the patient away. They
10 would be establishing a patient-physician relationship.
11 Q And -- and saying I can't treat you today, you have to
12 be seen at a later date?
13 A Yes.
14 Q All right. Do these guidelines tell us that we have to
15 do that?
16 A The guidelines say that, "All such prescribing..." --
17 this is the second page. "All such prescribing must be
18 based on clear documentation of unrelieved pain and in
19 compliance with applicable state or federal law." And
20 my bottom line that I've stated multiple times is that
21 we need to have a legitimate diagnosis to prescribe
22 these medications.
23 Q And what you're saying is you can only establish a
24 legitimate diagnosis based on the documentation of
25 other people?

1 A No, I didn't say that.
2 Q You can -- you can establish it on your own, can't you?
3 A You need a urine drug screen, which does not --
4 Q Do urine drug screens diagnose pain, Dr. Christensen?
5 A No. They --
6 Q No. They diagnose addiction, right?
7 A Yes.
8 Q Okay. In fact, can you look at these guidelines and
9 tell me where they tell physicians they should perform
10 a urine drug screen on a patient at all?
11 A I'm gonna repeat myself again, sir. It has to be
12 within -- it has to be consistent with federal law,
13 which means it has to be prescribed for a legitimate
14 purpose, which means you have to know the diagnosis,
15 and --
16 Q Sir, I understand you're answering the question you
17 want to answer, but I'd like you to answer my question.
18 And my question is where in these guidelines does it
19 tell Dr. Oesterling that he should get a urinalysis
20 test on a patient prior to prescribing a medication?
21 A Under Guidelines, Number 3, it says, "If the patient is
22 determined to be at high risk for medication abuse or
23 have a history of substance abuse, the physician may
24 employ the use of a written agreement ... including
25 urine..." or "...serum medication levels ... when

1 requested... ."

2 Q So you have to determine if the patient is a high risk

3 according to these guidelines before you check

4 urine/serum medication levels?

5 A Yes.

6 Q All right.

7 A Well, I'm sorry. If you see a patient who is on

8 controlled substances and they are coming to you from

9 another practice, you need to be concerned about why

10 they're coming to you. You need to be concerned about

11 if they were discharged from the previous provider's

12 practice.

13 Q Sir, again you're providing me things that are outside

14 of this documentation. I'm asking you specifically

15 about this documentation here or this document here.

16 This document says if the physician first determines

17 the patient is high risk, then you check urine/serum

18 medication levels.

19 A Yes.

20 Q Okay. Now --

21 A In my opinion --

22 Q This doesn't say --

23 A -- if the patient was referred to me --

24 Q Sir --

25 THE COURT: Wait.

1 BY MR. CHAPMAN:

2 Q Sir, you've answered the question, sir.

3 THE COURT: Yeah. Answer his questions,

4 please.

5 THE WITNESS: Sorry, Your Honor.

6 BY MR. CHAPMAN:

7 Q This doesn't say I need to check or Dr. Oesterling

8 needs to check their urine for the presence of illicit

9 substances, does it?

10 A No.

11 Q It says check for medication levels, right?

12 A Yes.

13 Q Okay. Nowhere in the standard you applied does it say

14 that on the first visit Dr. Oesterling should conduct a

15 urinalysis test to check for the presence of illicit

16 controlled substances? I'm sorry. Illicit substances.

17 A Other than what I stated before, no.

18 Q No. All right. Where in this document does it say

19 that Dr. Oesterling prior to seeing a patient or during

20 the first visit should check a MAPS report?

21 A My prior statement.

22 Q Can you repeat your prior statement for us?

23 A To be prescribed for a legitimate purpose, which

24 requires a diagnosis, a proper diagnosis.

25 Q Sir, where in this document, though? That's the

1 question. And the standard that you applied in this
2 case to Dr. Oesterling.
3 A Are you speaking about federal law?
4 Q I'm not talking about federal law. I'm talking about
5 the document.
6 A I'm talking about this document which says, "All such
7 prescribing must be based on clear documentation of
8 unrelieved pain and in compliance with
9 applicable..." -- "...applicable state or federal law."
10 Q Okay. What federal law tells you that you must check
11 the MAPS report?
12 A The federal law says that I must prescribe it for a
13 legitimate purpose.
14 Q Okay.
15 A It's my responsibility to determine if it's a
16 legitimate purpose.
17 Q What federal law mandates checking prescription drug
18 monitoring reports, Dr. Christensen?
19 A Nothing outside the statement I just made.
20 Q Okay. What Michigan law applicable at the time that
21 Dr. Oesterling was practicing and treating these
22 patients said that he must check Michigan Automated
23 Prescription System reports?
24 A My previous statement. Federal law.
25 Q Okay. No Michigan law?

1 A These Michigan guide- -- well, let me say it again.
2 I'm sorry, sir. "All such prescribing must be based on
3 ... compliance with ... federal law." Must be.
4 Q I guess I'm asking what -- in the text of the federal
5 law, what -- or state law, what state law says that
6 Dr. Oesterling must have checked MAPS reports?
7 A It does not.
8 Q Okay. These reports were created by the state, right?
9 A Yes.
10 Q All right. Pursuant to the MAPS program, there's a
11 statute associated with that, right?
12 A Yes.
13 Q And that statute, that law does not say that physicians
14 must even check the reports?
15 A The state law does not.
16 Q It does not. Okay. So it's not in the document and
17 it's not in federal law and it's not in state law?
18 A Not a specific statement about MAPS.
19 Q It's in your interpretation of federal law?
20 A Federal law.
21 Q Okay. But there's no words in the statute you can
22 point me to that says he must do this?
23 A No.
24 Q Now, this document appears to require a physical exam,
25 is that right?

1 A Yes.
2 Q All right. It says it should be "...documented in the
3 medical record?"
4 A Yes.
5 Q Okay. But, again, deviations of this may be
6 appropriate for good cause shown?
7 A For a good cause, yes.
8 Q All right. Are you aware of something called
9 neuropathic pain?
10 A Yes.
11 Q Are you able to diagnose that on a physical exam?
12 A Sometimes.
13 Q Sometimes. Not always, right?
14 A Not always.
15 Q There's other types of pain that you can't diagnose on
16 a physical exam?
17 A That's correct.
18 Q All right. Are you aware that Dawn Rise, a patient in
19 this case, complained of neuropathic pain?
20 A She was on gabapentin. Yes.
21 Q Okay. Are you aware that she complained of neuropathic
22 pain?
23 A Yes.
24 Q What other types of pain can -- cannot be diagnosed
25 with a physical examination?

1 A You can have what's called a central pain syndrome,
2 which is widespread, diffuse pain that is believed to
3 be decreased inhibition by the central nervous system.
4 You can have what's referred to as a chronic pain
5 syndrome, which is chronic pain associated with
6 psychiatric illness which may present typically as a
7 central pain syndrome.
8 Q Okay.
9 A You can have thalamic pain which is due to a stroke.
10 Q Kidney pain. Something else Dawn Rise complained of.
11 You can't touch the kidney and figure out where the --
12 A You touch --
13 Q -- pain is?
14 A You touch the flank, sir, right --
15 Q (Indicating.)
16 A It's right on top of your kidney.
17 Q Right where I did?
18 A Yeah, right where you did, sir.
19 Q But you can't always tell if that was the source of the
20 pain?
21 A If the kidney is the source of the pain, you will
22 typically have what's called costovertebral angle
23 tenderness which is right where your ribs meet your
24 spine. You push it and it's very painful.
25 Q If the patient tells you that their kidney's painful,

1 then that would be a sign that it could be in the
2 kidney area, right?
3 A That's an indication to examine that area, yes.
4 Q And you're just saying that palpitation may confirm
5 that they have kidney pain --
6 A Yes.
7 Q -- that -- that's located there?
8 A Yes.
9 Q So really you're not diagnosing what's wrong. You're
10 locating whether or not they have kidney pain when you
11 do the flank exam.
12 A I'm not sure what -- I'm sorry, sir. I don't know what
13 you mean by diagnosing.
14 Q Well, you can't determine what kidney condition
15 somebody has, what is causing their kidney pain simply
16 by touching their flank, right?
17 A No, sir.
18 Q You can only confirm that they have flank pain?
19 A Yes.
20 Q Okay. And so for those types of issues that patients
21 complain of that can't be diagnosed on a physical exam,
22 would you agree that that would be good cause for
23 deviating from the requirement for a physical exam?
24 A No.
25 Q You wouldn't?

1 A No.
2 Q So you still have to go through the motions of a
3 physical exam even if somebody is complaining of
4 something like neuropathy that can't be diagnosed on a
5 physical exam?
6 A If someone is complaining of neuropathy, that makes a
7 physical examination critical.
8 Q Now, you don't have to do this physical examination
9 that you require every visit, do you?
10 A No, sir.
11 Q All right. In fact, you don't do that, right?
12 A No, sir.
13 Q Insurance wouldn't reimburse it every visit, right?
14 A They -- yes. Yes, sir, I think they would.
15 Q You think they would? Okay. But the reason you don't
16 do it is because it's not medically necessary every
17 visit?
18 A Not once a diagnosis has been established.
19 Q Once a patient has been established and their chronic
20 pain has been diagnosed, you can see them periodically
21 to, as the guidelines call it -- well, conduct a
22 periodic review?
23 A Yes.
24 Q In fact, you don't even need to see a patient in person
25 to prescribe to them, right?

1 A No, sir.
2 Q All right. Sometimes when a patient has already been
3 established you don't even need them to come into the
4 office?
5 A Within DEA guidelines.
6 Q The DEA allows you to prescribe up to 90 days of
7 controlled substances?
8 A Ninety days for Schedule II and 180 days for Schedule
9 III.
10 Q Okay. And hydrocodone is Schedule II?
11 A Yes.
12 Q So according to the DEA, which is federal law, the DEA
13 would allow Dr. Oesterling to prescribe in let's say
14 June to somebody and not see them until September?
15 A For a legitimate purpose, yes.
16 Q If the prescription's for a legitimate purpose?
17 A Yes, sir.
18 Q And that would be a Schedule II. And -- and sometimes
19 a physician can simply have a phone conversation with
20 the patient during the interim to make sure that
21 everything's going okay?
22 A Yes.
23 Q Check a urinalysis test?
24 A Yes.
25 Q Okay. And you yourself have engaged in that practice

1 of not seeing your patients every month when
2 prescribing?
3 A Yes.
4 Q All right. We discussed this briefly earlier, but
5 hydrocodone is a Schedule II controlled substance?
6 A Yes, sir.
7 Q All right. It was previously a Schedule III?
8 A I believe two years ago.
9 Q Which means it didn't require a prescription, written
10 prescription, at that time?
11 A That's correct.
12 Q It could be phoned in?
13 A Yes.
14 Q Up until two years ago?
15 A Yes.
16 Q It was October of -- well, it was two years ago.
17 And there are more potent controlled
18 substances than hydrocodone, correct?
19 A Yes.
20 Q And I understand potency is sort of relative, but you
21 talked about morphine. Morphine is more potent than
22 hydrocodone?
23 A They are actually considered equivalent by the Center
24 for Medicaid Medicine -- Medicare Services [sic].
25 Q Well, you said that methadone -- I'm sorry. You said

1 that morphine was a very dangerous drug and was the
2 cause of more overdose deaths than other drugs, is that
3 right?
4 A I was speaking of methadone, sir.
5 Q Methadone. I'm -- I'm sorry. Not morphine.
6 Oxycodone, more potent than hydrocodone?
7 A By one-third, yes.
8 Q All right. Dilaudid, more potent than hydrocodone?
9 A Yes.
10 Q Fentanyl, more potent than hydrocodone?
11 A Yes.
12 Q All right. So as far as controlled substances -- let's
13 talk about the whole range of Schedule II opiate type
14 medications. Where does hydrocodone fall on that list?
15 A So the Schedule II assessment is due to abuse potential
16 and not potency, so in that list hydrocodone and
17 morphine I believe are the bottom of that list and
18 they're considered equivalent.
19 Q Okay. So the bottom of the Schedule II controlled --
20 controlled substances. There's a lot more potent
21 medications that a physician could choose to prescribe?
22 A In the same abuse category, yes.
23 Q A lot more addictive medications that a physician could
24 prescribe?
25 A That depends on the way it's given.

1 Q Okay. Going back to the guidelines -- I forgot to
2 cover this. The guidelines tell us -- it tells
3 physicians that, "Pain should be assessed and treated
4 promptly... ," is that correct?
5 A Yes.
6 Q And so when it talks about pain being assessed and
7 treated, when a patient complains of pain, a doctor
8 should try to assess it and treat it quickly, is that
9 right?
10 A Yes.
11 Q You're familiar with something called the fifth vital
12 sign?
13 A Yes.
14 Q I -- I know -- I know that you're not a fan of it. It
15 comes up in these cases quite a bit, right?
16 A Yes, sir.
17 Q And the reason why you're not a fan is because that was
18 an initiative that was put out by the American Medical
19 Association?
20 A American Pain Society, yes.
21 Q American Pain Society. And it -- it was taught to
22 virtually all doctors in the United States?
23 A It was reversed by The Joint Commission I believe in
24 2014.
25 Q All right.

1 A It's still present in hospitals.
2 Q So despite the fact that it was reversed, people still
3 believe that pain is the fifth vital sign?
4 A It's described that way, yes.
5 Q At some point -- well, explain to the jury what The
6 Joint Commission is.
7 A So The -- The Joint Commission on the [sic]
8 Accreditation of Healthcare Organizations is a national
9 organization that travels around the country and visits
10 hospitals to make sure that they're doing everything
11 correctly. And I can't give the exact year, but The
12 Joint Commission and the American So- -- American Pain
13 Society established what is called the fifth vital
14 sign. The other vital signs are blood pressure,
15 temperature, pulse, respiration, and they wanted the
16 pain level to be assessed whenever the other vital
17 signs were being taken.
18 Q And at some point that was found not to be a very good
19 idea?
20 A After the opioid epidemic, no.
21 Q Okay. Because as a result of patients complaining of
22 very severe, significant pain, we started to see
23 opiates being prescribed more frequently, is that
24 right?
25 A Yes.

1 Q Because there was a requirement that when a pain was a
2 certain level, physicians should immediately treat the
3 pain, right?
4 A It was strongly suggested.
5 Q Strongly suggested. And it was strongly suggested for
6 hospitals who were accredited to engage in that
7 practice?
8 A Yes.
9 Q And since then there has been sort of a reeducation
10 trying to get physicians to not look at pain as a fifth
11 vital sign?
12 A Trying to get hospitals to not look at pain as a vital
13 sign, yes, sir.
14 Q But you've found that despite that many people still
15 believe that pain is a fifth vital sign?
16 A Yes.
17 Q Okay. And these guidelines appear to reflect that
18 idea, pain should be treated promptly and it should be
19 assessed?
20 A "Pain should be assessed and treated promptly... ."
21 Q Okay. Now let's talk about your review in this case.
22 You would agree with me that prior to reviewing a
23 physician's treatment it's important to look at all of
24 the medical records that the physician had available at
25 the time?

1 A The entire practice?
2 Q All of the medical records the physician had available
3 at the time for the patient.
4 A Oh. I'm sorry. For that patient, yes. I'm sorry.
5 Q Because physicians routinely look back into history to
6 see what was wrong with the patient to try to help
7 understand what is going on with them now, right?
8 A That's helpful, yes.
9 Q And in order for you to do your review as a physician,
10 it's important for you to look at all of those records?
11 A I would not agree with that.
12 Q You don't need to look at all of the records that a
13 physician reviewed when he made the decision to write a
14 controlled substance in order to evaluate that
15 decision?
16 A I agree that I would need to see the records that he
17 saw, the physician saw.
18 Q That he saw?
19 A Yes.
20 Q Okay. I think we're in agreement.
21 A Yes.
22 Q So in some of these charts, you saw that there was a
23 notation -- in fact, you testified to it -- see prior
24 medical records. It was notated in the chart, right?
25 A Yes.

