2019 PENNSYLVANIA STATEWIDE HIGH SCHOOL MOCK TRIAL COMPETITION

Commonwealth of Pennsylvania

v.

Rae Shafer, M.D.

SPONSORED BY THE YOUNG LAWYERS DIVISION OF THE PENNSYLVANIA BAR ASSOCIATION

By: Jon Grode, Paul W. Kaufman, Jonathan D. Koltash & Talia Charme-Zane

Version: 11.5.2018

TABLE OF CONTENTS

Problem Questions & Contact Information

Questions concerning these case materials should be sent to David Keller Trevaskis at the Pennsylvania Bar Association (PBA). Case material questions will be answered by the Mock Trial Executive Committee. Questions regarding mock trial procedure, including any questions involving the Rules of Competition or Rules of Evidence, should be directed to your District or Regional Mock Trial Coordinators.

Answers to legitimate and non-repetitive questions will be posted periodically in a supplemental memo on the mock trial website www.pabar.org under the Young Lawyers Division (YLD) link.

You may begin submitting questions anytime. **The deadline for submitting questions is noon on January 7, 2019**. The final update will be posted no later than **January 11, 2019**.

Questions must be sent in writing using email. Please be sure to include return contact information in the event we need to reach you to clarify a question. **No questions will be considered unless submitted under this procedure**.

E-mail: david.trevaskis@pabar.org

Introduction and Acknowledgments

Welcome to the 2019 Pennsylvania Statewide High School Mock Trial Competition - the 35th year of one of the top secondary level academic competitions in the Commonwealth! The competition, which commenced in 1984, is sponsored by the Young Lawyers Division of the Pennsylvania Bar Association (PBA/YLD). It provides high school students with firsthand experience of the American judicial system. The Mock Trial Competition is one of a series of law-related and civic education programs conducted by the PBA to demystify the law for Pennsylvanians, including Freedom's Answer, I Signed the Constitution, Project PEACE, Law Day, and Stepping Out for Seniors.

This year's case, *Commonwealth of Pennsylvania v. Rae Shafer*, is a criminal case to determine whether the defendant is guilty of illegal prescribing that lead to death.

The case was written by Jonathan A. Grode, Paul W. Kaufman, Jonathan Koltash, and Talia Charme-Zane. This is the fourth year running that the quartet has authored the Commonwealth's case material. Mr. Grode and Mr. Kaufman have co-written the Pennsylvania problems since 2011, and they co-wrote the national problems in 2010, 2012, 2014 and 2015. Mr. Grode also adapted and modified the 2007 mock trial problem and wrote the 2008, 2009, and 2010 mock trial problems. Mr. Kaufman was a four-time Delaware state champion mock trialer in high school and is Vice-Chair of the National High School Mock Trial Championship Board of Directors. Mr. Koltash co-authored the 2014 Pennsylvania case and is the PBA/YLD Mock Trial Co-Chair. Ms. Charme-Zane is a Senior Legal Assistant at Sanford Heisler Sharp LLP and an alumna of the Pennsylvania mock trial program, where she captained the Central High School (Philadelphia) team that won the John S. Bradway Philadelphia High School Mock Trial Competition.

Mr. Grode thanks his wife, Jayne Bird, who tolerates his ongoing obsession with mock trial drafting. Mr. Grode also thanks Roberta West for introducing him to the wondrous world of Pennsylvania Mock Trial. In addition, Mr. Grode recognizes the entire case writing team for dedication beyond words and a humor that entertains his most outlandish plots.

Mr. Kaufman thanks his wife, Sarah for everything that they do to make his life a joy. Mr. Kaufman also especially thanks senior counsel Grode and Koltash, and he continues to be grateful beyond words for Ms. Charme-Zane, for whom he hopes someday soon to fill out Character and Fitness paperwork. He dedicates this case to Francis Oldham Kelsey.

Mr. Koltash thanks his wife, Alaina, for her patience and support each year during "mock trial season" - which never seems to end. He also thanks Mr. Grode and Mr. Kaufman, whose leadership in writing the problem each year is greatly appreciated. Their countless hours and dedication to ensuring a balanced, creative problem for the participants of the competition makes them the unsung heroes of the competition. For that, he is in their debt.

Ms. Charme-Zane is incredibly grateful to the members of the case writing team, who constantly inspire her with their creativity, dedication, and legal savvy. She also thanks the attorneys at

Sanford Heisler Sharp, LLP for their leadership in holding real-life opioid manufacturers and distributors accountable through advocacy and litigation.

The case authors would like to thank Richard McKee, Esquire and Assistant United States Attorney Anthony Scicchitano for their contributions to the case. It's good to have experts in your corner when you need them. It's even better when they are friends.

Thanks also goes to the other co-Chair of this year's Competition, Jennifer Menichini, Esq., for her efforts in organizing and implementing the many facets of this competition. The Mock Trial Committee would also like to express its appreciation to Alaina Koltash, current PBA/YLD Chair, for her support of the competition. And the case co-author.

Additionally, we thank David Trevaskis, PBA Pro Bono Coordinator and recent winner of the Isidore Starr Award for Excellence in Law-Related Education from the American Bar Association, for his continued involvement and experienced guidance in implementing the 2017 Mock Trial Competition, and we thank the incomparable Jane Meyer, whose tireless work over the years has ensured that the many errors that reach her desk do not leave it.

Finally, we thank the hundreds of volunteers who annually contribute their time and energy to the overall organization and running of the program. Last, but certainly not least, we thank the PBA staff, headed by Executive Director Barry Simpson and Deputy Executive Director Fran O'Rourke, and the many PBA staff members who provide valuable time and talent throughout the mock trial season. Without their assistance, this competition would not be the tremendous success that it is each year.

Special thanks go to Maria Engles, the PBA/YLD Coordinator, whose contributions to the program are so numerous as to defy description.

We hope you find these materials interesting, and we wish you all the best of luck!

Case Summary

Pain. It can be unrelenting. It can destroy lives. And yet it leaves no mark and admits to no objective measure of its existence. One person calls pain an 8, another calls it a 4. Who is suffering more? Who needs greater relief, for longer?

At the frontiers of medicine, doctors and pharmaceutical companies once thought they had an answer. Derived from the same chemistry that gave morphine its life-changing power on battlefields from Antietam to Normandy, opioid painkillers came onto the scene in the early 1990s, and the dream of neurologists and pain management specialists seemed near fruition.

That dream has become our nightmare. The best estimates suggest that opioid painkillers were responsible for over 60,000 deaths last year. That is more than traffic deaths, more than firearms deaths, and more than cocaine and heroin put together. For the past two decades, pills have not had the same reputation as other street drugs, and the wide availability and legitimate uses for painkillers caused their abuse to spread as few other illegal substances have. And the opioid epidemic is as wide-ranging as it is devastating. Rural areas are hit just as hard as inner cities as communities come under siege.

This year's case takes place at the bleeding edge of the opioid crisis in America. Hadley McAdoo, a beloved member of the Wisawe, Pennsylvania community died at her house just hours after visiting the offices of Dr. Rae Shafer, a local pain management specialist. The cause of that death is the empty syringe of hydromorphone, a potent narcotic, mixed with the Xanax already in McAdoo's blood along with an untold volume of Oxycodone.

The question for trial arises: was Shafer's administration of hydromorphone and prescription for Oxycodone an act of mercy to a local hero in crippling pain? Or was it the criminal act of a doctor driven to desperation by financial and reputation ruin, far beyond the bounds of acceptable medicine in a world which had, at last, recognized the danger posed by prescription opioids?

The Commonwealth calls three witnesses to prove its case: Fran Kelsey, a nurse practitioner who observed Shafer's practice first-hand; JJ Teva, a local businessperson and friend of Hadley McAdoo, and Royal Copeland, a diversion investigator for the United States Drug Enforcement Administration.

Shafer responds in her/his own defense and calls an expert of her/his own, Ry Haight, and one of McAdoo's closest friends and confidants, Sal Abbott.

Is Rae Shafer an angel of mercy or a drug dealer? Should s/he spend the rest of her/his life in a white coat or a prison jumpsuit? Trial is joined.

HISTORICAL NOTE

The first witness in this case is named Fran Kelsey, after Frances Oldham Kelsey an M.D./Ph.D. who worked for the Food and Drug Administration in what is now the Center for Drug Evaluation and Research. From 1960 through 1962, Dr. Kelsey fought a running battle with the pharmaceutical company Richardson-Merrill over their attempts to import a drug marketed in Europe under the trade name Contergan into the United States. Dr. Kelsey was unconvinced that the drug data showed that the medication would not cross the placental barrier and harm infants in utero.

Between 1958 and 1962, Contergan – better known by its chemical name, Thalidomide – caused severe limb deformity in children in 46 countries. At least 10,000 individuals suffered from these defects, and some estimates place the number affected at nearly 100,000. The United States accounted for only 17 of these cases.

In 1962, President John F. Kennedy gave Dr. Kelsey the President's Award for Distinguished Civilian Service, the highest award that can be given to a career civil servant. She had been at the Food and Drug Administration for two years.

In response to the Thalidomide crisis, Congress amended the Food, Drug, and Cosmetic Act to require that all new medications in the United States be proved safe and effective before they could be sold. This amendment also required that drug advertising contain accurate information about drug effectiveness and side effects.

Dr. Kelsey retired from the FDA in 2005, at the age of 90, after 45 years of federal service. In 2010, the FDA presented its first Drug Safety Excellence Award, which it awarded to Dr. Kelsey. The award was then and is now named for her. Dr. Kelsey died in 2014 in Ontario, shortly after being presented with the Order of Canada, one of that nation's highest honors.

* * *

The final witness in this case is named for Ryan Haight, a high school senior who ordered Vicodin, a prescription painkiller, from the internet. His death from an overdose of these pills led Congress to strengthen the ban on internet prescribing.

* * *

Other witness names are also taken from various aspects of the history of pharmaceutical drugs in the United States. Students are encouraged to do research into the connections referenced in the case material as time permits.

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF**
	)	**THE 71st JUDICIAL DISTRICT,**
Complainant,	)	**PENNSYLVANIA**
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D.,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in**
	)	**Death (1 Count)**

CRIMINAL COMPLAINT AND PROBABLE CAUSE AFFIDAVIT

I, Detective Harvey Washington Wiley, Badge 62438, of the Laurel County Police Department, do hereby state:

1. **I accuse:**

   Rae Shafer, M.D., who resides at 1405 Eye St., Wisawe, Pennsylvania.

2. **The acts committed by the accused were:**

   * * **DRUG DELIVERY RESULTING IN DEATH** **COUNT 1**

   On or about December 16, 2016, the accused did intentionally administer a controlled substance, hydromorphone, and/or prescribe a controlled substance, Oxycodone, to another human, Hadley McAdoo, in a manner that was not in good faith or in a manner that was not in the usual course of the accused's practice or in a manner that was not medically supported or justifiable, causing the death of McAdoo.

3. **The accused committed these acts against the peace and dignity of the Commonwealth of Pennsylvania and contrary to the Acts of the General Assembly: . . .**

   18 Pa. C.S. § 2506(a).

4. **I ask that a warrant of arrest or a summons be issued and that the accused be required to answer the charges I have made.**

5. **I verify that the facts set forth in this Complaint are true and correct to the best of my knowledge, information, and belief subject to the penalties of 18 Pa. C.S. § 4904, relating to unsworn falsification to authorities.**

DATE: August 30, 2017 Harvey Washington Wiley

(Signature of Complainant)

AND NOW, on this date, **September 1, 2017**, I certify the Complaint has been properly completed and verify that there is probable cause for the issuance of process.