1 Q All right. Do you know who Dr. Quines is?
2 A No, sir.
3 Q Did you know that prior to Dr. Oesterling treating some
4 of these patients he took over the practice or part of
5 the practice of another physician?
6 A No.
7 Q Did you know that there were prior medical records in
8 Dr. Oesterling's possession for that prior treating
9 physician?
10 A For these patients?
11 Q Yes.
12 A No.
13 Q And do you know whether or not Dr. Oesterling looked at
14 those prior treatment records for that physician?
15 A There is no documentation of it.
16 Q Well, there was documentation that said see prior
17 medical records, wasn't there?
18 A That is in the EMR, yes.
19 Q Okay. Incorporating the prior medical records into his
20 current documentation?
21 A Could you repeat that?
22 Q In -- the note see prior medical record incorporates
23 those medical records into his -- into his chart,
24 right?
25 A No, sir.

1 Q You don't believe so?
2 A No.
3 Q Okay. So every time a physician takes over for another
4 physician, they need to look through the entire prior
5 medical record and re-document everything that has
6 occurred with that patient?
7 A If they have a detailed history of present illness,
8 which is what has occurred in the past or what is going
9 on with the patient, that may be adequate.
10 Q But that would really be -- and if you fail to -- to
11 re-document, that would really be a documentation
12 error, not necessarily a prescribing error, is that
13 right?
14 A It would depend on the diagnosis.
15 Q Okay. Let me ask you would you have liked to see the
16 prior medical records of Dr. Oesterling's patients when
17 they were treated by Dr. Quines to see if he made the
18 right decision?
19 A I would have liked to have seen what he saw.
20 Q Okay.
21 A Or what he looked at.
22 Q And if he saw Dr. Quines's records, you would have
23 liked to see those?
24 A I never saw any mention that he reviewed them.
25 Q Other than the note see prior medical record?

1 A Which is mostly or usually part of an EMR template.
2 Q All right. You never saw Dr. Quines's prior medical
3 records, right?
4 A I saw some dictations by other physicians in these EMRs
5 contemporaneous, I mean at the same interval, not prior
6 to that, no.
7 Q Well, you reviewed the entire patient file that you
8 were given, and you don't recall the name Dr. Quines
9 coming up at all?
10 A I believe I recall that name from one of the interviews
11 with law enforcement. That's my recollection.
12 Q But not from the medical records?
13 A No.
14 Q But you would agree that it is permissible for a
15 physician to rely on the prior documentation and
16 charting of another physician, correct?
17 A Could you be more specific?
18 Q Okay. Let me give you an example. If a patient sees a
19 physician prior to seeing Dr. Oesterling the month
20 prior and that physician does a complete physical
21 examination, takes a complete history, Dr. Oesterling
22 would not need to redo that physical examination and
23 history necessarily prior to treating the patient.
24 A If the history was sufficient to rule out conditions
25 that would contraindicate prescribing opioids and the

1 intervening history had not changed.
2 Q So if the history meets the standard, if the physical
3 examination meets the standard, Dr. Oesterling doesn't
4 need to redo the examination just to meet the standard?
5 A The --
6 Q The guideline, I should say.
7 A -- practice is to ask if there is -- and this is from
8 CMS guidelines. If there are any changes in the --
9 Q Well --
10 A -- personal, family, social history.
11 Q -- sir, we're talking and we're limited to talking
12 about these Michigan guidelines because that's what you
13 used in evaluating this case. Do these Michigan
14 guidelines tell you that you can't rely on the
15 documentation of another provider?
16 A If you can confirm they're adequate, I would say no.
17 Q So it's okay to rely on the documentation if you can
18 confirm they're adequate?
19 A For the initial evaluation.
20 Q Perfect. Thank you.
21 For all of these patients except for the two
22 you saw videos for, you weren't in the examination room
23 when Dr. Oesterling was treating these patients?
24 A No, sir.
25 Q You didn't hear the conversation between Dr. Oesterling

1 and these patients?

2 A No, sir.

3 Q You did see two patient visits, one for Dawn Rise and

4 one for Jeff Jones or Jay Mineau, is that right?

5 A Yes, sir.

6 Q Okay. And for that you effectively were inside the

7 examination room?

8 A Yes, sir.

9 Q All right. But the others, you don't know what -- what

10 actually went on between Dr. Oesterling and the

11 patients?

12 A No.

13 Q So it's your belief that when you evaluate the

14 documentation of those patient visits, that's really

15 all you have to go off of to see if Dr. Oesterling

16 properly evaluated the patient?

17 A That and the urine drug screens, yes.

18 Q Which is part of the documentation?

19 A Yes.

20 Q It's in the file. Okay. So if there were things that

21 weren't documented and weren't put in the file, that

22 wouldn't have been part of your review necessarily,

23 right?

24 A Correct.

25 Q If a physician made documentation errors by not

1 completely documenting what went on, your review would
2 be incomplete.
3 A And there's no documentation to the validity of the
4 visit.
5 Q Okay. But that would be a documentation error, not
6 necessarily a prescribing error?
7 A I -- if a practice continues on each visit over and
8 over again, I -- I wouldn't consider that a
9 documentation error. I would consider that to be a
10 practice.
11 Q Are you familiar with something called Meaningful Use?
12 A Yes.
13 Q All right. It sounds like you don't like that one
14 either.
15 A No, sir.
16 Q Can you tell the jury what Meaningful Use is?
17 A Meaningful Use was started I believe in 2011 or 2012.
18 It was an effort by the government to get physicians to
19 document what Medicaid and Medicare felt was important
20 on the chart. And it required the use of an electronic
21 medical record, and it required you to document
22 multiple things that the government thought was
23 important. And they paid you for doing it over a
24 period of about three years.
25 Q Everybody who billed federal health care programs had

1 to comply with Meaningful Use at some point, right?
2 A The federal qualified programs? I'm not sure. I don't
3 know, sir.
4 Q Everybody had to participate in Meaningful Use
5 eventually?
6 A No, sir.
7 Q That's part of the Affordable Care Act?
8 A That's not my understanding.
9 Q That's not your understanding. Did you have to comply
10 with it?
11 A I chose to.
12 Q Okay. Many physicians were required to comply with it?
13 A Not to my knowledge.
14 Q Okay. So you thought it was a voluntary participation?
15 A Well, if a hos- -- if a hospital implemented Meaningful
16 Use, then if you were in the hospital, you were
17 required.
18 Q If you were in the hospital system, right?
19 A Otherwise, the penalty was a cut in reimbursement.
20 Q If you had privileges at that hospital, you would
21 normally have to comply with Meaningful Use, right?
22 A Eventually, yes.
23 Q Okay. And so as a result -- well, let me lay some
24 foundation for this. You are familiar with -- as an
25 expert, you've evaluated other physicians' practices?

1 A Yes.
2 Q You're very familiar with other -- with what other
3 physicians do for documentation?
4 A Yes.
5 Q You saw around the time of Meaningful Use a significant
6 number of physicians had to go to electronic medical
7 records, right?
8 A Chose to, I believe.
9 Q Chose to?
10 A Yes.
11 Q Okay. Well, otherwise they would get a significant cut
12 in their reimbursement?
13 A Years down the road, yes.
14 Q Sort of a Hobson's choice, right?
15 A Yes.
16 Q You must comply or we will not pay you very much?
17 A Yes.
18 Q All right. And as a result of that, we saw a lot of
19 physicians who didn't use EMRs move to start using
20 EMRs, correct?
21 A Yes.
22 Q And did we start seeing a lot of mistakes in the EMRs
23 as a result of physicians who are older and more
24 established, not familiar with computers, using EMRs?
25 A I won't ask what older means, but yes, sir.

1 Q Yeah. Okay. I think that's a fair answer. Physicians
2 who used paper and pen for years and years and years
3 now had to switch to checking boxes on a computer and
4 filling out data on a keyboard, right?
5 A Yes, sir.
6 Q All right. Can you tell me whether or not the use or
7 the requirement to use an EMR has impacted a
8 physician's practices overall when documenting patient
9 visits?
10 A The -- it's been twofold. The accuracy of some of the
11 diagnostic criteria has increased, especially the ones
12 required by Meaningful Use, and additional mistakes
13 have occurred going from record to record or from
14 patient to patient.
15 Q So Meaningful Use drastically increased the amount of
16 stuff that a physician had to put into a record, right?
17 A Yes.
18 Q And all of these electronic medical record companies
19 created templates for what was compliant with this
20 Meaningful Use program?
21 A Yes.
22 Q And in order to get through the medical record and fill
23 it out, you had to fill out all the stuff that
24 Meaningful Use required you to fill out, right?
25 A Yes.

1 Q Okay. Did you have this transition in your practice?
2 A Yes.
3 Q Was it a tough transition?
4 A Yes.
5 Q Was it expensive?
6 A It matched the reimbursement.
7 Q Okay. So you have to do this. We'll pay you, but --
8 A Yes.
9 Q -- it will be just as expensive as what you're making.
10 That's what the government did?
11 A Yes.
12 Q Okay. So let's talk about some of the individual
13 patients now?
14 MR. CHAPMAN: And, Your Honor, I don't know
15 when you plan on taking the midmorning recess, but I'm
16 about to make a transition here.
17 THE COURT: All right. Why don't we do that
18 right now because we've been at it for almost two
19 hours.
20 We'll take our morning recess, ladies and
21 gentlemen.
22 (Jury excused at 10:22 a.m.)
23 THE COURT: Court's in recess.
24 (Court recessed at 10:23 a.m.)
25 (Court reconvened at 10:57 a.m., jury not

1 present.)

2 THE COURT: Mr. Wanink, are you -- oops.

3 Sorry. Mr. Wanink, are you ready for the jury?

4 MR. WANINK: Yes, Your Honor.

5 THE COURT: Mr. Chapman?

6 MR. CHAPMAN: I am, Your Honor.

7 THE COURT: All right. Mr. Oprea?

8 Dr. Christensen, you can retake the stand.

9 Thank you.

10 (Jury present at 10:58 a.m.)

11 THE COURT: You may continue, Mr. Chapman.

12 MR. CHAPMAN: Thank you, Your Honor.

13 BY MR. CHAPMAN:

14 Q Now, Dr. Christensen, I'd like to turn to the specific

15 patients that you reviewed, but first I want to talk a

16 little bit about the selection that went into the

17 patient files that you reviewed. How many patient

18 files did you review in total?

19 A I believe it was about ten files.

20 Q Okay. And how --

21 A Maybe a little more.

22 Q I didn't mean to cut you off. You said maybe a little

23 bit more?

24 A Yes.

25 Q And how many did you testify to on the stand yesterday

1 and today?
2 A Five.
3 Q Five. And do you know how the files that you reviewed
4 were selected?
5 A No.
6 Q You don't know who selected them?
7 A No.
8 Q And you don't know whether or not -- obviously
9 whether -- whether they were a random sample of patient
10 files from Dr. Oesterling's office or whether they were
11 preselected for some reason?
12 A I don't know.
13 Q Okay. And you haven't had an opportunity to look at
14 Dr. Oesterling's entire practice, right?
15 A No.
16 Q Just the ten files that you reviewed -- you've
17 reviewed?
18 A Yes.
19 Q And then you've testified about five of them?
20 A Yes.
21 Q Okay. One of those files that you reviewed was related
22 to a patient, Dawn Rise?
23 A Yes.
24 Q And you also saw a video with respect to patient
25 Dawn Rise, right?

1 A Yes.
2 Q Okay. Actually, you saw a couple of videos. Do you
3 recall that?
4 A I don't remember how many were for Dawn.
5 Q All right. Let me ask you this. Did you see a video
6 of Dawn Rise attempt to see Dr. Oesterling but ended up
7 receiving some new patient paperwork and just speaking
8 to a gentleman in the waiting room for quite some time?
9 A No.
10 Q All right. One of the videos you saw was Dawn Rise
11 coming in for her visit where she actually got to see
12 Dr. Oesterling?
13 A Yes.
14 Q And did you listen to any audio?
15 A Yes.
16 Q Did you hear audio of Dawn Rise seeing Dr. Oesterling
17 with another person, Jillian Fitch?
18 A No.
19 Q Did you hear any other audio with respect to Dawn Rise?
20 A I don't believe so, no.
21 Q Okay. So if there were -- if there was a video and
22 another audio that you hadn't seen -- well, let me --
23 let me rephrase that question. I'll just move on.
24 Is it -- just to be clear, is it your
25 testimony you only saw one video of Dawn Rise then?

1 A I believe so, yes.
2 Q Okay. And during that video, Dawn Rise received
3 medications?
4 A That was her first visit with Dr. Oesterling. Yes.
5 Q All right. Are you aware that there was a subsequent
6 visit where Dawn Rise was told that she wouldn't get
7 medications from Dr. Oesterling because she hadn't
8 scheduled her appointment to receive I believe it was a
9 CT scan?
10 A If I saw that video, it was when I initially had
11 reviewed the charts back in April. I don't remember
12 that.
13 Q You don't know whether or not that went into your
14 review?
15 A No.
16 Q All right. I'm going to show you -- and -- and I'm
17 going to try to put these up on the screen, but if you
18 can't see it, just let me know and I'll be able to hand
19 you a copy as well.
20 I'm handing you what's been marked as
21 People's Exhibit 7, the patient chart of Dawn Rise,
22 Page 7, and, Doctor, can you see the top of this
23 document?
24 A It says History and Physical Report Number 2.
25 Q Okay. And on this document do you see a problem list

1 for this patient?
2 A Yes.
3 Q And -- and so it appears that on May 9th, 2016, someone
4 named Laura Green put this into the chart. Is that
5 what -- is that what happened?
6 A Appears to be, yes.
7 Q Okay. And -- and this patient's problem list was
8 neuropathy?
9 A That's one of them listed, yes.
10 Q And -- and Dawn Rise also listed arthritis?
11 A Yes.
12 Q And she listed a ruptured disc?
13 A Yes.
14 Q And she listed bipolar disorder?
15 A Yes.
16 Q And anxiety and depression, is that correct?
17 A Yes.
18 Q All right. Now let me ask you, you talked a little bit
19 about hydrocodone and whether or not hydrocodone --
20 well, actually, we talked about the board guidelines,
21 and the board says one of the things that we need to do
22 is look at the diagnosis and the medication, see if
23 it's appropriate, right?
24 A Yes.
25 Q All right. Hydrocodone can be used to treat a ruptured

1 disc, right?
2 A It is one of the medications used, yes.
3 Q It can be used?
4 A Yes.
5 Q It can be used to treat pain associated with arthritis?
6 A It can be, yes, if appropriate.
7 Q All right. And then Ultram can be used to treat
8 neuropathy, is that right?
9 A That's not a typical indication for Ultram or tramadol,
10 no.
11 Q Can -- can it be used off label to treat neuropathy?
12 A It could be, yes.
13 Q All right. That's one possible off-label use?
14 A Yes.
15 Q And when somebody uses a medication off label, they're
16 using it for a purpose that is not approved by the FDA
17 but may be successful in treating the condition, is
18 that right?
19 A It's up to the prescriber to determine that, yes.
20 Q Okay. Thank you. So if Dawn Rise was prescribed
21 hydrocodone, it could be appropriate to relieve pain
22 associated with at least the arthritis and the ruptured
23 disc, right?
24 A Again, if appropriate, yes.
25 Q Okay. And Xanax can be prescribed for the treatment of

1 anxiety, right?
2 A Yes.
3 Q And, in fact, that's its primary -- that's the primary
4 condition Xanax treats?
5 A That's the primary FDA indication, yes.
6 Q Now, we talked about the fact that Dawn Rise complained
7 of a ruptured disc. What is the best way in your
8 opinion to determine whether or not somebody has a
9 ruptured disc?
10 A That's outside the scope of my expertise, but it would
11 typically be a CAT scan, an MRI or what's called a
12 discogram.
13 Q So if Dr. Oesterling sent Dawn Rise for an MRI, a CAT
14 scan, that's something you would expect to show the
15 cause of -- show the ruptured disc, right?
16 A If it hadn't resolved.
17 Q Now, you can't always determine whether or not somebody
18 has a ruptured disc based on a physical exam, is that
19 right?
20 A If the patient has a symptomatic ruptured disc, they'll
21 have typical physical findings.
22 Q Well, range of motion would -- might be different,
23 right?
24 A That's right.
25 Q But you can't palpate the spine and determine that

1 somebody has ruptured their disc, is that right?
2 A You can't feel the disc, no.
3 Q It would be indistinguishable from normal back pain
4 when you're doing your range of motion on your physical
5 exam, right?
6 A I wouldn't agree with that, no.
7 Q Okay. That's fine. But you can't -- you can't
8 determine a disc is ruptured based on your hands?
9 A No, you can't.
10 Q You can't determine that somebody has arthritis based
11 on your hands, physical exam, right?
12 A You may be able to, yes.
13 Q You may be able to?
14 A Yes.
15 Q You can't always?
16 A No.
17 Q Okay. Now, if you have a patient, you do a physical
18 exam on them and they have -- they say they have
19 arthritis and they have a ruptured disc and you don't
20 find anything, do you refuse to treat them until they
21 receive an MRI? Is that what you would do?
22 A If they were coming to me asking for pain medications
23 and their examination was normal, I would want
24 additional information, yes.
25 Q Okay. But -- but that's not what the guidelines tell

1 us. The guidelines tell us to promptly assess and
2 treat pain, right?
3 A My interpretation of promptly is that you should do it
4 in a quick fashion, but it does not mean opiates on
5 demand.
6 Q But if you attempt to assess and you can't find it, the
7 next thing a physician should do is send somebody --
8 the next thing the guidelines require for assessment is
9 to send somebody for radiology?
10 A Additional testing.
11 Q And isn't that what Dr. Oesterling did in this case?
12 A If a CAT scan was ordered, yes.
13 Q Okay. If a CT scan was ordered, would that change your
14 position?
15 A CT and a CAT scan?
16 Q Yeah.
17 A Same thing. Yes. Yes.
18 Q Okay. Thank you.
19 Now, I don't know if I completely understood
20 your testimony. Was it your testimony that Dawn Rise
21 had a urinalysis test performed in May of 2013?
22 A Could I see the document?
23 Q Sure. I can put it up for you. I'm showing you
24 People's Exhibit 7, Page 13. Are you able to see the
25 date on this urinalysis test, Doctor?