*Louisa Lasagna*_____

Judge
Issuing Authority

Clerk of Courts – Original

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF**
	)	**THE 71st JUDICIAL DISTRICT,**
Complainant,	)	**PENNSYLVANIA**
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D.,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in**
	)	**Death (1 Count)**

TRANSCRIPT OF PROCEEDINGS BEFORE ISSUING AUTHORITY

1. Defendant Rae Shafer, M.D., who resides at 1405 Eye St., Wisawe, Pennsylvania, was arrested on September 6, 2017 and charged by Complainant with one count of Drug Delivery Resulting in Death, 18 Pa. C.S. § 2506(a).

2. A preliminary arraignment for Defendant Rae Shafer, M.D. was held before the undersigned at 10903 New Hampshire Ave., Laurel, Pennsylvania, on September 6, 2017.

3. At the preliminary arraignment, Defendant Rae Shafer, M.D. was advised of her/his right to apply for assignment of counsel and was given a copy of the Criminal Complaint.

4. At the preliminary arraignment, the defendant was released on her/his own recognizance.

5. On September 15, 2017, a preliminary hearing was held before undersigned at 10903 New Hampshire Ave., Laurel, Pennsylvania. Defendant Rae Shafer, M.D. was present and was represented by counsel. The Commonwealth was represented by the assigned Assistant District Attorney. Detective Wiley was sworn and testified for the Commonwealth.

6. At the conclusion of the preliminary hearing on September 15, 2017, Defendant Rae Shafer, M.D. was held for court on the charges of Drug Delivery Resulting in Death.

AND NOW, on this date, September 24, 2017, I certify the transcript of proceedings before the issuing authority has been properly completed.

Louisa Lasagna
Judge
Issuing Authority

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF**
	)	**THE 71st JUDICIAL DISTRICT,**
Complainant,	)	**PENNSYLVANIA**
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in**
	)	**Death (1 Count)**

INFORMATION

The charge(s) having been held over for court by the Court following a Preliminary Hearing, the District Attorney of Laurel County by this information charges that, on/or about December 16, 2016, in said County, Rae Shafer, M.D.,

First Count:

the accused did intentionally prescribe or administer a controlled substance, hydromorphone, to another human, in a manner that was not in good faith or in a manner that was not in the usual course of the accused's practice or in a manner that was not medically supported or justifiable, causing the death of that individual.

Against the Act of Assembly and the Peace and Dignity of the Commonwealth of Pennsylvania.

Paul Clementi

Paul Clementi
Assistant District Attorney

Citation(s): DRUG DELIVERY RESULTING IN DEATH, 18 Pa. C.S. § 2506(a)

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF THE 71st JUDICIAL DISTRICT, PENNSYLVANIA**
Complainant,	)	
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in Death (1 Count)**
	)	

ARRAIGNMENT

I, Rae Shafer, M.D., having been advised by the District Attorney of Laurel County, Pennsylvania, that I am charged by Information with DRUG DELIVERY RESULTING IN DEATH, 18 Pa. C.S. § 2506(a). I have been advised of my right to have an attorney represent me at all hearings and the trial of these charges.

I have been advised and fully understand that I/my lawyer have/has the right to request discovery or disclosure from the District Attorney within fourteen (14) days of today's date.

I have been advised and I fully understand that I/my lawyer have/has the right to file with the Court any pre-trial application for relief in the form of a single omnibus pre-trial motion within thirty (30) days of today's arraignment date.

I hereby enter a plea of Not Guilty to the above charges and request a trial by Jury. Trial is scheduled for Winter 2019 Term of Court. I waive [waive/do not waive] my right to be indicted, rather than proceeding under this Information.

DATE: September 6. 2017

R Shafer, M.D.
Defendant

Roberta Patterson
Attorney for Defendant

Paul Clementi
Attorney for the Commonwealth

JURY INSTRUCTIONS

At the conclusion of a jury trial, the judge will instruct the jury how to apply the law to the evidence. Hypothetically, if the judge in your mock trial case were to provide instructions to the jury, they would look something like the following:

[**NOTE**: Teams cannot use a copy of these instructions as an exhibit during the mock trial competition; however, students may use these concepts in fashioning their case and making arguments to the jury.]

ROLE OF THE JURY

Members of the jury, all the evidence has been presented to you and you have heard the arguments of the lawyers. Now I will instruct you on the law.

You have two duties as a jury. Your first duty is to decide the facts from the evidence that you have heard and seen in court during this trial. That is your job and yours alone. I play no part in finding the facts. You should not take anything I may have said or done during the trial as indicating what I think of the evidence or what I think about what your verdict should be.

Your second duty is to apply the law that I give you to the facts. My role now is to explain to you the legal principles that must guide you in your decisions. You must apply my instructions carefully. Each of the instructions is important, and you must apply all of them. You must not substitute or follow your own notion or opinion about what the law is or ought to be. You must apply the law that I give to you, whether you agree with it or not.

Whatever your verdict, it will have to be unanimous. All of you will have to agree on it or there will be no verdict. In the jury room, you will discuss the case among yourselves, but ultimately each of you will have to make up his or her own mind. This is a responsibility that each of you has and that you cannot avoid.

Perform these duties fairly and impartially. Do not allow sympathy, prejudice, fear, or public opinion to influence you. You should also not be influenced by any person's race, color, religion, national ancestry, or gender.

JURY SOLE JUDGE OF FACTS; SYMPATHY OR PREJUDICE NOT TO INFLUENCE YOUR VERDICT

You are the sole judges of the facts in this case. It is your duty to determine the facts from the evidence produced here in court. Your verdict should not be based on speculation, guess, or conjecture. Neither sympathy nor prejudice should influence your verdict. You are to apply the law as stated in these instructions to the facts as you find them, and in this way decide the case.

Although the lawyers may have called your attention to certain facts or factual conclusions that they thought were important, what the lawyers said is not evidence and is not binding on you. It is

your own recollection and interpretation of the evidence that controls your decision in this case. Also, do not assume from anything I may have done or said during the trial that I have any opinion about any of the issues in this case or about what your verdict should be.

CREDIBILITY OF THE WITNESSES

As I stated in my preliminary instructions at the beginning of the trial, in deciding what the facts are you must decide what testimony you believe and what testimony you do not believe. You are the sole judges of the credibility of the witnesses. Credibility refers to whether a witness is worthy of belief: Was the witness truthful? Was the witness' testimony accurate? You may believe everything a witness says, or only part of it, or none of it.

You may decide whether to believe a witness based on his or her behavior and manner of testifying, the explanations the witness gave, and all the other evidence in the case, just as you would in any important matter where you are trying to decide if a person is truthful, straightforward, and accurate in his or her recollection. In deciding the question of credibility, remember to use your common sense, your good judgment, and your experience.

In deciding what to believe, you may consider several factors:

(1) The opportunity and ability of the witness to see or hear or know the things about which the witness testified;

(2) The quality of the witness' knowledge, understanding, and memory;

(3) The witness' appearance, behavior, and manner while testifying;

(4) Whether the witness has an interest in the outcome of the case or any motive, bias, or prejudice;

(5) Any relation the witness may have with a party in the case and any effect the verdict may have on the witness;

(6) Whether the witness said or wrote anything before trial that was different from the witness' testimony in court;

(7) Whether the witness' testimony was consistent or inconsistent with other evidence that you believe; and

(8) Any other factors that bear on whether the witness should be believed.

Inconsistencies or discrepancies in a witness' testimony or between the testimony of different witnesses may or may not cause you to disbelieve a witness' testimony. Two or more persons witnessing an event may simply see or hear it differently. Mistaken recollection, like failure to recall, is a common human experience. In weighing the effect of an inconsistency, you should also

consider whether it was about a matter of importance or an insignificant detail. You should also consider whether the inconsistency was innocent or intentional.

You are not required to accept testimony even if the testimony was not contradicted and the witness was not impeached. You may decide that the witness is not worthy of belief because of the witness' bearing and demeanor, or because of the inherent improbability of the testimony, or for other reasons that are enough to you.

After you make your own judgment about the believability of a witness, you can then attach to that witness' testimony the importance or weight that you think it deserves. The weight of the evidence to prove a fact does not necessarily depend on the number of witnesses who testified or the quantity of evidence that was presented. What is more important than numbers or quantity is how believable the witnesses were, and how much weight you think their testimony deserves.

PRESUMPTION OF INNOCENCE; REASONABLE DOUBT; BURDEN OF PROOF

The defendant, Rae Shafer, M.D. pleaded not guilty to the offense charged. The Defendant is presumed to be innocent. S/he started the trial with a clean slate, with no evidence against her/him. The presumption of innocence stays with Rae Shafer, unless and until the government has presented evidence that overcomes that presumption by convincing you that Rae Shafer is guilty of the offense charged beyond a reasonable doubt.

The presumption of innocence requires that you find Rae Shafer not guilty, unless you are satisfied that the government has proved guilt beyond a reasonable doubt. The presumption of innocence means that Rae Shafer has no burden or obligation to present any evidence at all or to prove that s/he is not guilty. The burden or obligation of proof is on the government to prove that Rae Shafer is guilty, and this burden stays with the government throughout the trial.

For you to find Rae Shafer guilty of the offense charged, the government must convince you that Rae Shafer is guilty beyond a reasonable doubt. That means that the government must prove each and every element of the offense charged beyond a reasonable doubt. A defendant may not be convicted based on suspicion or conjecture, but only on evidence proving guilt beyond a reasonable doubt.

Proof beyond a reasonable doubt does not mean proof beyond all possible doubt or to a mathematical certainty. Possible doubts or doubts based on conjecture, speculation, or hunch are not reasonable doubts. A reasonable doubt is a fair doubt based on reason, logic, common sense, or experience. It is a doubt that an ordinary reasonable person has after carefully weighing all the evidence and is a doubt of the sort that would cause him or her to hesitate to act in matters of importance in his or her own life. It may arise from the evidence, or from the lack of evidence, or from the nature of the evidence.

If, having now heard all the evidence, you are convinced that the government proved each and every element of the offense charged beyond a reasonable doubt, you should return a verdict of guilty for that offense. However, if you have a reasonable doubt about one or more of the elements of the offense charged, then you must return a verdict of not guilty of that offense.

STIPULATIONS OF FACT

Statements made by counsel are not evidence and are not binding on you. However, there are exceptions to this rule. One of these is when attorneys reach a "stipulation." When the district attorney and counsel for the defendant stipulate, that is, when they agree, that a certain fact is true, their stipulation is evidence of that fact. You should regard the stipulated or agreed fact as proven.

JURY MUST NOT CONSIDER THE PENALTY

You must not consider the consequences of your verdict. That is, do not trouble yourself with the consequences to Rae Shafer.

ROLE OF THE JURY – DELIBERATIONS, UNANIMOUS VERDICT, DUTY TO CONSULT

That concludes my instructions explaining the law regarding the testimony and other evidence, and the offenses charged. Now let me explain some things about your deliberations in the jury room, and your possible verdicts.

First, the first thing that you should do in the jury room is choose someone to be your foreperson. This person will speak for the jury here in court. He or she will also preside over your discussions. However, the views and vote of the foreperson are entitled to no greater weight than those of any other juror.

Second, I want to remind you that your verdict, whether it is guilty or not guilty, must be unanimous. To find Rae Shafer guilty of an offense, every one of you must agree that the government has overcome the presumption of innocence with evidence that proves each element of that offense beyond a reasonable doubt. To find Rae Shafer not guilty, every one of you must agree that the government has failed to convince you beyond a reasonable doubt.