1 A May 2016.
2 Q Okay. So is it May 5th, 2016?
3 A That's when it says the specimen was collected, yes.
4 Q Does this appear to be the urinalysis test associated
5 with her first visit?
6 A This is -- we have been using the term urinalysis, but
7 this is urine drug testing with that date.
8 Q Okay. And by urine drug testing, you're saying that
9 this was a test for drugs in the urine?
10 A Drugs of abuse, yes.
11 Q Drugs of abuse. Okay. And it was your testimony that
12 this was positive for alprazolam?
13 A Yes.
14 Q Was that a drug that Dawn Rise said that she was
15 prescribed?
16 A I would need to look at the document.
17 Q Okay. I show you the next page. This test is also
18 positive for hydrocodone?
19 A Yes.
20 Q Okay. And you said you want to see the -- the document
21 to see what she was previously prescribed or what she
22 claimed she was previously prescribed. You would
23 normally put what was previously prescribed in a
24 medication history, is that correct?
25 A Yes.

1 Q All right. And her medication history that was put in
2 on 5-9 indicated that she was taking Xanax, correct?
3 A It indicated she was taking it. I don't see it being
4 listed as prescribed.
5 Q What's the difference?
6 A A patient can be taking a medication that's not
7 prescribed.
8 Q Well, this says medication history. Is it -- when
9 something's called medication, doesn't that mean that's
10 what's prescribed to them?
11 A In my experience, it means what they're taking.
12 Q Okay. All right. She also claimed she was taking
13 Neurontin prior to seeing Dr. Oesterling? Do you
14 recall that from --
15 A Yes.
16 Q -- the video?
17 A Yes.
18 Q Okay. Also said that she was taking Norco, Zoloft and
19 Seroquel, is that right?
20 A Yes.
21 Q And her urine drug screen was consistent for those
22 controlled substances, is that right?
23 A The drug screen we just saw?
24 Q Yeah.
25 A Yes.

1 Q And, I'm sorry, the -- yeah, the drug screen that we
2 just saw.
3 A Shows Norco and Xanax, yes.
4 Q Okay. So her drug screen appears consistent with what
5 she claimed that she was taking when she first showed
6 up to see Dr. Oesterling?
7 A It stated what she was taking, yes.
8 Q Okay.
9 A I don't know what she was prescribed.
10 Q All right. Do you know whether or not the Michigan --
11 or the MAPS system is able to determine whether or not
12 somebody was prescribed the medication in Arizona?
13 A At that time, I believe not.
14 Q Okay. So if a patient comes in and says I'm from
15 Arizona, I was prescribed this medication, there's no
16 way for a physician to quickly check to see if that's
17 the truth?
18 A Sure. He just asks to see the bottles.
19 Q If the patient had the bottles on them?
20 A If they're still taking the medication, they should
21 have the bottles.
22 Q Okay. Now, are you aware that after prescribing
23 initially to Dawn Rise, Dr. Oesterling ordered
24 Dawn Rise to go receive a CT scan?
25 A I believe so, yes.

1 Q Are you aware that Dawn Rise came back for another
2 visit or second visit seeing Dr. Oesterling?
3 A If I could see the document. I'm going from memory
4 here, so I would prefer to see the document.
5 Q Well, I -- this is on video, and I didn't want to
6 replay the entire video for you. Do you recall on
7 video?
8 A I did not see a subsequent visit that I remember with
9 Dawn Rise.
10 Q Okay. And do you recall whether or not Dawn Rise
11 received prescriptions on the subsequent visit?
12 A I don't remember.
13 Q You don't remember. Do you recall whether or not
14 Dawn Rise went to get the MRI? I'm sorry. The CAT
15 scan.
16 A Not without the document, no, sir.
17 Q All right. I'm showing you People's Exhibit 7,
18 Page 11. Does this appear to be a report from a CT
19 scan?
20 A Yes.
21 Q And it's a CT of the abdomen and pelvis without
22 contrast?
23 A Yes.
24 Q Is that something that a physician would order to
25 determine the cause of right flank pain?

1 A One of the tests, yes.
2 Q All right. In fact, the clinical history here
3 indicates that -- chronic right flank and lower back
4 pain for six months. Do you see that?
5 A Yes.
6 Q How does that clinical history get into this record, if
7 you know, as a physician?
8 A Typically when a patient has an x-ray study done, the
9 radiology department interviews the patient and it's
10 also -- it may also be on the radiology requisition.
11 Q All right. So a doctor fills out a radiology
12 requisition, sends it off to the hospital, and that may
13 have a clinical history or indication?
14 A Yes.
15 Q And that's how radiology knows what to look for?
16 A Or by interviewing the patient, yes.
17 Q So it would be reasonable to conclude that this
18 information here, chronic right flank pain and lower
19 back pain for six months, either came from
20 Dr. Oesterling or the -- the patient herself?
21 A Yes.
22 Q In your experience, is -- is chronic right flank pain
23 and lower back pain something that would normally be
24 stated by patients or does this appear to be more a
25 statement made by a medical provider?

1 A That's more likely a medical statement.
2 Q Okay. All right. Now, you see here that there are
3 findings listed on this report, is that correct?
4 A Yes.
5 Q All right. And it indicates that a small portion of
6 the appendix visualized and contains air. Do you know
7 what that means?
8 A By itself, it's non-diagnostic. If there was a stone
9 seen, then it should be investigated.
10 Q All right. So that could be an indication that there's
11 some sort of stone?
12 A No. The stone would be visible --
13 Q All right.
14 A -- as well.
15 Q And then there's marked atrophy of the left kidney with
16 compensatory hypertrophy of the right kidney. Can you
17 tell us what that means?
18 A So the left kidney is shriveled up, atrophic, and the
19 right kidney has enlarged in order to compensate. And
20 there's no evidence of renal stones, no evidence of
21 obstruction and no evidence of a mass on either side.
22 Q Do you recall Dawn Rise during her patient visit
23 indicating that she had a shriveled-up kidney?
24 A Yes.
25 Q Okay. And issues with her other kidney?

1 A Yes.
2 Q So this appears to confirm the statements made by
3 Dawn Rise?
4 A Yes.
5 Q All right. Do you know whether or not Dawn Rise
6 received medications after -- well, do you know if she
7 ever came back to Dr. Oesterling with this CT scan?
8 A Not without seeing the document, no.
9 Q Okay. And so obviously you don't know whether or not
10 she received controlled substances on the -- the visit
11 after that?
12 A Don't know.
13 Q Okay. Is it fair to say that you were really only
14 reviewing this case for Dawn Rise's first visit and
15 didn't look for information related to subsequent
16 visits?
17 A I reviewed the information that was given to me.
18 Q Did you only derive an opinion related to the first
19 visit?
20 A I would have used the entire chart in writing my
21 opinion. The opinions were excluded, so I can't tell
22 you what I wrote down.
23 Q And I'm not talking about the opinions that you wrote
24 down. I'm talking about your opinion as a physician as
25 you're stand -- sitting on the stand.

1 A If I could look at the document, I can refresh my
2 memory, yes.
3 Q Refresh -- what document?
4 A The file that was available on Dawn Rise.
5 Q Oh, okay. You saw a video related to patient Jay
6 Mineau or Jeff Jones --
7 A Yes.
8 Q -- is that right? And for the purposes of this, I'll
9 just call Jeff Jones Jay Mineau, his patient name. And
10 you're aware that at some point the DEA or other agency
11 sent Jay Mineau into Dr. Oesterling's office to attempt
12 to obtain prescription medication?
13 A Yes.
14 Q Okay. You had no involvement in those operations, is
15 that right?
16 A No, sir.
17 Q You didn't speak to any of the officers prior to them
18 going in?
19 A No, sir.
20 Q All right. You're aware from watching the video that
21 Jeff Jones complained of various conditions, is that
22 right?
23 A Pain, yes.
24 Q Pain. Okay. He specifically said that he had pain, is
25 that right?

1 A Yes.
2 Q He specifically said that he had some popping and
3 grinding in his back region, is that right?
4 A Yes.
5 Q He specifically said that it was like hell getting out
6 of bed in the morning?
7 A Yes.
8 Q He specifically said that he had been taking Motrin for
9 quite some time but it wasn't working very well?
10 A Yes.
11 Q He said that he bent over in the shower at one point
12 and hurt his back and couldn't -- he had trouble
13 getting back upright?
14 A Yes.
15 Q In fact, he said he had to crawl out of the shower, is
16 that right?
17 A Yes.
18 Q Now, as a physician, when you hear of those types of
19 complaints, you are thinking in your mind that this
20 person may have some sort of back injury, is that
21 right?
22 A It's possible.
23 Q Okay. Disc injury?
24 A It's possible.
25 Q It could be a muscular injury but it could be a disc

1 injury, is that right?
2 A Yes.
3 Q All right. One of the best things to do in order to
4 diagnose that would be to perform some imaging study,
5 is that right?
6 A After a physical examination.
7 Q All right. And a physical examination would only
8 confirm that the person has pain?
9 A I don't agree with that.
10 Q You don't agree?
11 A No.
12 Q You believe that a physical examination could determine
13 whether or not somebody's had a ruptured disc?
14 A It will give you additional information, yes.
15 Q But it can't determine whether or not somebody's had a
16 ruptured disc?
17 A It may be effective at ruling out a ruptured disc.
18 Q Okay. It can't determine whether or not somebody has a
19 muscle injury versus a ruptured disc?
20 A It does not give you a diagnosis, no.
21 Q You would agree that the standard of care would
22 normally require a physician facing a patient like that
23 to order an imaging study?
24 A After a physical examination, yes.
25 Q And to see if there were any prior imaging studies in

1 the record, right?
2 A Yes.
3 Q Okay. And, in fact, Dr. Oesterling did send Jay Mineau
4 for a CT scan, isn't that right?
5 A Yes.
6 Q Actually, it might have been an MRI, but he sent him
7 for some radiology?
8 A CT scan, I believe.
9 Q CT scan. In order to determine the cause of -- of his
10 pain?
11 A Yes.
12 Q And are you aware that Dr. Oesterling did not prescribe
13 medication to Jay Mineau on the second visit?
14 A Yes.
15 Q And you're aware that instead he provided him Motrin?
16 A Yes.
17 Q And you're aware that during that visit he ordered him
18 to go receive some sort of imaging on his back?
19 A Yes.
20 Q Okay. And then you're aware from your review in this
21 case that Jay Mineau came back to Dr. Oesterling with
22 the report and Dr. Oesterling informed him that the
23 imaging revealed no problems with his back?
24 A The imaging revealed lumbar stenosis.
25 Q You believe the imaging in this case revealed lumbar

1 stenosis?
2 A Yes.
3 Q Let's take a look at the image.
4 Is lumbar stenosis something that can cause
5 pain?
6 A Yes.
7 Q Something that you can treat with hydrocodone?
8 A That's not the first choice, no.
9 Q My question was whether or not it was something that
10 you can treat with hydrocodone.
11 A If the pain is moderate to severe and the prescription
12 is not contraindicated by any other diagnosis --
13 Q Yeah.
14 A -- you could do that, yes.
15 Q Your first choice would probably be something like
16 Motrin?
17 A It would depend on the symptoms.
18 Q You would first want to start with something called an
19 NSAID prior to moving to narcotics?
20 A Or Tylenol, yes.
21 Q Or Tylenol?
22 A Yes.
23 Q It's true that Jay Mineau indicated to Dr. Oesterling
24 that he was not receiving pain relief from taking
25 Motrin?

1 A Yes.

2 Q He was not receiving pain relief from taking

3 over-the-counter medications?

4 A Yes.

5 Q And I apologize. I'm trying to find this study for you

6 so that you can tell us about Jay Mineau's spinal

7 stenosis.

8 I'm showing you People's Exhibit 6.

9 A Yes.

10 Q Page 15. Are you able to read this?

11 A Yes, sir.

12 Q Okay. Now, it's the second portion of the impression

13 which tells you that he may have some spinal stenosis,

14 right?

15 A Yes.

16 Q Okay. But it's also true that a lot of middle-aged

17 males could present with these very similar findings?

18 A Yes.

19 Q Okay. And it's very difficult to tell whether or not

20 this could cause pain or could just be a normal finding

21 from somebody having a sedentary job, let's say?

22 A That would be a reason not to order the study in the

23 first place, yes.

24 Q Okay. So you're not really sure whether or not Jay

25 Mineau has spinal stenosis, but this study revealed

1 something that could be spinal stenosis?
2 A The primary finding that I saw on there was that where
3 the nerves come out of the spine, there's narrowing,
4 and one side was worse than the other. I can't
5 remember which.
6 Q Okay. And those findings could also be present in
7 normal middle-aged males?
8 A Yes.
9 Q Could be very prevalent in normal middle-aged males?
10 A Yes.
11 Q Okay. Turning to patient Dennis Marcum, you testified
12 that there were a number of urinalysis tests -- urine
13 drug screens, I should say, where Dennis Marcum was not
14 positive for hydrocodone, is that right?
15 A Yes.
16 Q Hydrocodone that he was prescribed on those months?
17 A The month prior, yes.
18 Q Month prior. Let's talk about some reasons why
19 somebody might be negative on their test. It's very
20 possible that a patient could be negative on a urine
21 drug screen because they've self-escalated their use,
22 is that right?
23 A Yes.
24 Q And that would be a patient who is in increased pain
25 taking more medication than prescribed and -- and not

1 having enough to get them through the end of the month?
2 A That's one explanation.
3 Q Yeah.
4 A Yes.
5 Q And -- and that is an indication of abuse, is that
6 right?
7 A Technically, yes.
8 Q Technically?
9 A Yes.
10 Q But it's not necessarily a reason to cut a patient off?
11 A If that's the correct reason, no.
12 Q So if after a conversation with the patient the
13 physician determines that it is self-escalating use,
14 the physician would normally warn the patient this
15 isn't appropriate or decide to prescribe something
16 different or an increased amount, is that right?
17 A Those are possibilities, yes.
18 Q So when somebody is negative for hydrocodone, the
19 answer isn't always cut them off, kick them out of the
20 practice, move them on their way?
21 A No. You need to speak with the patient.
22 Q Speak with them. Find out the result?
23 A Yes.
24 Q And you weren't in the courtroom to hear Dennis Marcum
25 testify, were you?

1 A No, sir.
2 Q If Dennis Marcum said that Dr. Oesterling had
3 conversations with him about those tests, that would
4 have been the appropriate thing for a physician to do?
5 A I would need to know what the conversation was to
6 determine if it was appropriate.
7 Q Okay. Another possible reason that somebody could be
8 negative for hydrocodone in their system is because of
9 as-needed use, is that right?
10 A Yes.
11 Q All right. When medications are prescribed on an
12 as-needed basis, patients are instructed to use them
13 when their pain flares up?
14 A If that's the instructions, yes.
15 Q If that's the instructions. And sometimes a patient
16 can show up for a urinalysis test -- or urine drug
17 screen and maybe they hadn't needed their medication in
18 the last few days and your test could be negative, is
19 that right?
20 A Yes.
21 Q And that may be another reason why a patient wouldn't
22 have it in their system?
23 A Yes.
24 Q As-needed use? Patients also metabolize drugs
25 differently, is that right?

1 A There are patients who will metabolize drugs faster,
2 but typically what you will see is more of the
3 metabolite in their urine and not the regular drug.
4 Q Okay. For instance, I believe hydrocodone can
5 metabolize as norhydrocodone?
6 A That's one, yes.
7 Q And oxymorphone?
8 A No.
9 Q No?
10 A No.
11 Q Okay. And if you see more norhydrocodone in the system
12 and none of the actual drug, that would be an
13 indication of a high metabolizer?
14 A That's one explanation.
15 Q One explanation.
16 A Yes. You have to take into account all the drug
17 screens that you have reviewed.
18 Q But at some point the metabolize -- the -- the
19 metabolite of the drug also moves through the system
20 quicker and a patient would have a negative test if
21 they were a fast metabolizer a lot quicker than a
22 patient who is a normal metabolizer?
23 A Not necessarily.
24 Q But sometimes?
25 A It's possible.

1 Q Okay. And you don't know whether any of those things
2 that we talked about that could cause a negative test
3 apply to Dennis Marcum?
4 A No, I don't.
5 Q Because you weren't -- you weren't there, right?
6 A No.
7 Q Okay. Now, it is also true that some patients might be
8 selling their medication?
9 A Yes.
10 Q And if you have evidence of that, that would be
11 something that you would want to kick somebody out of
12 the practice for?
13 A I would stop prescribing them controlled substances.
14 Q Okay. I guess -- I guess that's what I mean. And then
15 if you had hard evidence of that or if you had proof of
16 that, that would cause an immediate discharge?
17 A It would -- I can't say that. I would say that there
18 would be no more controlled substance prescriptions.
19 Q No more --
20 A Yes.
21 Q -- controlled substance prescriptions. Absent that
22 occurring, selling your medication, all other instances
23 that could cause negative tests are merely reasons to
24 investigate, is that right?
25 A Yes.

1 Q All right. Similarly, when somebody has a drug that
2 wasn't prescribed in their system, the result is a
3 physician should have a conversation with the patient,
4 is that right?
5 A Yes.
6 Q It's not necessarily a reason to refuse to prescribe
7 medication or to discharge them from the practice?
8 A It would depend on the -- on the finding. You would
9 speak to the patient first. If there was a change in
10 diagnosis, then you would -- you may discontinue the
11 medication.
12 Q Well, let's say a patient tested positive for
13 alprazolam when you had prescribed some other
14 benzodiazepine and their response was I got it from my
15 mother-in-law, I was having a panic attack and I
16 self-treated with her medication because my medication
17 wasn't around. Do you discharge that patient solely on
18 that basis?
19 A No, but I'm gonna be very concerned about continuing to
20 prescribe a controlled substance.
21 Q Of course, they would be considered one of those
22 high-risk types that the Michigan guidelines talk
23 about, right?
24 A Yes.
25 Q You'd want to watch them a little closer?

1 A I would -- if I was a primary care provider, I would
2 refer that patient for an addiction evaluation. That's
3 markedly abnormal behavior.
4 Q Based off one instance of taking mother-in-law's drugs
5 to self-treat a --
6 A And her drugs are gone, yes, sir.
7 Q Okay. But the guidelines don't say to do that, right?
8 In fact, they don't even tell you to perform a urine
9 drug screen?
10 A "Special attention should be given to those pain
11 patients who are at risk for misusing their medications
12 and those whose living arrangement pose a risk for
13 medication misuse or diversion. The management of pain
14 in patients with a history of substance abuse or ... a
15 comorbid psychiatric disorder may require extra care,
16 monitoring, documentation and consultation... ."
17 Q Okay. So first you give -- well, once you define
18 somebody as high risk by hearing about that behavior,
19 then you monitor them a little closely and you can
20 refer out to addiction medicine, is that right?
21 A If somebody's on an opiate and a benzo, that I believe
22 is the definition of high risk.
23 Q Okay. And in some cases it can be -- it can be
24 appropriate to give a patient another chance and
25 continue to treat them?

1 A It would depend on the findings from your discussion
2 with the patient.
3 Q From your conversation. Okay. But then if you've
4 given patients a number of chances and they continue to
5 not have the medication show up, discharge may be
6 something that would be considered?
7 A Again, we -- we talk about discharge, but the important
8 thing to do is to discontinue the controlled substance
9 which may be making things worse and to not abandon the
10 patient unless they are stealing from you or something.
11 Q Discontinue and refer out to another --
12 A Yes.
13 Q -- provider? Are you aware that Dr. Oesterling made
14 the decision to discontinue Dennis Marcum's medication,
15 discharge him from the practice and refer him to
16 addiction treatment?
17 A Again, I am not gonna try and rely on my memory. I
18 would like if I could see the document.
19 Q Sure. So during your direct examination, you reviewed
20 Dennis Marcum's June 2016 visit, People's Exhibit 9,
21 Page 3, and you discussed that Dr. Oesterling diagnosed
22 him with pelvic pain syndrome. Do you recall
23 testifying to that?
24 A Yes.
25 Q Do you recall looking further back in the chart and

1 being asked whether his prior diagnosis was knee and
2 elbow pain?
3 A From earlier this morning, yes.
4 Q Yes.
5 A Yes.
6 Q And do you recall being asked whether or not there was
7 anything in the chart that changed the diagnosis from
8 elbow pain to pelvic pain?
9 A I believe we were discussing back pain was the new
10 diagnosis.
11 Q Back pain was the previous diagnosis?
12 A I believe back pain was the new diagnosis we discussed
13 this morning. I'd have to see the document to --
14 Q All right. Let me show you the June 13, 2016. It was
15 your testimony that knee and elbow pain was the prior
16 diagnosis?
17 A I believe so, yes.
18 Q Okay. And here we see the patient complaint. Did you
19 read this? Patient presents with right elbow and knee
20 pain. Also having marked difficulty with depression.
21 A Yes.
22 Q Okay. Do you see down here also has mod bph? What
23 does that mean?
24 A Moderate benign prostatic hypertrophy.
25 Q Okay. And sxs, what does that mean?

1 A Symptoms.

2 Q And occasional pelvic perineal --

3 A Perineal.

4 Q Perineal discomfort?

5 A Consistent with prostatitis.

6 Q Okay. Check uroflow. All right. When you were asked
7 whether or not there was anything that would change
8 that diagnosis, did you read this before making that
9 statement?

10 A Regarding back pain?

11 Q No. Regarding changing the diagnosis to pelvic pain.

12 A No, I did not.

13 Q You did not. Okay. And as a result of that complaint,
14 do you see that Dr. Oesterling ordered an ultrasound of
15 the pelvis for Mr. Marcum?

16 A Yes, that's what it states.

17 Q Is that an appropriate response to a complaint of pain
18 of that nature?

19 A No. Physical exam.

20 Q Well, do you know whether or not a physical exam was
21 done?

22 A I didn't -- no, I don't.

23 Q You weren't in the patient room at the time, right?

24 A No, sir.

25 Q Okay. If in addition to a physical exam an ultrasound

1 was done, would that have been an appropriate response?
2 A If in addition to a physical exam, yes.
3 Q Okay. You also testified that you reviewed People's
4 Exhibit 9 to determine Dr. Oesterling's treatment of
5 Dennis Marcum. Was that the only document that you
6 reviewed?
7 A I believe so.
8 Q You believe so. Did you review any notes made by other
9 physicians in your review of People's Exhibit 9,
10 Dennis Marcum's patient file?
11 A I believe there was Behavioral Health notes, but I
12 would need to see the document.
13 Q Okay. Did you review any notes created by a Dr. Ahsan?
14 A I don't remember the exact name, but I would need to
15 see the document.
16 Q All right. You testified earlier that it's reasonable
17 for a physician to rely on the prior medical records of
18 a physician if they're appropriate?
19 A Yes.
20 Q Okay. I don't want you to comment on appropriateness
21 here, but I want you to see -- and I'm showing you
22 People's Exhibit 28. These didn't have page numbers.
23 I don't have a specific page number to give you. But I
24 want you to see if there is any indication that a
25 physical examination was done on this document.

1 There's a header right here.

2 A Yes.

3 Q Physical Examination. Do you see right upper

4 extremities, lower extremities, five out of five?

5 A Yes.

6 Q What does that mean, five out of five?

7 A That's testing for -- typically testing for the

8 strength of the muscles in the upper, lower extremity.

9 Five is considered normal or maximum.

10 Q Okay. And it's very possible for somebody to still be

11 in pain but still have a negative finding on a physical

12 examination or a normal finding on a physical

13 examination, right?

14 A Of the involved muscle?

15 Q Yes.

16 A It's not typical. Typical patients have what's called

17 giveaway pain where they can't exert enough strength

18 because it hurts too much.

19 Q Okay. And let's -- let's go to the date of this. Do

20 you see the date here, 1-14, 2015? January of 2015?

21 A Yes.

22 Q Okay. And you see the -- the treating provider here?

23 This might be very small. Does that look like

24 Dr. Ahsan?

25 A It starts with an A. That's all --

1 Q All right.
2 A -- I can tell you, sir.
3 Q Do you know Dr. Ahsan to be the treating provider that
4 treated patients just before Dr. Oesterling saw them?
5 A No.
6 Q Okay. Because you didn't review any of Dr. Ahsan's
7 records, right?
8 A I have not seen this record that I recall.
9 Q All right. Do you see an Assessment and Plan down
10 here?
11 A Yes.
12 Q All right. Now, that first word -- I understand we're
13 trying to interpret Dr. Ahsan's writing.
14 A It says lumbago.
15 Q Lumbago. Okay. What's lumbago?
16 A Lumbago is low back pain.
17 Q Is that what you saw Dr. Oesterling diagnose Dennis
18 Marcum with in his records?
19 A I don't know how the two dates correlate, no.
20 Q Well, assuming that Dr. Ahsan only treated patients
21 prior to Dr. Oesterling treated them, was that the same
22 diagnosis that Dr. Oesterling diagnosed Dennis Marcum
23 with?
24 A It was present on a later visit, yes.
25 Q Okay. Do you also see bilateral knee pain?

1 A Yes.
2 Q And what's this next one starting with an S?
3 A Oh, up. Depression arrow see psychiatry or psychology.
4 Q What about -- what about this one here?
5 A That's spon- -- spondylosis.
6 Q Is that back pain as well?
7 A That's back degeneration.
8 Q Okay. And those are both conditions for which
9 controlled substances could be appropriate?
10 A Possibly, yes.
11 Q Both conditions that hydrocodone could be appropriate?
12 A Possibly, yes.
13 Q And those are both conditions that can't be reversed,
14 right?
15 A You would need more information to say whether or not
16 it was correctable.
17 Q Okay.
18 A Some patients will have advanced surgery for that kind
19 of condition.
20 Q Advanced surgery to repair the back?
21 A Yes.
22 Q Absent advanced surgery, sending somebody to physical
23 therapy is not going to cure the lumbago or the
24 spondylosis?
25 A The pain will not go to zero.

1 Q Okay. I'd like to show you the same thing from
2 People's Exhibit 28. Did you ever review this record
3 during your review of Dennis Marcum's treatment in this
4 case?
5 A I don't recall seeing it.
6 Q Does this appear to be a Dr. Ahsan medical record from
7 February of 2015?
8 A I can't read the doctor's name, but it starts with an
9 A.
10 Q Okay. Same -- same type of medical record that we saw
11 on the last one we looked at?
12 A Yes.
13 Q Do we see the patient's complaints here?
14 A Backache, bilateral knee pain, bilateral elbow pain.
15 Q And this appears to be an increase in pain, is that
16 right?
17 A Yes.
18 Q Increase in pain on the right side?
19 A Yes.
20 Q What would cause a physician to document an increase of
21 pain on the right side?
22 A Typically a patient complaint.
23 Q And that's where you would put it, in the patient
24 complaint spot, right?
25 A Yes.

1 Q And he's complaining of bilateral knee pain and elbow
2 pain, right?
3 A Yes.
4 Q Does bilateral mean both sides?
5 A Yes.
6 Q So for Dennis, on February 2015 his back hurts, both
7 knees hurt and an elbow hurts according to him?
8 A He has pain complaints, yes.
9 Q Okay. Do we see whether or not a physical examination
10 was done?
11 A It's listed.
12 Q And it still appears normal?
13 A The muscle strength is normal. I --
14 Q What -- what else is -- what's abnormal? Is this over
15 here on the right side helping you out a little bit?
16 A That talks about shingles on the right side.
17 Q All right.
18 A Zoster.
19 Q He was prescribed Lidocaine gel for that?
20 A Yes.
21 Q And there was an assessment and plan created by
22 Dr. Ahsan in this document, is that right?
23 A Yes.
24 Q And in addition to -- well, I don't think this mentions
25 hydrocodone, but cortisone gel -- a cortisone shot was

1 prescribed for the knee pain?
2 A I don't know if it was a shot or prednisone, but it's
3 most likely a shot.
4 Q Now, if Dr. Ahsan prescribed Dennis Marcum with
5 hydrocodone during this visit, assuming there was
6 according to you a urine drug screen done and that was
7 not showing any abnormal findings, that would be an
8 appropriate prescription, right?
9 A That's one choice, yes.
10 Q Same thing for the January visit that we looked at.
11 Assuming that urinalysis came back -- and I'm not --
12 we're not looking at January here. That's a different
13 visit. Assuming urinalysis came back in January and it
14 was okay, that would have been an appropriate
15 prescription if Dr. Ahsan prescribed hydrocodone?
16 A If the pain was moderate to severe, yes.
17 Q And -- and these conditions, the spondylosis and
18 degenerative disc disease, those are chronic
19 conditions, right?
20 A Yes.
21 Q So it's fair to say that Dennis Marcum is a gentleman
22 who has chronic pain if you believe the chart?
23 A If the chart's correct, yes.
24 Q Let's look at March 2015. Does this look like the same
25 type of record that you looked at previously?

1 A Yes.
2 Q Dr. Ahsan's visit notes?
3 A Yes.
4 Q All right. And what does the patient complain of again
5 the next month?
6 A States patient here for medication, pills and checkup,
7 backache, bilateral knee pain, and I believe that says
8 bilateral elbow pain.
9 Q Now, when you see a patient who complains of pain in
10 four of their joints, what is a possible additional
11 diagnosis?
12 A That's really -- you really need more information than
13 we have now. You -- the possibilities are
14 osteoarthritis, rheumatoid arthritis, autoimmune
15 disease, and each presentation is different.
16 Q Okay. And do we see that Dr. Ahsan has that a physical
17 examination was done here on 5-5?
18 A The extrem- --
19 Q Not 5-5. On March 2005.
20 A The extremities, strength appears normal. It says
21 lungs clear to auscultation. Heart. First heart
22 sound, second heart sound.
23 Q Abdomen soft?
24 A I believe that says abdomen soft.
25 Q Okay. I -- I could not understand what that was but

1 thank you. And is there an assessment and plan?
2 A Lumbago, low back pain --
3 Q All right.
4 A -- bilateral knee and elbow pain and shingles.
5 Q If hydrocodone was prescribed on those visits after a
6 urinalysis was done and appropriate, that would be an
7 appropriate prescription?
8 A Yes.
9 Q Okay. So it's your testimony that Dennis Marcum -- at
10 least for three months in a row immediately prior to
11 seeing Dr. Oesterling, Dennis Marcum was prescribed
12 appropriate prescriptions?
13 A You specified that the urine drug screens were normal,
14 sir. I didn't see --
15 Q Okay.
16 A -- any drug screens.
17 Q All right. But, again, the -- the guidelines don't say
18 that you have to do urine drug screening prior to
19 prescribing, right?
20 A Not the Michigan guidelines, no.
21 Q Okay. So let's talk about immediately after seeing
22 Dr. Oesterling. Are you aware of whether or not Dennis
23 Marcum based on your review of the record went to the
24 emergency room during his treatment of
25 Dr. Oesterling -- during his treatment by

1 Dr. Oesterling?
2 A I believe he did. I don't remember when. I would need
3 to see the document.
4 Q Do you recall whether or not he was prescribed
5 hydrocodone?
6 A I would need to see the document.
7 Q Okay. Showing you a document from People's Exhibit 9,
8 Dennis Marcum's patient file, do you know what
9 HealthSource Saginaw is?
10 A I believe it's a behavioral health center.
11 Q And for the record, this is Page 66 of 99. I'm sorry.
12 I have the wrong record. I'm going to move on from
13 that, but just one other question on that issue,
14 Doctor. Without seeing the record, do you have any
15 recollection of reviewing an ER visit by Dennis Marcum
16 during the time that he was treated by Dr. Oesterling?
17 A I do recall an ER visit, yes.
18 Q Okay. Do you recall seeing what he was prescribed?
19 A No.
20 Q Okay. You testified with respect to Dennis Marcum that
21 on February 29th, 2016, there was a urinalysis test
22 conducted? Do you recall discussing that test?
23 A Not the specific test. I would need to see it.
24 Q Okay. First, can you tell me what metabolites there
25 are for the drug hydrocodone?