Third, if you decide that the government has proved Rae Shafer guilty, then it will be my responsibility to decide what the appropriate punishment should be. You should never consider the possible punishment in reaching your verdict.

Fourth, as I have said before, your verdict must be based only on the evidence received in this case and the law I have given to you. You should not take anything I may have said or done during trial as indicating what I think of the evidence or what I think your verdict should be. What the verdict should be is the exclusive responsibility of the jury.

Fifth, now that all the evidence is in, the arguments are completed, and once I have finished these instructions, you are free to talk about the case in the jury room. In fact, it is your duty to talk with each other about the evidence, and to make every reasonable effort you can to a reach unanimous agreement. Talk with each other, listen carefully, and listen respectfully to each other's views and keep an open mind as you listen to what your fellow jurors have to say. Do not hesitate to change your mind if you are convinced that other jurors are right and that your original position was wrong. But do not ever change your mind just because other jurors see things differently or just to get the case over with. In the end, your vote must be exactly that-- your own vote. It is important for you to reach unanimous agreement, but only if you can do so honestly and in good conscience. Listen carefully to what the other jurors have to say and then decide for yourself if the government has proved the defendant guilty beyond a reasonable doubt.

No one will be allowed to hear your discussions in the jury room and no record will be made of what you say. You should all feel free to speak your minds.

Sixth, once you start deliberating, do not talk about the case to the court officials, or to me, or to anyone else except each other. If you have any questions or messages, your foreperson should write them down on a piece of paper, sign them, and then give them to the court official who will give them to me. I will first talk to the lawyers about what you have asked, and I will respond as soon as I can. In the meantime, if possible, continue with your deliberations on some other subject.

One more thing about messages. Do not ever write down or tell anyone how you or anyone else voted. That should stay secret until you have finished your deliberations. If you have occasion to communicate with the court while you are deliberating, do not disclose the number of jurors who have voted to convict or acquit on any offense.

NATURE OF THE CHARGE

Defendant has been charged with committing the crime of prescribing or administering a controlled substance in a manner that unlawfully caused the death of Hadley McAdoo. For Defendant Rae Shafer to be found guilty of committing this Crime, the Commonwealth must prove to you each of the following elements, on proof beyond a reasonable doubt. They are:

(1) that Defendant Rae Shafer intentionally administered or prescribed a controlled substance (hydromorphone and/or Oxycodone) to Hadley McAdoo within the scope of a practitioner/patient relationship; and

(2) that Hadley McAdoo died as a result of having been administered hydromorphone and/or or prescribed Oxycodone by Rae Shafer; and

(3) that when Defendant Rae Shafer injected Hadley McAdoo with hydromorphone:

(a) s/he was not acting in good faith; or

(b) s/he failed to act in accordance with treatment principles accepted by a responsible segment of the medical profession.

The Commonwealth and defendant have agreed that Dr. Shafer was treating Hadley McAdoo as a patient at the time that the prescription and administration occurred, that Rae Shafer intentionally administered hydromorphone and prescribed Oxycodone to Hadley McAdoo within the scope of their practitioner/patient relationship, and that Hadley McAdoo died as a result of the injection and/or prescription.

Therefore, in order for the Commonwealth to prove that Defendant is guilty of this crime, it must prove to you, beyond a reasonable doubt, one of the following: that when Defendant Rae Shafer injected Hadley McAdoo with hydromorphone and/or prescribed Oxycodone to Hadley McAdoo (a) s/he was not acting in good faith OR (b) s/he s/he failed to act in accordance with treatment principles accepted by a responsible segment of the medical profession.

"Good faith" means a state of mind consisting in honesty in belief or purpose, faithfulness to one's duty or obligation, or observance of reasonable standards within a profession.

A "responsible segment" of the medical profession does not mean that every doctor would have agreed with the decision made by Rae Shafer. To the contrary, there is a range of appropriate medical practice, and even very good, diligent doctors often disagree on what the best treatment is. However, a "responsible segment" also does not mean that only a fringe group of practitioners out of step with modern medicine would agree with the decision made by Rae Shafer. Just because there are a handful of individuals who reject the consensus of the studied, reasonable members of the medical profession does not mean that Rae Shafer's actions were justified. Rather, a "responsible segment" of the medical profession is one that takes seriously its obligations to protect and care for its patients and its legal obligation to provide safe and effective patient care. In order to find that Rae Shafer failed to act in accordance with the treatment principles accepted by a "responsible segment of the medical profession," you must find – beyond a reasonable doubt – that no responsible portion of the medical profession would have agreed with her decisions.

The Commonwealth does not have to establish with direct evidence that Rae Shafer so acted. Circumstantial evidence alone may be sufficient. Circumstantial evidence is evidence that relies on an inference to connect it to a conclusion of fact.

TWO DRUGS

You have heard evidence that Rae Shafer administered hydromorphone and prescribed Oxycontin to Hadley McAdoo on December 16, 2016. The parties have stipulated that these opioids together reacted with Xanax to cause McAdoo's death. Accordingly, if you find beyond a reasonable doubt that *either* of these actions was not in good faith or that *either* of these actions would not have been accepted by a responsible segment of the medical profession, you must find Rae Shafer guilty.

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF THE 71st JUDICIAL DISTRICT, PENNSYLVANIA**
Complainant,	)	
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in Death (1 Count)**
	)	

VERDICT FORM

To the jury:

To further clarify instructions given to you by the trial judge, you are being provided with the following verdict form. At the conclusion of your deliberations, one copy of this form should be signed by your foreperson and handed to the court clerk. This will constitute your verdict.

Question 1:

Do you find that the Commonwealth presented proof beyond a reasonable doubt that when Defendant Rae Shafer administered hydromorphone and/or prescribed Oxycodone to Hadley McAdoo, Rae Shafer failed to act in good faith?

Yes _____ No _____

Question 2:

Do you find that the Commonwealth presented proof beyond a reasonable doubt that when Defendant Rae Shafer administered hydromorphone and/or prescribed Oxycodone to Hadley McAdoo, Rae Shafer failed to act in accordance with treatment principles accepted by a responsible segment of the medical profession?

Yes _____No

You have finished your deliberations. Please sign at the bottom of this form. Please return to the courtroom.

_____
Jury Foreperson

_____
Date

Applicable Law

18 Pa. C.S. § 2506 – Drug delivery resulting in death.

(a) Offense defined – A person commits a felony of the first degree if the person intentionally administers, dispenses, delivers, gives, prescribes, sells or distributes any controlled substance or counterfeit controlled substance in violation of section 13(a)(14) or (30) of the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act, and another person dies as a result of using the substance.

(b) Penalty –

(1) A person convicted under subsection (a) shall be sentenced to a term of imprisonment which shall be fixed by the court at not more than 40 years.

(2) Paragraph (1) shall not apply to a person convicted under section 2502(c) (relating to murder) when the victim is less than 13 years of age and the conduct arises out of the same criminal act.

***

35 P.S. § 780-113
The Controlled Substances, Drugs, Device, and Cosmetic Act

Section 13. Prohibited Acts; Penalties –

(a) The following acts and the causing thereof within the Commonwealth are hereby prohibited: …

(14) The administration, dispensing, delivery, gift or prescription of any controlled substance by any practitioner or professional assistant under the practitioner's direction and supervision unless done (i) in good faith in the course of his professional practice; (ii) within the scope of the patient relationship; (iii) in accordance with treatment principles accepted by a responsible segment of the medical profession.

***

28 Pa. Code § 25.51

The term ‘‘prescription’’ or ‘‘prescription order’’ means an order for a controlled substance, other drug, or device for medication which is dispensed to or for an ultimate user but does not include an order for a controlled substance, other drug, or device for medication which is dispensed for immediate administration to the ultimate user. For example, an order to dispense a drug to a bed patient for immediate administration in a hospital is not a prescription order.

***

28 Pa. Code § 25.52

(a) A prescription for a controlled substance must be issued for a legitimate medical purpose by a licensed practitioner in the usual course of professional practice. The responsibility for proper prescribing of controlled substances is upon the practitioner but a corresponding responsibility rests with the pharmacist who dispenses the medication and interprets the directions of the prescriber to the patient.

***

49 Pa. Code § 16.92

(b) When prescribing, administering or dispensing drugs regulated under this section, a person licensed to practice medicine and surgery in this Commonwealth or otherwise licensed or regulated by the Board shall carry out, or cause to be carried out, the following minimum standards:

(1) Initial medical history and physical examination. An initial medical history shall be taken, and an initial physical examination shall be conducted unless emergency circumstances justify otherwise. Medical history and physical examination information recorded by another licensed health care provider may be considered if the medical history was taken and the physical examination was conducted within the immediately preceding 30 days. The physical examination shall include an objective evaluation of the heart, lungs, blood pressure and body functions that relate to the patient's specific complaint.

(2) Reevaluations. Reevaluations of the patient's condition and efficacy of the drug therapy shall be made consistent with the condition diagnosed, the drug or drugs involved, expected results and possible side effects.

(3) Patient counseling. The patient shall be counseled regarding the condition diagnosed and the drug prescribed, administered or dispensed. Unless the patient is in an inpatient care setting, the patient shall be specifically counseled about dosage levels, instructions for use, frequency and duration of use and possible side effects….

(8) Adherence to standards of practice. Compliance with this section will not be treated as compliance with the standards of acceptable and prevailing medical practice when medical circumstances require that the licensed health care provider exceed the requirements of this section.

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF THE 71st JUDICIAL DISTRICT, PENNSYLVANIA**
Complainant,	)	
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in Death (1 Count)**
	)	

MEMORANDUM AND OPINION

Before the Court is defendant's motion to dismiss this case. For the reasons that follow, defendant's motion will be denied.

At this stage, we must take all facts in the light most favorable to the Commonwealth. They are as follows. On December 16, 2016, the deceased, Hadley McAdoo, sought medical care from defendant Rae Shafer. On that date, Shafer was a medical doctor licensed by the Commonwealth of Pennsylvania and permitted to prescribe and administer prescription medication, including narcotic pain relievers. Shafer met with McAdoo and administered hydromorphone, one such narcotic. Before administering the hydromorphone, Shafer did not check Pennsylvania's Prescription Drug Monitoring Program (PDMP) database to confirm what, if any, other medications McAdoo had been recently prescribed. Also, without checking the PDMP, Shafer prescribed Oxycodone, a second narcotic pain reliever, to McAdoo. An autopsy not disputed by either party concludes that McAdoo's death resulted from respiratory failure caused by an antagonistic reaction between the opioid painkillers and alprazolam, a benzodiazepine more commonly known by its brand name, Xanax. McAdoo had been legally prescribed Xanax by Dr. Margaret Hamburg to treat mental health issues McAdoo had been experiencing. Dr. Hamburg's prescription was logged in the PDMP database prescribed, and then again at the time it was filled, November 27, 2016.

Defendant is charged with Drug Delivery Resulting in Death, 18 Pa. C.S. § 2506(a). The defendant objects that s/he is a victim of a *post hoc* campaign against opioid prescribing, which was an accepted practice at the time in question. S/He buttresses this argument by noting that although the PDMP database was created in the Achieving Better Care by Monitoring All Prescription (ABC-MAP) Act in June 2015, the law requiring that it be checked only became effective on January 1, 2017. Accordingly, defendant argues that this prosecution violates the *ex post facto* clause of the Pennsylvania Constitution, Article I, Section 17.

These arguments are meritless. Defendant is not charged with failing to check the PDMP database; *that* would be an *ex post facto* application of the amendments to ABC-MAP. Instead, defendant is charged with a violation of 18 Pa. C.S. § 2506(a), which long predated the date of McAdoo's death. In relevant part, that statute provides liability for any person "intentionally administers, [or] … prescribes any controlled substance… in violation of section 13(a)(14)" of The Controlled Substance, Drug, Device and Cosmetic Act.