1 A So hydrocodone can be broken up in first a drug called
2 norhydrocodone, which is the most common one you see.
3 It also turns into hydromorphone, which is Dilaudid.
4 It can turn into hydrocodeine [sic], which is not seen
5 that often, and then the final -- the last few ones you
6 see are where the liver converts it for the last time
7 and it's often called glucuronides or norhydrocodone
8 glucuronides.
9 Q Okay. Was it -- do you recall testifying that on
10 February 29, 2016, Dennis Marcum tested negative for
11 hydrocodone?
12 A I believe he tested positive for one. I -- again, I --
13 if you're going by the date, I would need to see the
14 document.
15 Q Okay. Let me ask you this. What date is this test?
16 A February 2016.
17 Q Okay. Is any of the metabolites of hydrocodone that
18 you discussed present in this test?
19 A Norhydrocodone.
20 Q Norhydrocodone would be an indication that somebody had
21 ingested hydrocodone, correct?
22 A Yes.
23 Q All right. The metabolite cannot be present in the
24 body without somebody ingesting the drug and
25 metabolizing the drug?

1 A Usually, yes.
2 Q Usually.
3 A Yes.
4 Q So this appears to suggest -- well, this shows that
5 Dennis Marcum tested positive for hydrocodone on
6 February 29th, 2016?
7 A Yes.
8 Q If you had testified that this was a negative test
9 previously, that would be inaccurate?
10 A Correct.
11 Q You testified that in another test on March 31st
12 Dennis Marcum tested positive for ethanol on an EtG
13 test?
14 A Yes.
15 Q And you said that it can be worrisome for somebody to
16 be using alcohol and benzodiazepines?
17 A It is worrisome.
18 Q Along with hydrocodone?
19 A Yes.
20 Q All right. With respect to EtG tests, when people are
21 instructed that they are to undergo EtG tests, are they
22 given any specific instructions about what to avoid?
23 A If they're being monitored for alcohol use, they are
24 instructed to avoid hand sanitizer, mouthwash, foods
25 that have alcohol in them.

1 Q Because those can cause a false positive on an E -- on
2 an EtG test?
3 A Depends on the level, yes.
4 Q Okay. But they can?
5 A They can, yes.
6 Q Do you know what cutoff levels are?
7 A Yes.
8 Q Cutoff levels are the level at which if somebody tests
9 positive for something it's not recorded because it's
10 an insignificant amount?
11 A That's the lab's -- the lab will assess the cutoff
12 level, yes.
13 Q All right.
14 A They will call it negative under that.
15 Q Do you know what the cutoff level typically for an EtG
16 test is?
17 A It varies lab to lab. It's anywhere between a hundred
18 and a thousand.
19 Q All right. Do you know what Dennis Marcum's EtG level
20 was?
21 A I would need to see the document.
22 Q Cutoff level of a thousand -- or a hundred would be a
23 pretty low cutoff level, right?
24 A Yes.
25 Q All right. I'm gonna show you the March 31st, 2016,

1 test for Dennis Marcum. You said a hundred was low.
2 What did Dennis test positive for? How much?
3 A Tested -- on the EtG, it was I believe 106. The EtS is
4 also positive.
5 Q But for the EtG, that's a pretty low amount, right?
6 A Yes.
7 Q That's not indicative of somebody with alcoholism, is
8 it?
9 A Not by itself, but it demands additional investigation.
10 Q Turning to patient Cassie Tappen, was it your testimony
11 that I believe her initial urine drug test showed
12 positive for Klonopin and Xanax?
13 A I would need to see it.
14 Q Need to see the record?
15 A Yes.
16 Q Okay. Well, let me ask you this. Do you have any
17 indication -- do you have any evidence to suggest that
18 Dr. Oesterling never discussed positive results with
19 Cassie Tappen?
20 A I don't see any documentation of it.
21 Q All right. So the issue is that you believe it wasn't
22 documented if it did occur?
23 A Yes.
24 Q All right. Was it your testimony that hydrocodone can
25 break down into hydromorphone?

1 A Yes.
2 Q All right.
3 A It's typically seen as 10 percent of the hydrocodone
4 value on the same lab test.
5 Q Do you recall testifying that Cassie Tappen tested
6 negative for hydrocodone on her February 18th, 2016,
7 test?
8 A I would need to see the document.
9 Q I'm showing you what's been marked as People's
10 Exhibit 5, Page 46.
11 A Yes.
12 Q Do you see a positive -- first of all, does hydrocodone
13 break down into hydromorphone?
14 A If they're seen together, yes.
15 Q Okay. In this case you do see hydromorphone, which is
16 a metabolite of hydrocodone, is that correct?
17 A What they're showing you is a metabolite of
18 hydromorphone without any other metabolites of
19 hydrocodone, which is extremely unlikely.
20 Q Well, it's extremely unlikely, but it's possible that
21 that could be a breakdown of hydrocodone, is that not
22 right?
23 A I have never seen that happen.
24 Q Okay. Well, let me -- let me show you this again, same
25 exhibit. It's true that the lab classified this as an

1 expected, right? An expected result?
2 A Yes, with all the above being unexpected.
3 Q But is it true that this could give the physician the
4 impression that hydromorphone was an expected result of
5 hydrocodone and thus the patient was taking it?
6 A I would say no with the above -- the 3 negative above
7 it.
8 Q Not all physicians have training in toxicology, right?
9 A No, sir.
10 Q Physicians routinely trust the lab for information on
11 whether or not a controlled substance is present in the
12 body?
13 A Or they call the lab.
14 Q Or they call the lab?
15 A Yes.
16 Q Okay. Are you aware that Cassie Tappen was discharged
17 from Dr. Oesterling's practice?
18 A I believe so, yes.
19 Q You believe so. Okay.
20 Let's turn to patient Juanita Huizar, and you
21 were shown two different records for Juanita Huizar, is
22 that correct?
23 A I believe there was a record with an addendum.
24 Q When you did your initial review, you were shown a
25 record which really only had one date of treatment on

1 it?

2 A With the addendum, I believe.

3 Q Okay. And then --

4 A I'd have to see it.

5 Q And then on the stand you were shown Defense Exhibit 10

6 which had additional records, is that correct?

7 A I would have to see it.

8 MR. CHAPMAN: May I approach, Your Honor?

9 THE COURT: Yes.

10 MR. CHAPMAN: I'm handing the witness

11 People's Exhibit 8 and Defendant's Exhibit 10.

12 BY MR. CHAPMAN:

13 Q People's Exhibit 8, could you look at it and tell me

14 whether that's the record you reviewed prior to issuing

15 your findings in this case?

16 A This was the record that I saw, Exhibit 8.

17 Q Okay.

18 A And I believe the defendant's exhibit came after I did

19 my evaluations.

20 Q All right. And in People's Exhibit 8, how many dates

21 of visit do you see there or visitation dates,

22 treatment dates?

23 A It says Report 1 and 2, but it is -- it appears to both

24 be the same date.

25 Q So one date of treatment?

1 A One date. I don't know if the patient was seen twice
2 or --
3 Q Okay.
4 A But it's both by Dr. Oesterling.
5 Q The Defense Exhibit 10, you see that it has additional
6 dates of treatment, right?
7 A There is a visit from November 3rd, a drug screen from
8 October 31st and a visit from Oc- -- visit from
9 October 31st.
10 Q All right.
11 A And then the original one from October 20th is also
12 attached.
13 Q All right. So Juanita Huizar was first seen by
14 Dr. Oesterling on October 20th, is that correct?
15 A Appears so, yes.
16 Q She received a prescription on that date?
17 A She was given Norco, Ultram, Neurontin and Valium.
18 Q She was then seen on October 31st and she was given an
19 additional prescription?
20 A I'm not seeing a prescription on the 31st.
21 Q All right. Well, I believe the prosecution showed you
22 a prescription. Do you recall seeing that? Do you
23 know what date that was?
24 A No. Without seeing it, no.
25 Q Okay. So we have no knowledge of a prescription on the

1 31st, we know there was a prescription on the 20th, and
2 then there was a prescription issued on November 3rd,
3 is that right?
4 A On November 3rd it states continued Neurontin, Ultram,
5 Norco and Valium.
6 Q Okay. And you were asked by the prosecutor whether it
7 would be normal or usual for a physician to prescribe a
8 month of controlled substances and then a couple of
9 weeks later prescribe an entire new prescription for a
10 whole month of controlled substances. Do you recall
11 that?
12 A Yes.
13 Q And you said that that's not very normal, right?
14 A Yes.
15 Q You would need additional documentation in the chart to
16 find out what was wrong?
17 A Or why it was done, yes.
18 Q Why there was an additional pain complaint --
19 A Yes.
20 Q -- right? All right. Let's look at the patient chart
21 for November 3rd, 2016. Did you have this record prior
22 to issuing your opinion in this case?
23 A No.
24 Q All right. You see the patient here? Is this
25 Juanita Huizar?

1 A Yes.
2 Q All right. And -- and what does the -- the present
3 illness part state? Well, I'll -- I'll read it to you.
4 You tell me if this is correct.
5 Patient presents on 11-3, 2016, with
6 persistent lower back pain secondary to herniated --
7 herniated disc and degenerative disc disease, muscle
8 spasms and anxiety.
9 Is that what it says?
10 A Yes.
11 Q So it appears that the patient came back and complained
12 of increased pain, muscle spasms and then her continued
13 anxiety?
14 A Yes.
15 Q All right. Now, on the first visit Dr. Oesterling
16 prescribed Juanita Huizar without any radiology
17 studies, right?
18 A Yes.
19 Q The visit you reviewed you saw he diagnosed her with
20 these conditions but he didn't have any radiology done?
21 A Did not see any.
22 Q After reviewing the complete chart while testifying
23 today, you do see some studies in there, correct?
24 A Yes.
25 Q And those studies -- you can look at them if you need

1 to, but those studies confirm the pain complaints that
2 Juanita Huizar made on October 20th, 2016, is that
3 right?
4 A It says right flank and back pain.
5 Q She also had the enlarged psoas muscle?
6 A Yes.
7 Q She had a disc herniation?
8 A Yes.
9 Q All right. Let's look at -- let's look at her -- this
10 is an MRI of the lumbar spine for Juanita Huizar?
11 A Let me pull up the -- do you know what page?
12 Q It just says Page 1 of 2 on the page number.
13 A I think I have it.
14 Q Okay.
15 A Yes.
16 Q And there were findings associated with that, right?
17 It says small to moderate midline -- can you help me
18 with that word? I don't know if you can see it.
19 A Sublig- -- subligamentous.
20 Q All right. Disc herniation --
21 A Below the ligament.
22 Q Go ahead. Sorry.
23 A Disc herniation superimposed on a mildly bulging
24 annulus, which is the -- part of the disc, contributing
25 to a mild focal acquired spinal stenosis at L4 to L5.

1 Q Okay. That's not necessarily something that just
2 happens acutely, is it?
3 A It may.
4 Q It -- it could. But it's also something that could --
5 could have occurred over time, spinal stenosis?
6 A This is a disc herniation. You don't know when it
7 happened.
8 Q All right. Prescribing controlled substances can be
9 appropriate for somebody who presents with a disc
10 herniation?
11 A Yes.
12 Q You reviewed a urinalysis test -- I'm sorry. Urine
13 drug screen that was conducted on Juanita Huizar, and
14 you found that it had abnormal or inconsistent results,
15 is that correct?
16 A Yes.
17 Q She tested positive for cocaine?
18 A On October 31st.
19 Q I'm gonna try to catch up here and find that record.
20 A It states alcohol, amphetamines, Klonopin and cocaine.
21 Q Now, there is a lag time generally between the time
22 that somebody tests, provides a sample, to the time
23 that it gets to the lab and the time that it's reported
24 to the doctor, correct?
25 A Yes.

1 Q And in this case the lag time was quite significant.
2 It was 10 or 11 days later.
3 A It states reported on November 10th.
4 Q Okay. So the physician wouldn't have known the results
5 of the positive cocaine test until November 10th, 2016?
6 A It depends how the lab is set up. Some -- I don't
7 know. Some labs will report, report the screen, and
8 then give you the final test.
9 Q What is this lab saying they do with their
10 documentation? They report it on November 10th, right?
11 A It appears the final report was on November 10th.
12 Q You have no reason to believe that's a false statement,
13 right?
14 A No.
15 Q And you have no reason to believe that Dr. Oesterling
16 knew of a positive cocaine result prior to November
17 10th, 2016, right?
18 A No, I don't.
19 Q All right. Was this drug screen in your file that you
20 reviewed?
21 A No.
22 Q No. Do you know whether or not Dr. Oesterling took any
23 action based on that report?
24 A There is a letter attached that discharges her from the
25 practice and refers her to behavioral health providers.

1 Q And that can be one of the appropriate responses by a
2 physician when faced with a patient who's tested
3 positive for cocaine that has recently received a
4 prescription for controlled substances, is that right?
5 A I don't believe it's appropriate to discharge the
6 patient, no.
7 Q You think he should have continued to treat her?
8 A No. Well, not with narcotics.
9 Q Okay. But you think that he at least shouldn't have
10 provided the hydrocodone prescriptions?
11 A Yes, I agree with that.
12 Q So when you're saying to continue to treat her, provide
13 her something else for her disc herniation, you mean
14 provide something like Motrin?
15 A Motrin or gabapentin.
16 Q Okay. Gabapentin's a controlled substance?
17 A No, sir.
18 Q It's noncontrolled?
19 A Yes.
20 Q But not over the counter, right?
21 A It requires a prescription.
22 Q All right. But your only issue with Norco and Ultram
23 being prescribed together is the fact that they are two
24 short-acting medications?
25 A They're both short acting. Tramadol is much less

1 potent than hydrocodone, and unless there's a specific
2 indication with a patient, you would not prescribe them
3 together.
4 Q But tramadol has other off-label uses, right?
5 A Yes.
6 Q What are some of the other off-label uses?
7 A It's used for a diagnosis of central pain syndrome.
8 It's used for fibromyalgia.
9 Q Okay.
10 MR. CHAPMAN: May I have one moment, Your
11 Honor?
12 THE COURT: Yes.
13 MR. CHAPMAN: Your Honor, I don't have any
14 further questions.
15 THE COURT: All right. It looks like this
16 would be a good time for us to break for lunch, so
17 we'll break for one hour until 1:20 if you can return
18 at that time. As a reminder, don't read, listen or
19 watch anything that has to do with this case and don't
20 discuss the case with anyone.
21 Thank you. We'll see you at 1:20.
22 (Jury excused at 12:19 p.m.)
23 THE COURT: Court's in recess. 1:20.
24 (Court recessed at 12:20 p.m.)
25 (Court reconvened at 1:29 p.m., jury not

1 present.)

2 THE COURT: Mr. Wanink, ready for the jury?

3 MR. WANINK: Yes, Your Honor.

4 THE COURT: Mr. Chapman, ready for the jury?

5 MR. CHAPMAN: We are, Your Honor.

6 THE COURT: All right. Mr. Oprea?

7 Dr. Christensen, you can come back up here.

8 (Jury present at 1:30 p.m.)

9 THE COURT: All right. Mr. Wanink, redirect.

10 MR. WANINK: Thank you.

11 R E D I R E C T E X A M I N A T I O N

12 BY MR. WANINK:

13 Q Dr. Christensen, Mr. Chapman began his

14 cross-examination talking to you about a subject called

15 good faith with regards to prescribing medication such

16 as Norco. What is -- what is good faith?

17 A My understanding is that good faith is prescribing for

18 a legitimate indication.

19 Q And where do you get that from?

20 A I -- my recollection is I actually saw the definition

21 of bad faith on one of the Michigan criminal laws, but

22 I can't tell you exactly which one it was.

23 Q And so we discussed this morning and a little bit

24 yesterday afternoon about these five patients, and of

25 those five patients, Dawn Rise, Jay Mineau or Jeff

1 Jones, Dennis Marcum, Cassie Tappen, Juanita Huizar, do
2 you see good faith in the prescriptions there?
3 A I'm concerned that the prescriptions were written
4 without complete evaluation which would have made the
5 correct diagnosis extremely difficult, yes.
6 Q So you see some legitimate concerns with good faith?
7 A Yes, sir.
8 MR. CHAPMAN: Objection. Leading.
9 THE COURT: Mr. Wanink?
10 MR. WANINK: I guess I was trying to
11 interpret, but I'll ask it as a question.
12 BY MR. WANINK:
13 Q Do you have concerns about good faith?
14 MR. CHAPMAN: Objection. Asked and answered.
15 THE COURT: Mr. Wanink?
16 MR. WANINK: I don't think it is, but --
17 THE COURT: I don't recall that being asked
18 and answered. Objection's overruled.
19 BY MR. WANINK:
20 Q Go ahead.
21 A Yes, I do.
22 Q Now, the guidelines that we discussed, these Michigan
23 guidelines, do you think with regards to these five
24 patients that Dr. Oesterling failed to follow those
25 guidelines?

1 A In terms of a complete history and physical examination
2 and lab tests, yes, and in terms of periodic
3 assessments, yes.
4 Q And Mr. Chapman asked you about whether you can deviate
5 from those guidelines if you have good cause. Do you
6 see any good cause with regards to our five patients
7 that you analyzed?
8 A I did not.
9 Q So in this particular case, with regards to all five of
10 these patients, if there are no exams that were
11 performed in the office, no confirmatory testing done,
12 no prior medical records, abnormal drug screens, are
13 these all things that you take into consideration in
14 making a determination of good faith versus bad faith?
15 A Yes.
16 Q And if a prescription is unjustified because it was
17 issued in bad faith, does that make it legitimate?
18 A My understanding is that it's not a legitimate
19 prescription.
20 Q Mr. Chapman asked you on cross if a prescription is not
21 legitimate, then that can meet the criminal standard he
22 asked you about.
23 A Yes.
24 Q Now, with regards to pain management, you described for
25 us yesterday some of the training and education you've

1 received in regards to pain management. Is that
2 something that you have to have to be a pain man- -- to
3 be a pain management specialist?
4 A There's different types of pain management specialists.
5 The most common type is someone who's actually an
6 anesthesiologist or a physical medicine specialist. My
7 specialty is managing pain medications, either
8 monitoring them or getting patients off them.
9 Q To operate as a private practitioner like
10 Dr. Oesterling did and engage in the type of pain
11 management he was endeavoring to engage into, is there
12 anything he -- any kind of specialized training he
13 would have had to had or should have had?
14 MR. CHAPMAN: Your Honor, I'm gonna object.
15 This is outside the scope of cross-examination.
16 THE COURT: Mr. Wanink, your response?
17 MR. WANINK: Well, I don't believe it is. I
18 thought we touched on that -- that issue.
19 MR. CHAPMAN: If I may, Your Honor, that was
20 during voir dire.
21 THE COURT: Well, I think there were some
22 different discussions regarding different types of
23 practitioners and what the standard would be. The
24 objection's overruled.
25 You can answer the question.

1 THE WITNESS: If someone is going to
2 prescribe controlled substances for a chronic condition
3 like chronic pain, they need to understand whatever
4 guidelines are involved. In this case we've been using
5 the Michigan Guidelines for the Use of Controlled
6 Substances, which also involves understanding the state
7 and federal laws involved.
8 BY MR. WANINK:
9 Q And if you don't have any of that, really do you have
10 any business engaging in that kind of practice?
11 A If someone is not familiar with those guidelines and
12 laws, I would recommend that they not engage in that
13 practice.
14 Q Can you actually do harm to these patients if you don't
15 know what you're doing?
16 A That is the main concern when prescribing opioids as
17 compared to prescribing other medications in that there
18 are significant risks associated with prescribing
19 opioids both for the individual patient and the
20 population and whether or not they actually help the
21 patient's pain.
22 Q To that end, Mr. Chapman talked to you a little bit
23 about tolerance, and you indicated that when someone
24 builds up tolerance, they may need more medication or a
25 higher amount of medication. Do you recall that

1 inquiry?
2 A Yes.
3 Q Can that road lead you to addiction?
4 A So the -- the -- our current state of knowledge is that
5 if somebody has no risk factors for addiction that the
6 chances of creating someone who has addiction are very
7 small, but since about 15 percent of the population at
8 least has the risk factors for addiction, there's a
9 significant chance of triggering addiction in somebody
10 or causing a relapse. So in those patients the answer
11 is yes.
12 Q So if you see things in urine toxicology screens such
13 as diversion or illicit drug use, does that tend to
14 lean towards the potential that that patient might have
15 addiction issues?
16 A That patient is at much higher risk and needs either
17 additional monitoring or referral if you're not trained
18 to do the addiction evaluation yourself, yes.
19 Q Is there ever an instance where with a patient such as
20 that you would just simply switch modality of
21 treatment, try something else and cut them off the
22 Norco?
23 A The guidelines don't specify narcotics versus
24 nonnarcotic, but there are many medications available
25 for pain treatment that are not controlled substances

1 and they may be much safer for a patient who has either
2 high risk for addiction or a diagnosis of addiction,
3 yes.
4 Q So if you have a patient who is abusing illicit drugs
5 or diverting their medication, would that be such a
6 patient that you would want to I guess switch or stop
7 the Norco, change course of treatment?
8 A I believe the guidelines would recommend referral, and
9 the referral is almost certainly going to recommend the
10 patient not take the controlled substance. And the
11 current federal guidelines on that which are put out by
12 the Substance Abuse Mental Health Services
13 Administration [sic] recommend that controlled
14 substances be avoided by someone with a history of
15 addiction.
16 Q Now, Mr. Chapman asked you about urine drug screens,
17 that the guidelines don't specifically state what
18 you're to do when you encounter a patient with illicit
19 drug results in their urine screens. Do you remember
20 that?
21 A I'm sorry. Could you repeat that?
22 Q Sure. Mr. Chapman asked you about whether the
23 guidelines prescribe what you're to do when you
24 encounter someone who is illicitly abusing -- or
25 abusing illicit drugs.

1 A The -- I believe the discussion was whether or not to
2 discharge the patient from the practice, and I believe
3 the proper recommendation for patient safety would be
4 to counsel the patient and consider discontinuing the
5 controlled substances.
6 Q And then running MAPS, Mr. Chapman asked you if running
7 MAPS was part of the guidelines, and you indicated it
8 was not.
9 A There's no current absolute requirement to run a
10 prescription search. There is only a requirement to
11 have the correct diagnosis to make it a legitimate
12 prescription.
13 Q Can MAPS do that?
14 A MAPS is one of the areas that helps, yes.
15 Q So it's really an issue of common sense as opposed to
16 guidelines?
17 A You need to have a --
18 MR. CHAPMAN: Objection. Leading, Your
19 Honor.
20 THE COURT: Mr. Wanink, it's leading. If you
21 could rephrase it, please.
22 MR. WANINK: All right.
23 BY MR. WANINK:
24 Q Is it more of an issue of common sense versus the
25 guidelines then?

1 A It's an issue of using all the available information
2 you can get to make the correct diagnosis in order to
3 avoid harm- -- in order to avoid harming the patient.
4 Q Mr. Chapman asked you if it was possible to diagnose
5 some of these maladies in these patients through a
6 physical exam conducted in the office. Do you remember
7 that?
8 A Yes.
9 Q And what did you indicate?
10 A You may not be able to make a diagnosis based simply on
11 an exam, but the conditions we've been talking about
12 have specific physical findings. For example, a
13 herniated disc will cause symptoms in the patient's leg
14 or both legs, a muscle spasm will be able to be
15 palpated by a physical exam. If someone has a problem
16 in their kidneys, that can be palpated on a physical
17 exam. So the diagnosis is not made, but there's
18 important information that should be obtained before
19 ordering additional testing.
20 Q Would confirmatory testing also help in that situation?
21 A If you could not find anything wrong in the patient's
22 physical exam, the guidelines don't demand any
23 additional testing, but if there's physical findings,
24 then I would proceed with additional testing, yes.
25 Q Now, if no exams -- physical exams are being done

1 period, does that change your answer?
2 A The first step after a patient has a complaint is to do
3 an examination. That's a critical part of medical
4 care, yes.
5 Q And would you expect patients complaining of bulging
6 discs to show in their physical exams normal gait,
7 normal movement, things of that nature?
8 A If they were -- if they were having symptoms, if they
9 were symptomatic, I would not expect them to have a
10 normal gait, but a lot of patients will have bulging
11 discs with absolutely no symptoms and no findings.
12 Q Again, is it a good idea to give a patient a
13 prescription -- an opioid prescription based on their
14 naked word that they're in pain?
15 A It's not an adequate amount of information to have to
16 prescribe a controlled substance, no.
17 Q Is it an acceptable practice to prescribe an opioid to
18 someone based on their naked word and then cross your
19 fingers that some confirmatory testing down the road
20 might I guess confirm your original prescription?
21 A If at all possible, the diagnosis should be made before
22 you make -- before you give the controlled substance
23 prescription.
24 Q Mr. Chapman asked you about, you know, that the -- that
25 the guidelines talk about basically a rapid response to

1 complaints of pain. What are -- what are the exact
2 words, if you recall?
3 A Prompt.
4 Q Prompt. Okay. Does prompt entail cutting corners
5 and -- and skipping things like exams and confirmatory
6 testing or reviewing prior medical charts?
7 A My understanding is the information should be obtained
8 as quickly as possible but that you should wait until
9 the information is obtained because without it you
10 cannot make the correct diagnosis.
11 Q In other words, does prompt I guess entail just simply
12 providing opioids on demand?
13 A It does not.
14 Q You still have to do things right?
15 A You have to make the diagnosis.
16 Q Now, periodic review, you used that word frequently.
17 Does that entail considering alternative methods of
18 treatment?
19 A You need to assess the patient's -- I believe the
20 guidelines state you need to assess the patient's
21 progress, the patient's functional level, and if the
22 progress that you're making is not satisfactory, you
23 need to make adjustments or find alternative
24 treatments.
25 Q And is that because -- can you be on these opioids

1 month after month after month?
2 A Many patients do remain on opioids long term. You need
3 to make sure that they are doing better on the opioids
4 than without them.
5 Q Should you at least look at alternative methods of
6 treatment in patients such as that?
7 A Typically the alternative treatment should have been
8 done before the opioids were started, and if the
9 opioids are not working, then you should try and
10 maximize or return to them. But you have to keep in
11 mind that the most -- in terms of patient safety, the
12 most risky thing that you're probably doing is giving
13 the patient opioids.
14 Q And if you subsequently -- after you've prescribed
15 opioids to a patient who made a naked complaint of pain
16 and you have a confirmation test done, MRI, CT scan,
17 whatever, and it shows nothing's wrong with that
18 patient, do you continue the patient on opioids?
19 A That depends on the patient's physical examination, the
20 patient's psychological examination. Patients with
21 chronic pain may have normal radiologic tests.
22 Patients who have no complaints and are actually
23 suffering from addiction may have an M -- abnormal MRI
24 or CAT scan, and that's why you only use the x-ray
25 testing as a part of your evaluation. So the answer is

1 you need additional information.
2 Q Thank you.
3 If a physician believes that a patient coming
4 to them is addicted to the opioid medication previously
5 prescribed by their former doctor, what is that
6 physician's responsibility under the guidelines, the
7 new physician?
8 A So if the new physician believes that the patient has
9 opioid addiction, opioid dependence, then if you were
10 to treat that patient with opioids without any
11 additional management or treatment, my opinion is that
12 that would be in violation of the Controlled Substance
13 [sic] Act. That would not be a legitimate
14 prescription. So the management of pain in that
15 patient is very complex, and that's a patient that
16 needs a referral.
17 Q Mr. Chapman asked you about the -- the EMRs, the
18 electronic magnetic charts.
19 A Medical records, yes.
20 Q Medical records. Excuse me. Electronic medical record
21 system. And you indicated that was a -- a big
22 adjustment getting used to using that?
23 A Yes.
24 Q And you have some personal experience with that?
25 A Yes.

1 Q Did you find it increasingly difficult to use?
2 A No. With any -- as with anything that you learn,
3 there's a learning curve. Things get better after a
4 while. There's complaints from doctors that it's very
5 time consuming and that it keeps them away from the
6 patient, but anything you learn to do gets easier after
7 a while.
8 Q In your own experience in switching over to using the
9 EMR system, did you find yourself accidentally putting
10 down that you were doing 18-point physical exams on the
11 patients?
12 A No, sir.
13 Q I want to switch gears just a little bit and talk about
14 our patients one more time just to go over a couple
15 things that we discussed in response to
16 cross-examination. Again, in response -- I'll hand you
17 People's Number 7 again. This is a patient chart you
18 identified yesterday as the patient chart for
19 Dawn Rise.
20 A Yes.
21 Q Again, you had the opportunity to see the video of the
22 visit that's of concern here, which is the May 5th,
23 2016, visit, correct?
24 A Yes.
25 Q Now, you saw on the video and you see in the chart that

1 day that Miss Rise makes a complaint of pain, atrophic
2 kidney, so on, so forth. Do you recall that?
3 A May 4th, 2016?
4 Q Yes.
5 A Yes.
6 Q I believe it's actually May 5th. The chart's somewhat
7 confusing, but --
8 A On Page 8, yes.
9 Q Yeah. And did you see anything in that video that was
10 done by Dr. Oesterling to confirm her complaint of
11 pain?
12 A I did not see any examination, no.
13 Q In fact, in that chart you see a full examination being
14 performed, correct?
15 A Yes, except for -- except for cardiac, I believe, yes.
16 Yes.
17 Q Is that of some concern with regards to your assessment
18 of whether these -- the prescription for Dawn Rise on
19 that date was justified or not that the exams that are
20 put in the chart are truly not done?
21 A My concern is that there would be no way to make sure
22 you have the correct diagnosis without doing an
23 examination and additional testing, so I'd have to say
24 yes.
25 Q And should you be giving a Norco prescription to a

1 patient such as Miss Rise twice in a row without any
2 physical exam and without any CT scan?
3 A The CAT scan would not automatically be indicated
4 depending on the complaint, but part of the initial
5 evaluation should include a physical examination.
6 Q And you testified earlier that, you know, there's no
7 urine test result preexisting this May 5th examination,
8 correct?
9 A The one that I see here is May 5th, yes.
10 Q And that -- that was a specimen collected May 5th,
11 correct?
12 A Yes.
13 Q So May 5th when a Norco prescription's provided to
14 Dawn Rise, there's no preexisting urinalysis?
15 A Not that I see, no.
16 Q Again, is it a good idea to give a Norco prescription
17 to a patient without knowing what's in their system
18 even?
19 A No.
20 Q So with regards to Dawn Rise, May 5th Norco
21 prescription, do you have an opinion whether that was
22 justified and legitimate?
23 A I do not believe it's justified because I don't believe
24 we had enough information to make the correct
25 diagnosis.