Section 13(a)(14) in turn prohibits "[t]he administration… or prescription of any controlled substance by any practitioner… unless done (i) in good faith in the course of his professional practice; (ii) within the scope of the patient relationship; [and] (iii) in accordance with treatment principles accepted by a responsible segment of the medical profession."

At oral argument on this motion, the Commonwealth conceded that McAdoo was Shafer's patient, at least within the meaning of subsection (ii) of the statute.

Thus, the questions at issue are whether this administration of hydromorphone was in good faith and whether the treatment was in accordance with treatment principles accepted by a responsible segment of the medical profession. The test outlined in section 2506(a) is conjunctive; accordingly, it is criminal to administer a medication under any circumstance in which any one of these two tests are not met. The Commonwealth bears the burden of proof, but it need only prove that one of these two tests is not met in order to prevail.

Thus, section 2506(a) may be violated even by a physician who did check the PDMP, if the conduct was otherwise in bad faith or beyond the pale of reasonable practice. For example, a doctor may face liability if she prescribes medication in bad faith, whether or not the doctor checks the PDMP. Likewise, a physician may be liable even if she checks the PDMP before administering high doses of opioids for a skinned knee, even if she acts in good faith and in the course of a professional practice, because a prescription in these circumstances would be condemned by responsible members of her profession. (Today, liability would be established by the amended legal requirements. But that law was not yet binding on her/his practice.)

This is not to say that the question of whether defendant ought to have checked the PDMP database is irrelevant. But some predicate is required. If the Commonwealth can show that no reasonable segment of the profession would have acted as Shafer did under the circumstances without checking the PDMP database, that would place Shafer's actions in violation of section 13(a)(14) and, thus, section 2506(a). Similarly, if the Commonwealth could show that good faith required checking the PDMP database, that would place Shafer's actions in violation of section 13(a)(14) and, thus, section 2506(a).

Nor is the PDMP the only path to making the foregoing showings. If other aspects of Shafer's prescribing took it outside the course of a reasonable segment of the medical profession or put Shafer in bad faith, as defined by Pennsylvania law, then that too would place the defendant in jeopardy of a violation of section 2506.

In sum, that Shafer did not check the PDMP database is neither necessary nor sufficient to demonstrate criminal liability. The trier of fact must consider all the circumstances – which may include this failure, if foundation is laid for its relevance – in reaching its conclusion.

Defendant's motion is denied. Trial date and time will be set by the Court.

BY THE COURT:

Louisa Lasagna, J.

THE COMMONWEALTH OF PENNSYLVANIA,	)	**COURT OF COMMON PLEAS OF**
	)	**THE 71st JUDICIAL DISTRICT,**
Complainant,	)	**PENNSYLVANIA**
v.	)	
	)	**Docket No.: CP-71-CR-1129-2017**
RAE SHAFER, M.D,	)	
	)	**Charges:**
Defendant.	)	**Drug Delivery Resulting in**
	)	**Death (1 Count)**

STIPULATIONS

1. All documents, signatures, and exhibits, including pre-markings, included in the case materials are authentic and accurate in all respects; no objections to the authenticity of the documents will be entertained. The parties reserve the right to dispute any legal or factual conclusions based on these items and to make objections other than to authenticity.

2. Jurisdiction, venue, and chain of custody of evidence are proper and may not be challenged.

3. All statements were notarized at the time they were initially made, and all statements were reviewed by their authors shortly before trial. No changes were made.

4. All evidence was constitutionally recovered, and all statements were constitutionally obtained. No objection will be entertained to the constitutionality of any evidence, nor will any motions to suppress on constitutional grounds be permitted.

5. From the date of her birth through December 16, 2016, Hadley McAdoo was a living person.

6. Hadley McAdoo died on December 16, 2016 of respiratory arrest.

7. Consistent with the findings of the Medical Examiner of Laurel County following an autopsy, Hadley McAdoo's death was caused by respiratory arrest.

8. Consistent with the findings of the Medical Examiner of Laurel County following an autopsy, Hadley McAdoo's respiratory arrest was caused by an adverse interaction between the opioids administered and prescribed by Rae Shafer, M.D. and alprazolam prescribed by Margaret Hamburg, M.D. on November 27, 2016 under its trade name, Xanax.

9. Hadley McAdoo was properly prescribed Xanax for mental health issues by Dr. Hamburg in the regular course of Dr. Hamburg's practice.

10. Pennsylvania's Prescription Drug Monitoring Program (PDMP) database functioned properly throughout the day on December 16, 2016.

11. The instant criminal trial is separate from the issue of sentencing, and the jury will be called upon only to determine guilt or innocence of the crime charged.

12. Rae Shafer, M.D. has waived her/his right not to testify in a criminal proceeding against her/him, and either side may comment on the fact of that testimony in opening statements or during the prosecution's case in chief, if such comment would otherwise be proper.

13. The grounds on which evidence may be admitted are defined by the Rules of Evidence. No objection will be entertained under any constitutional provision, including the Confrontation Clause of the U.S. Constitution or Article I, Section 9 of the Pennsylvania Constitution.

14. Exhibit 1 was kept by Pain Away. It was retrieved from the computer system at Pain Away by Royal Copeland during the execution of a lawful search warrant after Hadley McAdoo's death. By law, physicians are required to keep dispensing records for at least two years.

15. Exhibit 2 was produced by Sal Abbott to defense counsel in this action and was produced to the Commonwealth in accordance with the Rules of Criminal Procedure.

16. Exhibit 3 was retrieved from the patient files at Pain Away by Royal Copeland during the execution of a lawfully-issued search warrant after Hadley McAdoo's death.

17. Exhibit 4 was produced to Royal Copeland in her/his official capacity by JJ Teva.

18. Exhibit 5 was downloaded from the CBS Sports website archives immediately prior to trial.

19. Exhibit 6 is a fact sheet created by the Centers for Disease Control (CDC). It is published on the public website of the CDC as part of the CDC's long-standing efforts to educate both doctors and patients, consistent with its statutory mission to "support[] communities and citizens" to fight disease.

20. Exhibit 7 is a joint publication of the CDC and the American Hospital Association. It is published on the public website of the CDC as part of the CDC's long-standing efforts to educate patients, consistent with its mission.

21. Exhibit 10 was obtained by subpoena from the Wisawe Pharmacy and Topiary Shoppe by the DEA. By law, pharmacies are required to keep dispensing records for at least two years.

22. Exhibit 11 is a document retrieved from the Pennsylvania Department of Health Prescription Drug Monitoring Program database via the Wisawe city portal by Royal Copeland.

23. Exhibit 12 is a document obtained by subpoena from JEH Ambulance Co., the contract provider for emergency ambulance services for the city of Wisawe. Ambulance trip sheets are kept by JEH for seven years, consistent with federal and state regulations. If the patient is admitted to the hospital, the information on the ambulance trip sheet may be shared with the hospital providers electronically, to provide a medical history and history of care.

24. Exhibit 13 is a document created by the Wisawe Department of Health and the Drug Enforcement Administration. It was posted to the DEA and DOH websites and was mailed to all physicians and pharmacists in Laurel County by the Diversion Section of the Wisawe Regional Office of the Drug Enforcement Administration.

Paul Clementi

Paul Clementi
Assistant District Attorney

Roberta Patterson

Roberta Patterson
Defendant's Attorney

List of Witnesses

The prosecution and the defendant must call each of their respective witnesses.

For Prosecution, the Commonwealth of Pennsylvania:

- Fran Kelsey: Former employee of Pain Away
- JJ Teva: Loan Manager at First Wisawe, Former Friend of Defendant
- Royal Copeland: Diversion Investigator, United States DEA (Expert)

For Defendant, Rae Shafer:

- Rae Shafer: Defendant
- Sal Abbott: Friend of Hadley McAdoo, Pain Away Patient
- Ry Haight, M.D., Ph.D.: Retained Expert

PRONUNCIATION GUIDE

- Alprazolam - al-prah-zoh-lam
- Haight - hate
- Hydromorphone - hi-dro-mor-phone
- McAdoo - mack-a-doo
- Oxycodone - ox-ee-koh-dohn
- Shaf / Shaf's - Shafe / Shafe's
- Wisawe - wizz-a-wee
- Xanax - zan-aks

Please note for scientific terms used in the problem, pronunciation assistance is easily found on the web by searching "[term] + pronunciation"

Statement of Fran Kelsey

Pain is a funny thing. Some people can tolerate it and carry on as if they are floating on clouds. Others will sell their mother to end it. In 24 years as a nurse practitioner, I have learned that pain is both mental and physical; you can be in pain with no visible injury, and mentality matters.

Someday, we'll look at chemotherapy and marvel that we used poison to cure cancer, just like we will look back at opioids and marvel that we used synthetic heroin to treat pain. Until then, we'll have tragedies like the one that befell Hadley McAdoo. If Dr. Shafer hadn't been so self-centered, Hadley would probably still be alive today. But good can still come from her death.

After getting my RN from Temple in 1994 and working at hospitals in the Philadelphia area for about a decade, I craved a bit more clout and a bit more direction in the care I was able to give patients. So, I decided to go and get my Master of Science in Nursing from Kalmia University, so I could become a nurse practitioner. Nurse practitioners are more like doctors than nurses, but we are not the ultimate decision makers – at least not in Pennsylvania. I did not take the additional tests and certifications to prescribe controlled substances on my own; I was happy to work with a doctor for that. I planned to return to Philly and get a job at HUP or Jeff, but I fell in love with the rolling hills of Wisawe. And I met Rae Shafer. Dr. Shafer was different than the other docs; s/he wanted to practice medicine in a new way. The idea was to try and manage pain without using drugs. Positive psychology, Eastern medicine, and opioids only as a last resort. I saw it as the future. Maybe not a lucrative future, but one worth fighting for.

Dr. Shafer finished her/his residency around the same time I graduated. A few weeks later, in the summer of 2010, Dr. Shafer opened Pain Away in an old car dealership just off the main drag in Wisawe. As first, it was just us. I was the *de facto* office administrator, which was not my strong suit at all, and, of course, I was also the nurse practitioner. It was quiet, but then Dr. Shafer was featured in an article in the *Wisawe Lark*, and a forest fire, word-of-mouth campaign brought in folks suffering from pain. We were famous – well, at least for Laurel County.

One of my favorite patients was JJ Teva. Dr. Shafer first met JJ at the local bank, where JJ helped get some loans to open Pain Away. S/He is a local celebrity of sorts, and funny as the day is long. JJ came in complaining of elbow pain, from tennis. Some fancy ortho down in Philly told JJ s/he had severe tendinitis and needed surgery. Dr. Shafer disagreed and performed a double session of deep tissue electrical acupuncture, a combination of acupuncture and electrostimulation Dr. Shafer helped pioneer at Kalmia. Well, when JJ came back for a follow up two days later, the pain was completely gone. It never returned, but JJ couldn't stay away. Neither could her/his friends, family, and acquaintances. The best PR is always a happy client!

That's how Sal Abbott became a patient of the clinic. Sal was dealing with significant lower back pain as a result of an old injury from a skiing fall, but Dr. Shafer managed to control the pain with minimal opioid usage. Sal also helped a bit with our books – accountants think they know everything.

Anyway, business was booming and by the time January 2012 rolled around, we had already outgrown our space. Dr. Shafer got married that Valentine's Day, and we had a new doctor and

seven new staffers join the practice. I still did medical work, but really my main role was office manager. I was a little bitter about being off the floor for large chunks of time, but I also knew we were building something bigger and better than any other pain clinic in the area. In fact, in 2011, only 10% of our clients were on opioid painkillers, which was far below the national average for pain medicine specialists. That's when Dr. Shafer decided to make our platform even bigger. Ok, I maybe instigated that thought a bit, but Dr. Shafer was all for it. We had every right to be making a bit more money, what with the positive effect we were having on the community!

Dr. Shafer found a defunct textile factory on the Wisawe River. The space was massive, and relatively speaking, the asking price was low. Dr. Shafer dumped tons of money into it, well over a million dollars, and decided to buy all the equipment rather than lease it. I know a lot of that money came from lines of credit and a home equity loan. Doctors don't make the best business owners. Also, while I'm very smart, I was not really trained on business administration. I should have insisted we hire an outside consultant, but we got cocky. I know that Dr. Shafer got some advice from JJ and Sal, but they were friends, not hired help.

In March 2012, we moved into our new space. The mayor of Wisawe showed up for the ribbon cutting ceremony, and when our patients got to experience the new Pain Away facility, our reputation grew stronger and wider. In addition to the full range of traditional services, we had weight training, cardio machines, water therapy, and a state-of-the art patient room with calming ambient music. Patients loved our facility, loved Dr. Shafer, and loved that we respected their privacy. By July 2012, our patient footprint spanned over a hundred-mile radius. We had clients coming from Philadelphia and Harrisburg just to see Dr. Shafer. We even added some luxury overnight accommodations on the second floor of our building to meet the demand. The apex came when Dr. Shafer was invited to appear on *Today* with Dr. Oz on a special segment on the opioid crisis and alternative medicine.

In August 2012, we had our first celebrity patient come to the clinic – none other than Patricia Danica, the race car driver! She was suffering from neck stiffness following a collision. Dr. Shafer and I knew this was a very important moment for the practice. A stellar result could set us up for years. She first came in on Friday, August 10th. The first electroacupuncture treatment went better than could be expected. But, I figured as she was staying the weekend, it would be good to go the extra mile, so I booked her for a follow-up session the next day. I stopped by the room to check on Patricia about twenty minutes after Dr. Shafer set up the session. It looked like one of the needles in her neck was a bit dislodged, so I pushed it in a bit further, and unfortunately, the needle went deeper than I anticipated. Patricia screamed like she was giving birth, and I immediately called in Dr. Shafer. Dr. Shafer was able to rectify the situation quickly, but Patricia was furious. I didn't believe her, but she blamed me and started to complain that she had lost feeling in her left arm. The paralysis was temporary, but her fury was unending. Patricia missed the entire 2013 race season and filed a malpractice lawsuit against the practice, claiming it was our fault! Sports and entertainment media put two and two together, and we were headline news. The impact from the incident was not immediate, and we tried to carry on as normal. But the feeling of doom was pervasive.

It all really changed, or was revealed, when Superstorm Sandy hit the area on October 29, 2012. Most people don't realize that the storm damage reached this far inland, but it did! The Wisawe River swelled and then crested to heights not seen in a century. Water filled the first floor and stayed for days. When we were finally allowed to enter the space, everything was ruined. The dry wall was crumbling and molded; the equipment was destroyed; the floors bowed under our weight. The horror was amplified a few days later when I discovered that our insurance did not cover floods. Dr. Shafer was liable for the loss, because of personal guarantees placed on loans. S/He had no choice but to declare bankruptcy and close the facility. The closing of Pain Away got some national attention and when Patricia caught wind of our misfortune, she fired off a series of tweets rejoicing about it.

Out of a job and depressed, I remained unemployed until I got a call from Dr. Shafer in April 2013. S/He said that s/he was going back to her/his roots. S/He was going to rent a small office with three patient rooms and an office and treat a few local patients who had Medicare, Medicaid, or private insurance. Dr. Shafer wanted me back – just as a nurse practitioner and nothing more. I agreed and, at first, it was kind of like the old days. We kept the business name and relied on a few key clients, none more supportive than JJ Teva.

There was one big difference, though. Instead of focusing on the Eastern medicine Dr. Shafer loved, we started to offer what s/he called a "fuller range" of techniques. That meant that if a patient asked for narcotic painkillers, which includes all opioids, Dr. Shafer would usually prescribe them now. In fact, Dr. Shafer said that in order to serve the local community, it was a necessity. Long gone was the individual treatment of celebrities over the course of hours. We saw more and more regulars who would get scripts from Dr. Shafer for various painkillers, including opioids, with just a minor complaint of discomfort. Patient visits became much shorter, and Dr. Shafer would rotate them through like a factory. And, of course, we still didn't do urine testing for our patients. Dr. Shafer said it was about respecting patient privacy and autonomy, but I think it was that with so many people paying in cash, we would lose patients if we imposed another expense on them. Even when the national numbers for opioid scripts started to fall, ours went up, in relative terms. We had always kept track of those numbers. They used to be a point of pride. By 2016, the profits were outstanding, but the spirit was gone.

According to our records, JJ introduced us to Hadley McAdoo on January 14, 2014. I think JJ knew Coach – that's what Hadley liked to be called – from Wisawe High. That was kind of a thing around here. Coach had been a coach, sure, but people called her that because she yelled a lot and was never good at taking instructions. Coach had spent some time on City Council before the whole Xenopharma scandal broke. After that, Coach didn't have a job, as far as I could tell, either she was sitting on a pile of family money or doing something behind the scenes to get cash. Whatever it was, Coach's insurance claims always went through.

Coach suffered from what some folks call phantom pain, and she said she couldn't lift her arm above her head at a certain angle without experiencing shooting pain. But we ran X-rays, a CT scan, even an MRI scan, but nothing revealed any muscular or tendon damage. My professional view was that it was mental, like it gave her a reason to get sympathy. She was a real character, and I thought maybe she had a mental condition, but there was nothing on her patient intake

form that would suggest a complicating ailment. The old Dr. Shafer would have opted for a combination of acupuncture and lidocaine, but the post-Sandy Dr. Shafer just wrote a script for hundreds of doses of oxycodone. After that, Coach became a regular fixture at the clinic. The following summer, I think it was in June or July of 2015, I caught Coach handing over a wad of $100 bills to Dr. Shafer in the parking lot. Dr. Shafer said s/he had won a bet with Coach on a horse race and was collecting her/his winnings. I didn't believe it, but I didn't press the issue.

On February 15, 2016, things got a lot harder for Dr. Shafer. The bank foreclosed on her/his house and the textile factory, which I know Dr. Shafer had dreams of reopening. The next day, Dr. Shafer's spouse filed for divorce and moved out. Dr. Shafer was shattered. For the next few months, s/he walked around our tiny office barely saying a word, even refusing to engage in banter with our patients as s/he had in the past.

Even JJ Teva couldn't get a rise out of Dr. Shafer. A few weeks after Valentine's Day, JJ stopped by with a karaoke machine and cupcakes and tried to throw an impromptu "rock bottom" party for us. I definitely needed the laugh and was up for some fun. But Dr. Shafer was having none of it, and they wound up getting in a huge fight. Dr. Shafer started blaming JJ for the fall of Pain Away, claiming that JJ promised money and never came through. Dr. Shafer also went after Coach. I distinctly remember Dr. Shafer saying, "Patients like Coach keep the doors open. Does my banker not understand cash flow?" JJ responded that if Dr. Shafer didn't think Coach was in pain, why would s/he be giving her pills? Dr. Shafer looked at JJ for a long time, mumbled, "It's all your fault," and started crying. It was so out of character for both of them.

On August 23, 2016, I saw something I wish I had never seen, and to this day wish I had done something about. I meant to leave work early that day for a dentist appointment. But we were unusually busy, and I forgot my cell phone racing out the door and had to go back for it. I went into the office, and there was Dr. Shafer in the process of injecting her/himself. It looked like *Trainspotting*, like a heroin addict shooting up. Turns out that it was probably worse. I assume Dr. Shafer had prescribed her/himself hydromorphone, a potent painkiller derived from opium. Dr. Shafer said it was simply to dull the pain of loss and that s/he had it under control. When I asked how long s/he had been using, s/he said, without emotion, "since the court decision." I left, devastated. The person who I thought most believed that opioids had no place in medicine was a user, and based on six months of what I assumed was constant use, an addict.

I confronted Dr. Shafer again the next day, when s/he was sober. Dr. Shafer pleaded with me to keep secret what I had seen between us. S/He promised that s/he was going to get help. My gut told me that I had a duty to contact the Pennsylvania Medical Licensing Board, but I couldn't bring myself to do it. Maybe it was because I didn't want to lose my job again, but I know the real reason is that I wanted to believe Dr. Shafer.

And Dr. Shafer really did seem to pull it together for a while. But you could tell s/he didn't care like s/he used to. The office got busier and busier, but the grateful clients were replaced with addicts, hollowed-out shells of humanity. Despite the money we had to be making, Dr. Shafer failed to run my hours through payroll several times, paying me in cash instead. When I finally said something about it, Dr. Shafter responded, "Cash in, cash out." We all felt the pressure to bring in money, but I didn't want to believe that Dr. Shafer was selling out our patients and our

mission. But I was fooling myself. JJ never stopped by again. Sal Abbott kept coming, although s/he never got oxys that I saw. Coach? Well, her pain never subsided. Her visits remained regular.

On December 16, 2016, Coach called the office first thing in the morning, in a panic. She said that she couldn't handle the pain anymore. I was able to fit Coach in as a tack-on patient at the end of the day. When Coach arrived, she was clearly flustered. She was shaking, and there was sweat dripping from her forehead, but s/he could not wipe her brow because the pain of moving her arms was too severe. It looked to me like she was suffering from withdrawal. But when I asked her about it, she said that the pain in her arm was unbearable. I quickly recorded Coach's vitals and a short history into the intake log. I was in the process of confirming that Coach was not on anything else and was going to check the Prescription Drug Monitoring Program (PDMP), but before I could get a closer look, Dr. Shafer called Coach back into the patient room and told me to "take a break." I hadn't taken a break in the entire time we worked together. Something was wrong, I could feel it. But what could I do?

About 20 minutes later, Coach walked by my station smiling for all the world to see. I checked our patient management system to see Dr. Shafer's notes and not only had Dr. Shafer increased Coach's oral opioid prescription, s/he also gave him a shot of hydromorphone. That was the single greatest dose of narcotics Dr. Shafer had ever given to a patient in our office. It was all within the prescribed dosing amounts for each drug individually, but even with Coach in pain, I thought it was too much. I didn't say anything at the time, but I decided I was going to quit the next morning.

That evening, however, I saw on the news about Coach passing. I picked up my phone and called Dr. Shafer. "Rae, what did you do to Coach?" All I got was silence. The next morning, I went to the office and decided to check the PDMP on Coach. It was then that I realized that Coach was on a heavy dosage of Xanax, a medication that did not mix well with opioids. I left the office crying and haven't spoken to Dr. Shafer since.

Statement of JJ Teva

There's nothing more powerful than a personal recommendation. I'm an influencer – always have been, always will be. I called the shots in high school, dictating what was cool, and now at my job as the Commercial and Personal Loan Manager at First Wisawe, I have the final say on whether or not a business can open in town or somebody can buy a house. Folks ask me why I don't run for mayor or state representative, but all I have to do is look at what happened to good ol' Coach McAdoo. Coach was like me at one point – a real local celebrity. She was head of City Council, but now she's dead, her memory sullied by claims she took a bribe. Nope, not for me. I'm happy having my free time … and my opinion on the minds of everyone. I guess that is why it pains me to have been a part of Coach's death and Shaf's downfall. I didn't do anything wrong, but I feel like I could have stopped it from happening. Both of them were well meaning, but when Coach needed my help the most, I ghosted.