1 Q Moving on to Jay Mineau, aka Jeff Jones, handing you
2 People's Number 6 -- before I leave the subject of
3 Miss Rise, did any of the subsequent information that
4 Mr. Chapman gave you cause you to change your opinion
5 on regards to the May 5th di- -- May 5th prescription
6 to Miss Rise?
7 A I still believe the May 5th prescription was not
8 justified based on lack of a diagnosis.
9 Q Thank you.
10 With Mr. Jay Mineau, aka Jeff Jones,
11 Mr. Chap- -- excuse me. Mr. Chapman talked to you
12 about an MRI that was ordered after the initial visit
13 on May 12, 2016. Again, is it okay to give someone a
14 Norco script and then order the MRI and hope that it
15 confirms your diagnosis and prescription?
16 A Again, there's -- the indication for someone
17 complaining of pain after taking their history is to do
18 a physical examination. A CAT scan or MRI isn't always
19 justified if the examination shows something that is
20 treatable. But in this case we had no physical
21 examination that I saw in the video and no drug screen
22 results back before the patient was written a
23 prescription.
24 Q In fact, Mr. Mineau's chart shows a full examination
25 being done on May the 12th --

1 A Yes.
2 Q -- true?
3 A It does.
4 Q But you saw in the video there was none?
5 A I did not see one.
6 Q And, again, on May 12th was there any diagnosis for
7 prescribing Norco listed in that patient chart?
8 A I don't see one, no.
9 Q In fact, do you see any reference that Norco was
10 prescribed other than the addendum note dated June 9th?
11 A No. It's just in his addendum.
12 Q Does it indicate even an amount or how many times a day
13 he's supposed to take it?
14 A It says Norco 7.5 one pill twice daily as needed. It
15 doesn't state the duration.
16 Q If someone was given a Norco prescription, would you
17 expect to see more justification in a patient chart?
18 A You would need a diagnosis, and also in my opinion it
19 would need to be a legitimate diagnosis.
20 Q Let's talk about Mr. Marcum, handing you People's
21 Number 9. Now, you didn't have any of the previous
22 records of Dr. Quines when you conducted your
23 evaluation of Mr. Marcum, true?
24 A I don't believe so, no.
25 Q When examining Dr. Oesterling's charts, do you feel

1 that those explanations in those charts justify the
2 prescriptions he's giving to Dennis Marcum?
3 A The -- I'm sorry. Which explanations? The --
4 Q The explanations in Dr. Oesterling's records.
5 A So in the -- the follow-up visits, which are the --
6 what the guidelines would call the periodic reviews,
7 there's no assessment that I see of pain level or
8 functional level or any adverse effects, bad side
9 effects, or any abnormal behavior.
10 Q And do you ever see any discussions with the patient
11 noted about abnormal test results on urine drug
12 screens?
13 A No, I did not.
14 Q And we talked about Mr. Marcum on April 28 having
15 tested positive for alcohol the previous month. Do you
16 remember that discussion this morning?
17 A Yes.
18 Q If a patient comes to their doctor's appointment with
19 alcohol in their system that is testable, is that
20 something that a physician should be concerned about
21 the next month when they see that patient?
22 A If they're prescribed opioids, yes.
23 Q And you discussed for us this morning how those two do
24 not mix well together, alcohol and opioids.
25 A No, they don't.

1 Q Mr. Chapman asked you about negative tests and whether
2 that could indicate -- indicate increased use because
3 of tolerance. Do you remember that discussion?
4 A Yes.
5 Q Is increased use because of tolerance I guess akin to
6 any kind of abuse of that narcotic?
7 A I -- I believe by the DEA definition that taking
8 medication not as prescribed is abuse, but what you're
9 concerned about is that the patient is escalating their
10 own dose and losing control of their pain medications
11 without discussing it with you and all you're finding
12 is a negative drug screen and it happens month after
13 month without any complaint from the patient. That
14 makes a simple diagnosis of tolerance unlikely.
15 Q And you don't see any notes of -- of that actually
16 occurring in Dennis Marcum's charts, do you?
17 A No, I didn't.
18 Q You indicated also that failing to have the prescribed
19 medication in your system could indicate diversion. Do
20 you remember that discussion?
21 A That's one possibility, yes.
22 Q And that is, in a sense, a patient selling their pills
23 as a form of diversion, true?
24 A They're not -- typically not taking them. They're
25 selling them, trading them, giving them away.

1 Q Mr. Chapman asked you about a February 2016 lab result
2 which you should have in front of you there, and he
3 asked you about whether there was a metabolite of the
4 Norco prescription in Mr. Marcum's system.
5 A Yes.
6 Q Now, if a patient is being consistently prescribed the
7 four-times-a-day dosage regiment [sic] of Norco, would
8 you expect a different result than what you see in the
9 February urine screen?
10 A If a patient's taking hydrocodone four times a day,
11 it's extremely unlikely that there will not be any
12 hydrocodone in their system.
13 Q So just that little bit of metabolite, I mean does that
14 get Mr. Marcum off the hook that month?
15 A That's consistent with having taken hydrocodone
16 sometime in the -- in the recent past in my opinion.
17 Q So should that have still been a concern to
18 Dr. Oesterling seeing that result?
19 A Yes, because even if the patient's taking it sparingly,
20 that means that you're prescribing too much and you
21 need to address that, and that's one of the purposes of
22 a periodic visit. You need to adjust your
23 prescription.
24 Q And do you see that being done in Mr. Marcum's case?
25 A I did not.

1 Q Mr. Chapman asked you about the chart from June 23rd,
2 2016, to be more specific.
3 A I have that on Page -- no. June. Okay. I have that
4 on Page 3.
5 Q And it indicates some sort of knee pain in the
6 patient's description, right?
7 A Patient returns with right elbow and right knee pain,
8 depression.
9 Q And it indicates the date, correct?
10 A Yes.
11 Q Now flip back to the previous month, May 2016.
12 A I have that on Page 6.
13 Q What does it indicate in that same spot?
14 A Right elbow and right knee pain.
15 Q And it has the new date, correct?
16 A May 25th. Yes.
17 Q Go back one more month.
18 A Right elbow and right knee pain, having difficulty --
19 marked difficulty with depression.
20 Q Go back another month.
21 A Patient returns on March 31st with right elbow and
22 right knee pain, also having marked difficulty with
23 depression.
24 Q From what you're describing here, it sounds like the
25 same thing over and over and over again just with a

1 different date. Would you agree with that?
2 A Yes.
3 Q Let's look at January 2016. You looked at that this
4 morning. We saw a diagnosis of lumbago. Let's take
5 another look at that. That was the one time we
6 switched over from knee pain to lumbago.
7 A So I have that on Page 16.
8 Q All right. What does it indicate in that same area of
9 notes on that date in January 2016?
10 A The chief complaint?
11 Q Yes.
12 A Patient returns on January 16th with right elbow and
13 right knee pain, having marked difficulty with
14 depression.
15 Q Okay. So we got the same thing January, February,
16 March, April, May, June, but now we switch to lumbago
17 as a diagnosis that month. Do you see anything there
18 that would justify that change in diagnosis?
19 A No.
20 Q Does it appear he's simply repeating the same thing
21 month after month and just changing the date?
22 A It's showing up in the EMR as the identical thing each
23 month, yes.
24 Q Now, if a previous physician, as Mr. Chapman indicated,
25 Dr. Quines, had put Mr. Marcum on hydrocodone for pain

1 and then he becomes a patient of Dr. Oesterling, does
2 Dr. Oesterling have to continue that medication
3 regiment [sic], continue -- have to continue that
4 course of treatment?
5 A No, sir.
6 Q What is he free to do at that point?
7 A The physician should prescribe what they feel is
8 clinically indicated based on the diagnosis and the
9 severity of the illness.
10 Q And, again, if he suspects that a patient is addicted
11 to their medication, should he continue that course of
12 treatment?
13 A So if we're describing someone who's a primary care
14 physician, that patient should be referred for an
15 addiction evaluation.
16 Q You shouldn't just continue the course of treatment
17 then?
18 A No, sir.
19 Q Can you wean a patient down off these medications?
20 A That's one option, yes.
21 Q And what does that usually entail?
22 A It involves calculating the dose that they're on and
23 decreasing it by -- typically by 10 percent per week.
24 Sometimes the first dose can be -- the first dose can
25 be decreased 25 percent followed by about 10 percent

1 per week.
2 Q If the patient complains that that's not working for
3 them and you re-up the prescription to the original
4 dosage unit, is that helping the patient wean down?
5 A No. In that case you've abandoned the -- the opioid
6 taper.
7 Q And is weaning down continuing the same regiment [sic]
8 of 7.5/325, 120 pills for, oh, let's say 18 months
9 straight? I mean is that an indication of weaning
10 down?
11 A With the same prescriptions?
12 Q Yes.
13 A No, sir.
14 Q If you feel that your patient that you started on
15 Norco, assuming it's not an old patient but a new
16 patient, and you start to suspect the patient is
17 becoming addicted to their medication, what should you
18 do as a physician?
19 A So, again, if we're referring to a primary care
20 physician, that patient should receive a consultation
21 or referral to a -- someone who specializes or is
22 qualified in treating addiction and diagnosing it.
23 Q With regards to Mr. Marcum's exam on April 28th,
24 2016 --
25 A Okay. I have that on Page 8.

1 Q In light of his positive for alcohol and negative for
2 Norco script from the 31st of March and those preceding
3 months, was the prescription for Norco on that date to
4 Dennis Marcum justified?
5 A Not without a discussion, no.
6 Q Again, if -- a patient such as Dennis Marcum or
7 Cassie Tappen who are preexisting patients who have
8 been on Norco from their previous physicians, if they
9 start testing abnormally like we see here, what is the
10 physician's responsibility there?
11 A You need to have a discussion with the patient and, if
12 necessary, a referral.
13 Q Are you justified in simply continuing the Norco
14 scripts without having that discussion?
15 A No, because you may not have the correct diagnosis.
16 Q Again, if a prescription is unjustified, is it -- can
17 that be an indication of bad faith?
18 A My understanding is yes.
19 Q Finally, Juanita Huizar. Again, we have two
20 prescriptions given October 20th and November 3rd. Is
21 there -- let me give you her chart as well as
22 Defendant's Number 10. I'll take back Mr. Marcum.
23 Thank you. In looking at those medical records, do you
24 see any preexisting toxicology screen, urine drug
25 screen for her that predates those two prescriptions?

1 THE COURT: This is Plaintiff -- or
2 People's 8 and Defendant's 10?
3 MR. WANINK: People's 8 and Defendant's 10.
4 Thank you, Your Honor.
5 THE COURT: All right. Thank you.
6 THE WITNESS: I don't see any, no.
7 BY MR. WANINK:
8 Q In fact, the only toxicology result you testified with
9 Mr. Chapman was received on November 10th, correct?
10 A Yes.
11 Q Is it a good idea to prescribe Norco prescriptions,
12 opioid prescriptions to a patient a month's worth in a
13 matter of two weeks without knowing what's in their
14 system?
15 A No. The evaluation should be done before the
16 prescription is written.
17 Q And, again, you see no preexisting medical records in
18 that patient chart including Defendant's Number 10, do
19 you?
20 A No, sir.
21 Q You have an MRI result from an incident that occurred
22 on October 30th or 31st, is that accurate?
23 A Yes. Appears to be done on October 31st.
24 Q So in light of those records that are received by
25 Dr. Oesterling on October 31st regarding bulged discs,

1 does that make the prescription provided on
2 November 3rd justified?
3 A Without the -- I'm sorry. Without the -- okay. Could
4 you repeat that?
5 Q Sure. In light of the MRI results showing bulging
6 discs, is the script provided to Miss Huizar on
7 November 3rd, 2016, justified?
8 A Since there was no -- as I understand it,
9 Dr. Oesterling did not have a urine drug screen result.
10 I would say no.
11 Q And, in fact, we saw this morning that the actual
12 prescription is written for more than what's in the
13 chart. Is that again an area of concern?
14 A Yes.
15 Q Why is that?
16 A It was either a medical error or done on purpose. I
17 don't know which.
18 Q If a physician is asked by the patient can I have more
19 as they're going out the door and they change the
20 prescription, is there anything wrong with that?
21 A A physician would need to be concerned about why the
22 patient was asking for more and what the true
23 underlying reason for that was, and without a urine
24 drug screen on hand, I would be very concerned.
25 Q Do you see any discussion noted in the chart with

1 Miss Huizar on November 3rd to that effect?
2 A Let me double check. The history given on Page 1 says
3 that she's prescribed Ultram and Norco four times a
4 day, and then the prescription written is Norco twice a
5 day and then it was apparently changed to Norco four
6 times a day. I don't know what the final reason was.
7 There's no documentation of any discussion that I see.
8 Q And, again, would it be important to chart the right
9 amount you prescribe, the amount that is actually
10 prescribed?
11 A Yes.
12 Q And you still believe in light of all of the evidence
13 Mr. Chapman showed you that the script for Norco on
14 November 3rd, 2016, for Miss Huizar is unjustified?
15 A Without a drug screen, I would say yes.
16 Q Thank you, Dr. Christensen. I don't have anything
17 further.
18 THE COURT: Recross, Mr. Chapman.
19 MR. CHAPMAN: Thank you, Your Honor.
20 R E C R O S S - E X A M I N A T I O N
21 BY MR. CHAPMAN:
22 Q Let's go back to Dennis Marcum, Dr. Christensen. It
23 sounds like your concern with the April prescription --
24 April 2016 prescription issued to Mr. Marcum was that
25 there was no discussion of the negative urine drug

1 screen.
2 A I believe so, but I'm going to make the same request
3 that I've been making all morning to see the document.
4 Q I don't have a problem with you seeing the document.
5 A Okay.
6 Q I thought you still had it up there.
7 A No, sir. And which date are we --
8 Q April 2016. You were just asked on redirect
9 examination whether or not there should have been some
10 discussion with Dennis Marcum about the -- what you
11 called negative results.
12 A So he was seen on April 27th on the top of the chart,
13 and the --
14 Q And the prior drug test showed?
15 A Prior drug test would be March 31st?
16 Q I believe so.
17 A And there is no hydrocodone or hydrocodone metabolites
18 that I see.
19 Q So there's no norhydrocodone?
20 A Not on March 31st, no.
21 Q Okay. So your issue with that prescription, your
22 concern as you put it, is that you don't know whether a
23 discussion occurred with the patient?
24 A A discussion should have occurred with the patient,
25 yes.

1 Q Okay. And your concern is that there's no evidence
2 that you have in the chart of a discussion?
3 A Yes.
4 Q But obviously you weren't in the patient room when
5 Dennis Marcum was being treated, correct?
6 A My understanding of the guidelines in Michigan is that
7 they also discuss the prescriptions being valid based
8 on documentation. I don't see any documentation here
9 of that discussion.
10 Q So your issue is one of documentation, not whether or
11 not the prescription was medically justified?
12 A No. Both.
13 Q Okay. Going back to Juanita Huizar, you were first
14 asked by the prosecution whether or not there was any
15 documentation of the change in her dosage, and I
16 believe you just testified after looking at the chart
17 that there was documentation that her dosage was to be
18 changed or was changed, is that correct?
19 A No, sir, I don't believe I said that.
20 Q You don't believe you said that? Okay. You don't
21 believe you said there was documentation that her
22 dosage was changed?
23 A Correct.
24 Q All right. Let's take a look at the chart.
25 MR. CHAPMAN: I'm handing the witness what's

1 been marked as Defense Exhibit 10.
2 BY MR. CHAPMAN:
3 Q Just take a look at the November 3rd, 2016,
4 prescription. And I may be mistaken, but please take a
5 look at that and tell us if there's documentation of
6 the dosage change for Juanita Huizar.
7 A It appears there's doc- -- so the -- underneath what
8 says new patient, it says she's prescribed Norco 7.5
9 four times a day, and then -- that's on Page 1. And
10 then on Page 4 it states Norco 7.5 twice a day, and
11 there's no discussion as to the reason for the change.
12 Q Okay.
13 A And the written prescription was four times a day.
14 Q All right. The prosecution asked you whether or not
15 it's appropriate to give additional medication to
16 somebody who simply walks up and says I want more, and
17 you said that that would cause a concern.
18 A If I had written the prescription for a medication
19 twice a day and the pa- -- if the patient had said, no,
20 I want it more, yes, I would be concerned.
21 Q Do you have any indication that Juanita Huizar did such
22 a thing?
23 A No.
24 Q Do you have any indication that that happened in the
25 patient room at all?