Did I mention I was a state champ in tennis? I even landed a scholarship to Kalmia University which allowed me to study finance and stay in the area. There was no way I was getting into school there based on my grades – that's for sure. Problem was that I had really weak tendons in my right elbow, and my college career only lasted two semesters. I flirted with the idea of joining some mega investment firm in New York, but when I landed a job at First Wisawe, the decision was easy. Sure, it was my only job offer, but the thought of the rat race in NYC disgusted me. I need to be somewhere where everyone knows your name.

Everything was great for me, save my elbow. Some days, I could barely lift my arm. I was taking Advil like Pez and always used some pain-killing gel before going to bed. Over the years, I visited some orthopedic specialists, even going down to Philly a couple of times. The diagnosis was the same – lateral epicondylitis, commonly known as severe tennis elbow, requiring multiple surgeries. So, I dealt with it. A couple of friends suggested taking painkillers, but I didn't want anything that would dull my perception or negatively affect my personality. When you got what I got, that would be like buying a Porsche and feeding it 87 octane gas. I'm a performance machine, end of story.

By the summer of 2010, I was in a ton of pain, barely able to type on the keyboard. That's when I met Shaf. In walks this nerdo doctor for a 10:30 AM appointment with an idea for the cheesiest sounding clinic ever – Pain Away – looking for a $100,000 loan. I was used to giving loans to doctors. Great bet for the bank: they operate at terrific profit margins and in a medically underserved area like Wisawe, there were always patients in need. So long as the doctor played ball and accepted most major insurances, it was a quick loan process that would leave me with time for a long lunch or a quick trip to the gym.

But Shaf had a different idea. S/He wanted to take the old Chevy dealership on Main Street and turn it into an alternative medicine pain clinic. On paper, it looked like a terrible idea, especially for someone barely out of residency. The business plan was five pages, and it read like a mission statement. No numbers. Maybe I was desperate, but as Shaf began to explain her/his plan in greater detail, the treatment regimen seemed like it would benefit someone like me. So, I made a deal I had never made before. I told Shaf to put up or shut up; if s/he could help with my elbow pain, I would give her/him the loan. An hour later, I found myself at Shaf's small

apartment being injected with these long acupuncture needles hooked up to some battery source. Shaf turned on the power and the needles began to pulse. It was possibly the most painful thing I ever experienced. The treatment lasted about 30 minutes and Shaf told me to call back in two days. Yeah right. Then something funny happened. By the next night, my pain was fading. Over the next week, my range of motion came back. For the first time in a decade, I actually wanted to pick up a tennis racket. I was shocked. It worked! That was eight years ago! And I play tennis almost every week!

I called Shaf the next day and said that not only did s/he have the loan, s/he had a lifelong friend! We gave Shaf a $200,000 loan with no personal guarantee– that is how sure I was that s/he was going to succeed. When Shaf said it was too much money, I said, you can never have too much capital when starting a new enterprise. And I started recommending Shaf left and right, including to my closest friends. Sal Abbott had a major ski accident a few years back. Sal had the same success that I did with Shaf, though s/he needed regular visits.

Sal even ended up donating some time helping with the office accounting as a thank you. Shaf did have this office manager named Fran Kelsey doing the day-to-day financials, but neither Sal nor I trusted her/him much.

The best thing I did for Shaf was getting in touch with my friend who wrote for the *Wisawe Lark*, Ellie Lille. Ellie and I are neighbors in Laurel Bluff, and we do Rotary stuff together. Like I said, when I make a recommendation, people listen. They ran a multi-part story not only on the opioid epidemic, but also how practices like Pain Away were breaking stigma and trends of addiction. Shaf was flooded with new patients from Wisawe and neighboring towns and cities. S/He had to hire three more staff members and carve out a few new offices just to handle them.

We stayed very close over the next two years or so – me and Shaf. I will not deny the fact that I enjoyed a few libations – usually red wine – but Shaf always declined. S/He told me that s/he had an addictive personality and didn't want to get on any "slippery slope." At the beginning of 2011, Shaf met that special person, Sam, and knew right away it was love. When they got married in 2012, I was even asked to be a member of the wedding party. Pretty cool – Shaf probably insisted on inviting me because s/he knew that I was going to give the best toast ever.

That was also right around when Pain Away went national. At the practice Christmas party in '11, Shaf confided in me that the old auto dealership was not going to cut it anymore. S/He was now getting regular intake calls from folks in New York and Philadelphia and occasional ones from as far away as Chicago. Shaf thought this new type of pain management was taking off and making a difference in the world, and s/he needed a more impressive flagship location. I think Fran had planted a bug in Shaf's ear that s/he should consider franchising the clinic's concept and try to generate income across the country.

Whatever it was, Shaf suddenly wanted not only state-of-the-art equipment but also lodging for out-of-town patients. It sounded like a pain spa or something. I guess it was not that bad of a concept, but the problem was that as it moved further and further away from a doctor's office, the more of a challenge it would be to get the bank to loan more money. Shaf was never late in paying, but $2.5 million dollars to retrofit an old mill is a lot different than $100k to clean up a

small structure. That didn't even include the cost of the land and the structure already in place. Even so, on January 12, 2012, we were able to get Shaf $3.25 million dollars in working capital, comprised of a $2 million improvement loan and $1.25 million in small business funds. But the bank had to be protected; we made her/him sign a personal guarantee, and for the property purchase, Shaf had to not only take out a second mortgage on her/his home, but also a large home equity line of credit. Shaf had realized her/his goal but was leveraged to the hilt. With all this credit on the books, I would have been surprised if Shaf could've gotten a car loan. Still, s/he seemed happy.

2012 seemed like it would be awesome. The wedding was amazing; the new location overlooking the river was unbelievable; and the equipment was top notch, and it had the atmosphere of a place where something special was happening. Travel agents started offering weekend packages to those suffering from pain conditions! Shaf was having no trouble making her/his loan payments. S/He even met Dr. Oz! The bank was ecstatic. A C-level executive position at First Wisawe was a definite possibility for me.

But beneath the surface, things were not as rosy as they seemed. I could tell the stress was getting to Shaf. I asked Shaf to come out after work around Independence Day, 2012, and Shaf ordered a drink instead of a club soda. I think s/he got some mild cocktail, but still. Running an office of that size and performing medicine was like having two full time jobs. Shaf confided in me that s/he was having trouble connecting with Sam and expressed real frustration with Fran.

But a pep-talk seemed to buoy Shaf's spirits, and the next week, we all heard that Patricia Danica was booking a full weekend stay. The problem was Shaf still put too much trust in Fran. No one is really sure what happened that Saturday at the clinic, but whatever it was, it was the beginning of the end. Apparently Shaf – or Fran! – messed up Patricia's treatment, and she suffered nerve damage or something. While insurance covered the cost of the medical malpractice suit, there was no way Shaf's reputation would recover.

Then came Sandy. The storm was bad. Really bad. The properties near the Wisawe River were hardest hit – including the Pain Away clinic. When the flood waters receded a week later, the place was a ruin. The equipment was destroyed, and the building itself appeared to be on the verge of collapse. I remember saying to Shaf, "well, at least you have flood insurance" and her/him responding, "what's flood insurance?!?" Turns out that Shaf wasn't covered for the damage at all. S/he still owed First Wisawe over three million dollars. S/He declared bankruptcy a couple weeks later. I did see Shaf a few times at Dhillon's Pub, but s/he snubbed me whenever I tried to strike up a conversation.

I wasn't surprised when s/he tried to rebuild her/his career in the spring of '13; Shaf still had a loyal local following. But without celebrities or vacationers, there was no way Shaf was going to make a living doing alternative pain care – well not at least in a place like Wisawe. I tried reaching out over and over again, but Shaf flat out refused to speak to me. I was upset. Everyone liked me, and it irked me that Shaf completely cut me off. Everyone thinks that banks are the bad guys. Not so! We make dreams come true. So, I decided to try and make Shaf's dreams come true one more time. In early 2014, I bumped into Coach McAdoo. No one really liked her much by then, but to me she would always be the person every single student looked

up to. But when I started asking her about what she was up to, the silence was deafening. She looked like she was depressed and probably on medication or something. She did manage to tell me about how much her arm hurt and how it was making grocery shopping painful.

So, I made the introduction. I popped Shaf a text saying that Coach was going to come to see her/him and for the first time in over a year, Shaf responded with a single, word, “thanks.” I wrote back right away and told Shaf to watch out for Coach as she seemed off, and I thought was suffering from depression. Same response from Shaf, “thanks.” Well, once Shaf realized that Coach was a good patient, Shaf invited me out for drinks and our relationship warmed a bit. In April 2014, Shaf said we could try and be friends again. I was pleased. But then Shaf started banging on and on about how I could really help her/him out if I could convince the bank to loan some more money. Shaf still thought that the massive celebrity clinic was salvageable. I was already in hot water over the loan and could not take any more risks where Shaf was involved. Shaf understood. S/He shook my hand and said, “I figured, but before I gave up the dream and moved to Plan B, I figured I should try.” I wish I had realized then that Shaf was sliding into the opioid prescription game head-first. Looking back, the request was more of a cry for help than a rational business request.

Another year or two passed by and Shaf and I were cordial, I guess. Well wishes at the holidays and the odd birthday greeting. On March 17, 2015, we were out at the Rotary Club annual gala. Sal, Shaf and I were seated at the same table with a few members of City Council. Unannounced, and uninvited, in walks Coach, right in the middle of the biggest speech of the night. Coach comes right up to our table, sits in the speaker’s seat, takes out a fork and starts playing the drinking glasses like a xylophone. All eyes turned towards her. I asked Coach to calm down, but that only created more agitation. She started singing! It was clear that Coach was all doped up, but after she was escorted out of the building, both Sal and Shaf defended Coach. They thought it was Coach’s way of getting back at City Council for kicking her out. That didn’t make sense; Coach was always big on proper behavior and chain of command. I’ll bet Shaf gave Coach the drugs that caused such an out-of-character reaction.

In January 2016, Shaf asked me to join her/him, for once. We went to Dhillon’s. Shaf said that her/his marriage was falling apart and that s/he was never going to be able to open the clinic or pay off the creditors even under the bankruptcy restructuring terms without additional revenue. S/He started full on sobbing! When Shaf pleaded with me to help, I wanted to end her/his pain so badly that I said I would help get a new loan from the bank. I knew it was a promise I would have to break, but it was the only thing I could think of in the moment. Shaf perked up immediately and said I was a life saver!

But less than a month later, the bank foreclosed all of Shaf’s properties, and Sam left. I knew Shaf would blame me rather than her/himself, so I waited a few weeks and decided to try and help one last time. I rented a karaoke machine and got a cake and went over to the Pain Away clinic to throw an impromptu “rock bottom” party. But, rather than embrace the idea, Shaf started unloading on me. We got in a huge fight and both said some things that we regretted. The most unnerving thing was how Shaf kept talking about Coach and how s/he was “cash flow.” I left shortly thereafter, knowing there was no way to talk any sense into Shaf.

But I couldn't leave things there. I wanted to smooth things over, and I went back to the clinic after I cooled down. When I arrived, the lights were off in the main room, but I could tell that Shaf was in her/his office. I walked in without knocking and approached Shaf's office. The door was ajar, and Shaf was sitting in the dim light injecting her/himself with what I think was heroin. I decided right there to cut her/him off completely and remove her/him from my life. Just say no.

I called Sal and told her/him all about what I saw and my fight with Shaf. Sal said I was crazy and that my upset over losing a friend was no reason to spread rumors. Plus, Sal said Shaf was still doing well with the treatment of Sal's skiing injuries, and s/he wasn't about to give that up. I then called Coach and told her/him that there were plenty of other doctors in the area and that she should stay far away from Shaf. Coach said, "don't worry, Dr. Shafer and I have a special arrangement. No need for me to go anywhere else. I get mine and s/he gets hers/his." No one wanted to listen to me. First time ever!

I decided to poke around into Shaf's finances to see what was really going on. From my desk at the bank, I checked out credit reports and other proprietary databases we use in deciding whether to give loans. You know, when you follow the money, you can learn a lot about a person. Turns out that while Shaf was in bankruptcy proceedings, her/his lifestyle hadn't changed much from what I saw. That's usually a sign of a cash business, one that isn't being reported to the accountants. But doctors don't do cash business, unless something is very off. I was fine not being liked for the first time in my life.

I didn't give much thought to Shaf or Coach for a few months until I bumped into Coach again at the market during the summer. She looked terrible. Coach said she needed money because she could no longer afford her medical care. She said she was suffering from anxiety and depression on top of the pain. She even asked me for a few dollars, so she could fill her Xanax prescription. At that point I didn't have time in my life for more drama, so I pretty much ignored her. Well, not completely. I did send Shaf a PM on Facebook around that time saying that it is fine for her/him to destroy her/his own life, but that s/he should leave Coach alone, especially since Coach couldn't even afford her script for anxiety meds. I never got a response.

If Coach had listened to me and stayed away from Shaf, she would still be alive. My advice is always right. I just hope others learn that lesson once and for all from this terrible event.

Statement of Royal Copeland

The DEA Registration Number is so many things. It is a set of keys to the kingdom, the right to prescribe any medication for any purpose. It is a mark of distinction, awarded only after years of all-consuming education and testing. It is a license to heal. It is a license to kill.

Sure, doctors are a profession beloved and revered through human history. And for good reason; they can perform miracles, to bring the dead to life, to let the cripples walk again. Any science sufficiently advanced is indistinguishable from magic, and doctors are our magicians. But they aren't angels, and like anyone else they can be corrupted. I figured that out in the least likely place: the streets of Cabrini Green.

Yeah, Cabrini Green. Chicago. Public Housing. That's where I grew up. My folks did their best, a nurse and a handyman, I guess you'd call him, but it was hard living. Drugs were everywhere, and the gangs ran the place. My folks made me stick it out and do my homework, even scraped together a dollar here or there to get me supplies I needed. It wasn't much, but it got me to community college. I went to school full time, working two jobs. That got me to UIC, ground out a degree. From there I went somewhere you wouldn't think someone from Cabrini would go: the Chicago P.D. But you see, I *knew* where I had to go. I *knew* who I had to help.

Turns out I was good at it. A few years on the beat, a few more in Major Crimes. Then my break came: a DEA task force in the Robert Taylor Homes. Undercover work. On TV, crimes are solved in a day or two. Some CSI nonsense, some clever quips, done. In real life it takes years. It took us three to break the Taylor Crips, and the day that indictment came down, I got arrested, too… gotta maintain your cover. DEA offered to take me on as an agent, and while I was happy to join up, I did not want to be a street agent.

You see, in the Homes I saw the next thing coming. Where and when I grew up, folks got hooked on heroin, maybe crack. Nobody could afford powder. By 2010, though, something new had arrived on the streets: opioids.

I mean, anything derived from poppies is technically an opioid. And that's nothing new. Opium was the original, way back in the day, *Gangs of New York* style. Then came heroin. By 2012, we were past stuff grown in Afghanistan, cut with who knows what by half a dozen middlemen and dealers. By 2012, it was about Oxycodone, Hydromorphone, Fentanyl… pharmacy-grade stuff. Heroin with quality control. A junkie's dream. A cop's nightmare.

And it could fool you, because it was *medicine*, see? A teacher, a professional football player, even a nurse with foot pain after a lifetime of working the floor at Cook County General… opioids sneak up on you, make you think they're ok. We lost my mom in '14. I'm not ashamed that's how she died; I'm proud of how she lived. And I was – and am – mad as hell at the white-coated pill pushers who sunk their hooks so deep she couldn't break away.

That's how I started in DEA's Diversion Section. Traditional DEA special agents work street crime, the kingpins, and even interdiction in South America. Diversion investigators stop *legal* drugs from being *diverted*, meaning going to a purpose other than that for which they were prescribed. When an oxy pill can go for $20 on the street, the incentives to get them are

incredible. And just like heroin, you build up a tolerance to opioids, so you have to take more to get the same high. And – God save us all – you *will* want that same high. I caught a lot of junkies and pushers over the years. More than most. I was suspended once for supposedly planting some drugs on a real bad hombre, but there was nothing there but jealousy in our own ranks. I was pretty much untouchable, and I had a nose for the bad guys. Even if the evidence wasn't always there.

Some docs make an honest mistake, trying to help patients who they think are in real pain. Others are crooks like Rae Shafer, using their license like an autopen, signing everything that comes in the door. Like it's not a license to kill. Shafer was particularly bad because not only was s/he prescribing opioids at an alarming rate, s/he was taking cash kickbacks from those s/he supplied.

The case on Shafer opened in 2013, right when I was starting in the Administration for real, assigned to the Laurel County Field Office, and it's been my baby since the day I saw it. Seeing what I saw at Pain Away even inspired me to get a Master's in Public Health degree online from the University of Phoenix. The DEA helped pay for it, and I focused on detecting drug diversion through unusual statistical patterns. It has also given me more credibility for the talks I do for physicians' groups on opioid management and diversion. Pain management is a profession shot through with crooks, and Shafer and her/his buddies were just another in that long, shameful tradition. I have little doubt that when Shafer started her/his practice it was filled with good intention. But between the entire Patricia Danica dust up and the flood, Shafer changed. The mind is really amazing. We can rationalize almost anything, even pushing poison out the door. Get away with it once, and it becomes contagious.

Oh yeah, I saw the ads, too, when Shafer reopened that new office about 6 months after the flood: "Eastern" medicine. I'm no genius, but you don't have to be one to know that insurance isn't going to pay much for that, and you're not going to run a profitable medical practice trying to convince UAW guys and ex-cons working the night shift at the Nash plant to pay $150 in cash for the privilege of getting used as a pincushion. Without the celebrities and the organic crowd from the cities, there was no way that business was going to fly. Wisaweans show up – and pay up – for one thing only: opioid painkillers. Maybe it's for personal use, to dull the pain for a few hours. Maybe they're letting their insurance cover it and then selling the pills for cash. We see that all the time; dealers sitting in their SUVs in pharmacy parking lots, trading cash for pill bottles like a drive-thru ATM.

Still, I couldn't make anything stick. We talked to a couple patients who got picked up on other things, but everybody thought the Doc was great. I did get lucky and catch some photos of Shafer taking some cash from Coach McAdoo one day, but my memory card was out of space, so the shots were not recorded. I started thinking that Shafer might be the One That Got Away.

In my experience, doctors get into selling 'scripts for all kinds of reasons, but the biggest is money. Doctors legally make money from office visits, paid for by the patient and/or insurance. So, the more patients you can move, the more money you can make. There are only two ways to make a lot of money: get a lot from a few people, or get some from a lot of people. Many folks have pain, especially the poor and the elderly. Those are covered by government

insurance – Medicare for those over 65, Medicaid for those in poverty. But those programs don't pay doctors much for office visits, even though there's a need. You're not getting that Lexus and house at the Shore doing government business. And in Wisawe, it's pretty much the government insurers or Blue Cross. They're no great shakes for docs, either. Of course, if you have a concierge practice, you can make money in cash from rich folks; you prescribe what they want, and you charge what you want. Not too much of that here in Wisawe, though. Not with our economy.

So, the doctor might start slow, but there's huge pressure to increase volume, see more patients for less time each. Pretty soon they're cramming as many as they can into the day, maybe only seeing them for a few minutes, maybe not ordering an MRI or a CT scan, just taking their words that the pain is real. Once word got out about a doctor with a loose prescription pad, the patient volume rises, and dope fiends come to get a fix. It's textbook.

Watching Shafer in 2015 and '16, both in person from my various vehicles DEA uses and through the prescribing data for the Pain Away practice, which DEA receives by law and which diversion investigators access all the time to track how things are going in practices they are investigating. I watched the trends in near-real-time, but I later learned from Fran Kelsey that Pain Away kept its own internal data. I compared theirs with DEA's, and theirs was accurate as to both the Pain Away numbers and the DEA's in all respects. The data was clear: Shafer was spiraling, increasing in rate of prescription opioids and the morphine milligram equivalents (MMEs) even when the national numbers were falling. MMEs track how much power each prescription packs in terms of morphine, so you can compare the power of, say, 30 mg of oxycodone with, say, .05 mg of fentanyl. The more potent, the more high, and the more opioid-tolerant addicts want it. So, Shafer was prescribing more and at greater potency.

There were always patients outside that dingy three-room office each morning, and Shafer would rotate them through like an assembly line over at the Nash plant. That is a sure sign of a pill mill. Oh, sorry. "Pill mill" is what we call a doctor's office when it stops providing individual care and becomes just a place to get pills. Catchy, ain't it?

Pharmacies as far as a hundred fifty miles away were filling Shafer's 'scripts – another telltale sign. Folks might travel a hundred miles to go to the "pain spa," but they won't to sit in a strip mall doctor's office unless there's a 'scrip at the end of the rainbow.

What, you thought patients came up from Philadelphia because they could not find someone in Chinatown to give them acupuncture? Oh, and don't even get me started on the opioid prescription records. CVS even warned the DEA that they weren't going to fill them anymore, because there were too many to be legit.

A prescription is an authorization or order for a medication or controlled substance (or a device, like portable oxygen or a wheelchair or whatever) that is issued to the ultimate user, the patient. In order to be valid, a prescription must be issued for a legitimate medical purpose by a licensed practitioner (a doctor or certain kinds of nurses) in the usual course of professional practice. There are a bunch of other requirements – like putting it in ink and keeping copies – but that's basically it. The work must be for a legitimate reason in a usual course of practice.

Shafer wasn't doing that. Instead of maybe thirty or forty percent of patients getting painkiller prescriptions, Shafer peaked at eighty-three percent. Eighty-three! Did some of those people have real issues? No doubt. But more of them were looking for a high or to sell the dealers lurking in the pharmacy parking lot.

And what does that dealer want? Things he can turn around and sell. That means opioids, for starters. They kill pain, but they also give a high, and they are staggeringly addictive. Perfect street drugs. But addicts are not especially particular; they'll take anything that gets them high. So, the dealer is almost as happy to get diet drugs or ADHD medication – which contain amphetamines – or benzos.

What's that? Oh, right. Benzos… benzodiazepines. It's a group of drugs for epilepsy and some mental disorders, especially anxiety and panic disorders. A lot of benzos are pretty obscure, but I'll bet you know Valium and Xanax, right? Yeah, well, so do the junkies. Don't get me wrong; for people who need these drugs, they're lifesavers. Heck, my dad was taking clonazepam for a solid year to help him sleep after Momma passed, and I once needed diazepam for some severe back spasms. But for people who don't need them, they're just a high. I mean, who doesn't want to get rid of their worries for a while? And remember, it's *medicine*. Yeah. That's what they'll tell you.