1 A Just the prescription was changed.
2 Q Okay. In fact, you don't know why Juanita Huizar came
3 back to Dr. Oesterling on November 3rd, 2016, do you?
4 A There is no documentation of why she was there, no.
5 Q Were you aware that she had injured herself while
6 working at the sugar beet factory just prior?
7 A Her CAT scan's consistent with an injury. I didn't
8 know what reason she stated it was caused by.
9 Q Were you aware that she contacted Dr. Oesterling and
10 then went to the emergency room immediately after?
11 A I didn't know that she contacted Dr. Oesterling.
12 Q Were you aware that she -- obviously you are aware that
13 she received x-rays as a result of that injury.
14 A Yes.
15 Q And then she came back to Dr. Oesterling and he
16 reviewed the x-rays?
17 A There's -- I don't see any of that in here. I'm sorry.
18 Q You did see the x-rays in the medical file?
19 A The x-rays, yes.
20 Q Okay. And you are aware that Juanita Huizar, you're
21 now aware, was discharged immediately after her urine
22 drug screen came back?
23 A Yes.
24 Q Okay. And -- and so one of the concerns of the initial
25 visit with Juanita Huizar was you think that you

1 shouldn't prescribe until you get the urine toxicology
2 screens back?
3 A In order to make the correct diagnosis, yes.
4 Q Okay. So there's one way that we can get immediate
5 results from a tox- -- from -- from a urine drug
6 screen, right? There's a type of screen that we can
7 use to get immediate results in the office?
8 A It's nowhere near as reliable in my opinion.
9 Q I'll get there.
10 A Yes.
11 Q But there's a type of screen that we can -- we can use
12 to get you immediate results, right?
13 A It's called point-of-care testing, yes.
14 Q Okay. And point-of-care testing as you've pointed out
15 already is inherently unreliable, right?
16 A It's got multiple flaws, yes.
17 Q In fact, the common belief in your profession is that
18 you shouldn't make medical decisions based on
19 point-of-care testing.
20 A Not unless you're looking for something specific, no.
21 Q Okay. So we can get immediate results in the office
22 when a patient comes in, but those results -- the only
23 way to get those results is a very unreliable method?
24 A Yes.
25 Q That means we have to send toxicology -- or urine drug

1 screens out to somebody else to analyze, right?
2 A Yes.
3 Q And they have to go through the sort of testing with
4 the machines that the labs use to determine whether or
5 not there's a drug in there or illicit substances?
6 A Confirmation, yes.
7 Q And that takes a couple of days?
8 A Yes.
9 Q So what you're saying is according to your opinion,
10 anytime a patient comes to a doctor, that doctor is not
11 allowed to prescribe on that visit until they get the
12 confirmation back from the lab a couple of days later?
13 Is that your testimony?
14 A If there's never been a drug screen before or if the
15 patient's -- I'm sorry, sir. I can't answer that.
16 Q I want to find out what your testimony is. Is it your
17 testimony that you can never provide a controlled
18 substance to a patient unless on that visit we have
19 confirmed toxicology, recent toxicology?
20 A No, that was never my testimony.
21 Q Okay. So it is in some circumstances appropriate to
22 prescribe to a patient in absence of recent toxicology
23 testing?
24 A There should be some toxicology testing.
25 Q Okay. So for a first-time patient, regardless of what

1 they present to you, you're going to make them wait --
2 you think that the guidelines require you to make them
3 wait a few days until you get the results of your
4 testing?
5 A Yes.
6 Q You think that Dr. Oesterling has to make
7 Juanita Huizar wait with her slipped disc for ten days
8 while he gets his testing back?
9 A Yes.
10 Q Okay. Don't the guidelines say that you should assess
11 and treat pain promptly?
12 A Promptly, yes.
13 Q Is ten days prompt for you, Dr. Christensen?
14 A Well, most drug testing companies do not require ten
15 days.
16 Q Well, this one did.
17 A I know.
18 Q It's --
19 A Yes.
20 Q -- Trident Lab. This is a big lab, right? This isn't
21 a small-time operation?
22 A Yes, sir.
23 Q So you think Juanita Huizar needs to wait on Trident
24 Labs ten days before she gets relief of her pain?
25 A If somebody's in severe enough pain from a chronic

1 condition and this is a first time you're seeing them,
2 I'm very concerned about their complaint that --
3 Q Dr. --
4 A -- their pain is severe enough that they should be
5 referred to the emergency department.
6 Q But, Dr. Christensen, she went to the emergency room,
7 didn't she? She went on October 31st?
8 A Yes.
9 Q And they saw her?
10 A Yes.
11 Q And they discharged her to see Dr. Oesterling?
12 A Yes.
13 Q And you take issue with his November 3rd prescription
14 because he didn't get the toxicology screen back?
15 A And obviously when you look at the toxicology screen,
16 it was the right -- it would have been the right
17 decision. This drug screen has alcohol, Adderall,
18 Klonopin and cocaine in it.
19 Q Sure, but she still had a slipped disc, didn't she?
20 A Yes.
21 Q And she still had obvious pain, didn't she?
22 A Yes.
23 Q And so you're saying she needs to go untreated for
24 those conditions because she happened to be a cocaine
25 user and slipped a disc?

1 A There's no definite reason why you have to prescribe
2 opiates to control a slipped disc.
3 Q Let me ask you this. Somebody goes to the ER with a
4 severe back injury and a toxicology screen shows the
5 presence of cocaine. Should they automatically be
6 denied immediate pain relief?
7 A It depends on the rest of the evaluation.
8 Q So there's some cases where it could be appropriate?
9 A Depends on the evaluation.
10 Q Okay. You testified to something, and I just want to
11 clarify. You said many patients remain on opiates long
12 term, correct?
13 A Yes.
14 Q Just because somebody is on a pain medication long
15 term, that doesn't tell you anything about the
16 appropriateness of treatment?
17 A No.
18 Q There -- there are many reasons why you can keep
19 somebody on opiates for years, right?
20 A If you evaluate them and their function is improved by
21 the opiates and their pain is decreased by the opiates
22 and the adverse effects are not too severe and there is
23 no evidence of aberrant behavior or addiction that
24 concerns you.
25 Q And -- and if you have somebody on a steady dose and it

1 relieves their pain and all of these concerns are
2 alleviated, it's okay to keep them on the exact same
3 medication for a long time?
4 A Yes, sir.
5 Q You have patients like that that have been on a steady
6 dose of the same medication for years, right?
7 A Yes, sir.
8 Q You also mentioned that chronic pain patients may have
9 normal radiology, is that right?
10 A Yes.
11 Q That means that some patients even suffering chronic
12 pain will show absolutely no symptoms of it even if you
13 do a radiol- -- radiology testing?
14 A Yes, sir.
15 Q I believe you testified that for Jay Mineau
16 Dr. Oesterling needed to have a diagnosis prior to
17 prescribing.
18 A There should be a legitimate diagnosis prior to
19 prescribing a controlled substance, yes.
20 Q Now, it's not always possible to achieve a diagnosis in
21 the first visit, right?
22 A Could you be more specific?
23 Q It's not always possible to achieve a diagnosis for a
24 patient in the first visit.
25 A If you --

1 Q There are some things that can't be diagnosed in the
2 first patient visit by a physician.
3 A Yes, that's true.
4 Q Fibromyalgia is one of them?
5 A Yes.
6 Q Very difficult to determine and diagnose?
7 A Yes.
8 Q Lupus is another one --
9 A Yes.
10 Q -- right? Those need additional testing --
11 A Yes.
12 Q -- right? Okay. And -- and so these guidelines don't
13 require a physician to have determined a diagnosis and
14 put it into a medical record in order to prescribe
15 medication and relieve someone's pain?
16 A They require a diagnosis that's legitimate, yes, they
17 do.
18 Q Okay. So somebody with fibromyalgia, they come and
19 complain of pain. They're not allowed to have
20 medication to relieve that pain until fibromyalgia has
21 been confirmed?
22 A Yes.
23 Q Okay. They must stay in pain until that's been
24 confirmed?
25 A Well, number one, if you're talking about fibromyalgia,

1 opioids should not be used for fibromyalgia.
2 Q I didn't ask that question, sir. I asked whether or
3 not they should be entitled to something to relieve
4 their pain before you determine a diagnosis of
5 fibromyalgia.
6 A There are many nonnarcotic medications that are used
7 for fibromyalgia.
8 Q Okay. What about a slipped disc? You said that it's
9 very difficult to properly diagnose a disc injury
10 without radiology.
11 A So if someone comes to you at their [sic] office and
12 they appear to have an acutely slipped disc, they
13 should be referred to the emergency department who can
14 do a CT scan on the spot and see if the medications are
15 appropriate.
16 Q Similar to Juanit- -- Juanita Huizar, right?
17 A And in her case I still have the opinion that the
18 medication should not be prescribed for weeks as it was
19 until you have a drug screen back.
20 Q What about in Jay Mineau's case where you have
21 indications of an injury that could be chronic -- well,
22 let me go back. Jay Mineau had complained of having
23 this pain for about five years, correct?
24 A Yes, and not -- and having not received opiates for the
25 past five years.

1 Q Do acute -- he said that he -- he had been taking
2 Motrin to try to grind it out for the past five years,
3 is that right?
4 A Yes.
5 Q Okay. Do you believe that somebody who's had prior
6 back injuries five years ago and is now in pain, that
7 that would be an acute injury that you could -- you
8 could find immediately in the first office visit?
9 A So if someone has a chronic injury, it's now acute?
10 I'm sorry.
11 Q Well, I'm -- I'm asking you.
12 A Could you repeat the question?
13 Q Jay Mineau's complained of pain for five years, right?
14 A Yes.
15 Q Because of a prior back injury?
16 A Yes.
17 Q That prior back injury according to him has caused
18 chronic pain, correct?
19 A Yes.
20 Q Chronic pain is something that is lasting for a long
21 period of time, right?
22 A Months or more, yes.
23 Q All right. When you evaluate Jay Mineau in the office,
24 it is very difficult to determine the initial cause of
25 his pain because it's chronic pain now, correct?

1 A Yes.
2 Q All right. You would have to do additional
3 radiological testing?
4 A And drug screening and --
5 Q And drug screening.
6 A -- obtain those records, yes.
7 Q And it's your position that Dr. Oesterling needs to
8 say, hey, Jay, you don't get any pain relief this visit
9 until I get your testing back? Is that your testimony?
10 A Yes, sir.
11 Q Okay. Despite the fact that the guidelines say you
12 need to promptly assess and treat pain?
13 A That is my definition of prompt. You can send the
14 testing off immediately. You can schedule a return
15 visit in a week.
16 Q Do you know how long it takes to get prior
17 authorization for the insurance company that patients
18 of Dr. Oesterling's use?
19 A It appears in this patient's case it was done quite
20 quickly.
21 Q Well, Jay Mineau was a cash patient, was he not?
22 A Allegedly, yeah.
23 Q Are you aware that Jay Mineau told Dr. Oesterling that
24 it was going to be very difficult to afford the
25 radiology testing, the CT scan, because --

1 A Yes.
2 Q -- he was jobless and living with his mom?
3 A And requesting narcotics, yes.
4 Q Five hundred bucks a month is a lot of money for
5 somebody who's jobless and living with their mom,
6 right?
7 A Yes.
8 Q That's a rent payment, right?
9 A And narcotics would pay for it.
10 Q Oh. You think that -- you think that those are
11 indications that he would be selling his drugs?
12 A Yes, sir, I do. Someone who has a five-year history of
13 chronic pain treated by a physician in another state
14 who is currently in prison shows up in your office
15 requesting narcotics after not having a prescription
16 for years and who is jobless and has financial
17 stressors, yes, sir, those are risk factors.
18 Q Wouldn't you agree that that sounds more like the
19 cynical approach of somebody who's been treating
20 addiction medicine patients as opposed to the
21 compassionate approach of a physician who sees family
22 practice patients?
23 A I believe it's a safety first approach, sir.
24 Q Okay. So your first -- your first instinct or you
25 believe the first instinct of a physician should be not

1 to believe their patient but to try to disprove
2 theories of diversion? Is that your testimony?
3 A First responsibility is a patient -- to a patient is
4 first do no harm.
5 Q I'm not talking about that. I'm talking about --
6 A I am talking about that.
7 Q -- whether or not your first duty is to disbelieve your
8 patient and try to disprove theories of diversion.
9 A No.
10 Q That's not your duty?
11 A Your first duty is to make a diagnosis and do the
12 safest thing for the patient.
13 Q Wouldn't -- wouldn't leaving a patient in chronic pain
14 be doing harm to the patient?
15 A Number one, your treatment that you're proposing is
16 probably more harmful than the chronic pain.
17 Q A low dose of an opiate medication you believe is more
18 harmful than the chronic pain?
19 A Yes.
20 Q Okay. Doctor, you testified that you learned about
21 good faith because you saw the definition of bad faith
22 in a Michigan criminal law?
23 A I believe so, yes.
24 Q What Michigan criminal law?
25 A I don't remember the number.

1 Q Do you know whether or not it had anything to do with
2 physicians?
3 A I don't know.
4 Q Okay. So right now as you're sitting on the stand you
5 can't tell us whether or not there's a statute that
6 applies to physicians that discusses good faith?
7 A A Michigan statute, no. I know the Controlled
8 Substance [sic] Act.
9 Q Okay. You were asked about whether or not a physician
10 needs a specialty certif- -- certification to prescribe
11 for chronic pain. That was early on in redirect. Do
12 you recall that?
13 A I didn't hear the word certification used.
14 Q Okay. But you were asked whether there was some --
15 something that physicians need to do prior to
16 prescribing for chronic pain by Mr. Wanink?
17 A They need to follow the guidelines, state and federal
18 guidelines.
19 Q Yeah. I'm just asking if you recall being asked --
20 A Yes.
21 Q -- that question. Okay. And your response was that
22 they need to follow the state and federal guidelines,
23 right?
24 A Yes.
25 Q Okay. So just to -- to -- to close that -- that door

1 there, any physician can prescribe to a patient for
2 chronic pain, right?
3 A Anyone with a DEA, yes.
4 Q All right. Regardless of specialty?
5 A Yes.
6 Q These guidelines do not put a limit on specialty? They
7 don't say that urologists can't treat people for
8 chronic pain?
9 A No, they don't.
10 Q They don't say that family practice people can't?
11 A No, they don't.
12 Q All right. So as long as you follow the Michigan
13 guidelines, it's appropriate for a physician to
14 prescribe for chronic pain?
15 A Yes.
16 Q Okay. Are you aware of any studies that discuss the
17 heaviest prescribers of controlled substances
18 historically in the United States?
19 A Overall, the greatest numbers of opioid prescriptions I
20 believe come from primary care providers. The overall
21 numbers, yes.
22 Q By primary care, you mean the type of field that
23 Dr. Oesterling was practicing in outside of his urology
24 practice?
25 A I don't know what the practice -- what his practice

1 was.

2 Q Okay. You only know about the ten patients that you

3 reviewed and the five that you've testified about?

4 A And that it's the Midwest Prostate Institute [sic] or

5 something.

6 Q Okay. You're not familiar with the name Caro Medical

7 Group?

8 A I've heard the name.

9 MR. CHAPMAN: Your Honor, I don't have any

10 further questions.

11 THE COURT: All right. Anything further,

12 Mr. Wanink?

13 MR. WANINK: No, Your Honor. Thank you.

14 THE COURT: All right. May this witness be

15 excused?

16 MR. WANINK: Yes, Your Honor.

17 THE COURT: All right. Thank you, sir, for

18 your testimony here today. You're excused from further

19 attendance in this matter. Watch your step.

20 THE WITNESS: Yup.

21 (Witness excused at 2:36 p.m.)

22 (Following reported, not ordered

23 transcribed.)

24 (Excerpt concluded.)

25

1 STATE OF MICHIGAN)
2) SS
3 COUNTY OF TUSCOLA)
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8 I certify that this transcript is a complete, true
9 and correct transcript excerpt of the proceedings and
10 testimony taken in this case before the Honorable Amy Grace
11 Gierhart, Circuit Judge, in Caro, Michigan.
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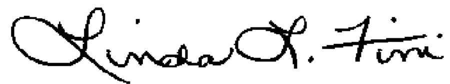
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