Coach McAdoo was part of the pill mill machine, a user *and* a supplier. Everybody in town knew about Coach, even the FBI, on account of that Xenopharma bribery investigation. We also knew that Coach had preached straight living and mental toughness, even as she was loading up on benzos and opioids. We always figured she was just a mule for a group in the richer suburbs like Laurel Bluff and Ruffed Grouse, handing out Mother's Little Helper to kids looking to escape school stress, creating a new generation of addicts right in the police chief's back yard. Coach was what we call a regular. Fill up, come back, fill up again, and grease Shafer's palm to make sure any inclination of backing out was impossible. We never were sure whether Coach paid Shafer in cash or in pills. Lotta time that's how it works; the doc gives a prescription for 60 oxys, the patient brings back 20. Then the doc either sells them or takes them. After all, docs have worries, too, right? And this way the Medical Board doesn't know a thing. Plus, Shafer needed the cash. Cash is safe from the bankruptcy court.

And Coach had an excuse to get painkillers. She would tell anyone who asked about when the power forward for Messiah College laid her out flat and how her arm was never the same. At first it was a local tragedy, then a local bummer, then kind of a local joke. Someone should have talked to her about it. I would have, but I was an outsider. Hard to get anyone here to talk, much less the town hero. Still, I would have done it if I knew she was mixing opioids and benzos. For whatever reason, when you put those together, they do two things real well: getting you high and telling your lungs that they don't need to work. Like, at all. Long-time abusers love to mix them, to get the high, but they cause respiratory distress and death at terrifying rates. About half of all opioid deaths include other drugs, and benzos are the lion's share of those. Addicts on the street know about the high – or they soon hear about it! – but they don't know – or can't afford to care – about the risks.

Of course, doctors know that you can't mix those two, for that reason. It's even on the opioid drug label. They will almost never prescribe an opioid and a benzo to the same patient. So, patients got clever. They start going to one doctor for one and another doctor for the other. Over time, as the addiction worsens, or they get greedier about what they can sell to a dealer, they will go to multiple docs for each drug. And, needless to say, they did not mention the drugs one doctor is prescribing to the others when giving a medical history. Pretty soon they can have two or three times the amount they should have of each kind of drugs. That's what Coach was doing to Shafer – getting the benzos from someone else, and the opioids from Shafer.

There are two basic ways as a physician to make sure you don't have this problem. The first is the PDMP. The Prescription Drug Monitoring Program keeps track of all the controlled substance prescriptions filled in Pennsylvania. Addicts can't get around it by just going to multiple doctors, because all the doctors enter their prescriptions. Before folks worried just how bad the opioid crisis had gotten, checking the PDMP was optional. PDMP became available for physician use in June 2015, but it was only made mandatory on January 1, 2017. Now, doctors must check the PDMP before writing any opioid prescription.

Even before it became mandatory, though, it's not like doctors didn't know that checking the PDMP was a good idea. The law was signed on November 1, 2016, so doctors knew what the standard of practice was and could start following it. And the PDMP was available to all doctors over the internet, even on smart phones. DEA worked with local Departments of Health to make it as easy as possible, and as well known.

The other way to detect diversion or abuse – or even side effects! – of opioids is to do routine urine screening. These days, that's the recommendation of both the CDC and the DOH, but again, even in 2016, it was a cheap way to make sure patients actually took the drugs, to monitor metabolic effects, and to make sure that your patients were not taking other drugs that could interact with the prescriptions. I mean, how else would you even know that your patients were not selling them the second they left the pharmacy?! One of the ways we at DEA spot a doc who isn't doing the right thing is to find one who bills for prescribing but not urine testing.

Tons of information was sent out about PDMP in 2015 and 2016. I gave a copy of one of the bulletins we published with the Wisawe Department of Health to the District Attorney during the investigation. And urine testing has been recommended for risky patients for years. Plus, over 30,000 people died from opioids in 2015, right up there with kidney disease, flu, and suicide. The numbers were even higher in 2017. It would have been impossible for any responsible practitioner not to know that opioid abuse was a problem.

And, of course, that goes double for a pain specialist whose focus is these exact drugs.

In other words, there was literally no reason a doctor would not check the PDMP before handing out an opioid prescription or giving an opioid injection. There was no cost and doing so reveals all kinds of suspicious behavior. And if your patient was on benzos, it could be a life-saver!

It may not have been a legal requirement until 2017, but common sense and good practice were in place long before that. There's no legitimate reason *anyone* would prescribe to Coach without

checking the PDMP. And that's doubly true if there were specific warning signs of benzodiazepine abuse, either then or in the past, that a trained professional would recognize. When it comes to opioid abuse or benzodiazepine contraindication, you have to be careful. Anything else is criminal. But not only did Shaf jack up the amount of pills s/he prescribed to Coach that day, s/he also gave her/him a shot of something even stronger at the office.

When we got the toxicology report that Coach was polydrug with benzos and opioids, the first thing I did was check the PDMP access logs to see if anyone from Pain Away had checked. Sure enough, nobody gave it a second thought until the day after Coach died. Guilty conscience, I suppose. But it was there. Margaret Hamburg, November 27, 2016, Xanax (alprazolam), 1 mg daily. A few clicks would have saved a life.

Yes, Coach was the first of Pain Away's patients to overdose, but you could see it coming a mile away. If you are up to your eyeballs in debt, you don't *want* to weed out the frauds. You'll sign and sign, and eventually someone will have filled a 'scrip the day before or picked up some benzos on the side and overdose. I know that Shafer is charged with prescribing leading to death – and that's richly deserved – but I wanted to see it charged as flat-out murder, because that's what it was in my book. If Shafer had prescribed a big, healthy dose of rat poison, would there be any doubt? Well, giving an opioid to a junkie like Coach, that might as well be cyanide.

So, no, I'm not going to apologize for going after a doctor. I wear it proudly. Rae Shafer is still practicing, and Pain Away's doors are still open. That's a disgrace. Doctors are responsible for the use of their DEA number. It's no excuse to say the secretary misfiled the paperwork, or the nurse made you do it, or whatever else. Your number, your responsibility. So if I've been criticized for showing up at doctors' offices unannounced? If some judge thinks I use "too much" force when I make an arrest, well, as Barry Goldwater said, moderation in pursuit of justice is no virtue. Anyway, Wisawe won't have to worry much longer. I hear there's an Assistant Special Agent in Charge position in the Windy City. I just need to wrap this one up, and they might as well put my name on it. ASAC Copeland. I like that. Get me out of this backwater and back home, with a nice salary bump to boot!

Statement of Rae Shafer

Do no harm. That's all people know of the Hippocratic Oath that physicians swear to. But that entirely unrealistic phrase was not even part of the original Oath! Hippocrates knew, even in 400 B.C.E., that the practice of medicine was much too complicated. He only required his students to pledge to avoid harm, *if possible*. Often during life-saving CPR, ribs are cracked or broken. But if you need CPR, you'd happily make that trade.

My point is, doctors have to make hard, messy decisions all the time. My mom was a doctor too. When she was practicing in the late nineties, most of her coworkers were raving about a new "miracle drug" that made patients who'd had untreatable, chronic pain for years feel comfortable in their own skin again. My mom kept saying Oxycodone was too good to be true, and she was right. She treated her patients holistically, with everything from acupuncture to herbal remedies to low-strength pain medication. Opioid-free treatment was not my idea; it was my legacy.

When I was starting medical school at Temple in 2002, my mom was diagnosed with cancer. It was way too far along to do anything but manage the pain. She used holistic regimens for a while, but soon the pain got to be too much. She started on Oxycodone and quickly developed a dependence. In just a few short months, she needed to take enough that it slurred her speech and affected her motor skills. I never expected my mom to become an unrecognizable addict.

Don't get me wrong – opioids serve a purpose. But I see my mom's face during her last few days, when she was so far gone she couldn't recognize me, every time I write a prescription for an opioid. I ask myself, is this the only option we have? Often it isn't, but sometimes it is. I prescribe opioids to my patients when I need to. I just never do so lightly. That's part of what's so ridiculous about these charges – I built my practice and my life around holistic medicine and opioid prescription as a last result. Why would I throw that all away?

When I finished my residency at Kalmia University in 2010, I decided to open my own pain management clinic, so I could practice the way I wanted to. My friend Fran Kelsey was always bragging about his/her business instincts, and s/he was graduating with his/her MSN at the same time I would be finishing. I thought Fran would make a perfect anchor employee.

Fran was skeptical of a clinic that treated the whole patient, not just his or her pain, and only prescribed opioids as a last result. In fact, Fran laughed in my face. Fran told me that my vendetta against opioids was business suicide, that opioids were where the money was. Then in June, I ran into Fran, getting fitted for his/her graduation gear. Fran brought up my pain clinic. All of a sudden, Fran seemed way less skeptical of my whole philosophy on pain management. In retrospect, I think that had more to do with Fran's lack of job prospects than any genuine change of heart, but I was getting desperate to find a qualified nurse. I offered Fran a job again, and s/he accepted. You can imagine how dearly I wish I had taken Fran's original gold-digging reaction to my proposal to heart and steered clear.

After graduation, I went to the local bank to look into financing options. While I was there, I met JJ Teva and we hit it off right away. JJ has an incredible personality – s/he's warm and outgoing and a real comedian, albeit a bit smug. JJ and I also connected over what I was trying to do with the clinic. JJ seemed to really get the uniqueness and importance of it all. In fact, I didn't just get a friend, I got a patient. JJ had chronic elbow pain from tennis, and his/her doctor had prescribed surgery without exploring any other options. Well, the elbow responded to treatment, and JJ ended up getting me a $200,000 loan – twice what I was asking for!

Even with JJ's help, we had to start off small. I bought an old car dealership in Wisawe, hung up a hand-painted sign that said Pain Away Clinic, and opened up shop with Fran as my only employee. It wasn't much, but I was happy. I gave time to our few patients and helped them achieve great results. JJ recommended tons of people to the practice, and we became very close friends for a while.

It was clear that Fran was not content to treat a handful of patients. Fran kept pushing me to recruit more patients, but my heart was never really in it. As long as I was practicing good medicine and paying the bills, I didn't care about the profits. I believe in treating the whole patient, and people respected that we did not require blood tests or urine tests while we treated them. Those things are icky to many people, and they would have been contrary to the Pain Away philosophy of healthy mind, healthy body. Pretty soon, Fran took matters in his/her own hands. Fran had a friend at the super popular blog, the *Wisawe Lark*, and s/he got the blog to publish a story about me and about Pain Away. It's not that easy to get a feature-length story published about a no-name doctor in the hottest blog in town. I don't have any evidence that Fran bribed someone at the *Lark*, but I wouldn't be surprised. JJ said that s/he actually made that happen, but JJ had a habit of claiming credit when anything went well.

Almost as soon as the feature dropped, our client base doubled. People from all over the Wisawe area poured in. I knew I couldn't keep up with the new wave of patients, so I hired another physician and a full staff of nurses and administrators in June of 2011. It's true that it got pretty crowded with all those new hires in our tiny clinic, and it's also true that I might have mentioned how cramped the quarters were to Fran, but I never suggested buying a bigger building. That was all Fran. I knew that even with our early success, we couldn't afford to move.

But Fran couldn't let it go. S/he kept telling me that if we moved to a new space we could make a lot more money. I think eventually s/he realized that I didn't care about the money, and s/he started saying that s/he was getting complaints from patients about how small our space was. That hit home for me. If it was really true that – as Fran claimed – the cramped quarters were impacting the patients' ability to heal, then of course we needed to make a change.

I wanted to upgrade, but I also wanted to be sensible, so I found an old textile factory that was being sold on the cheap. Unfortunately, the place needed substantial of renovations, and I ended up spending far beyond my means anyway. I know I took on too much debt and I know I should never have leveraged my house or given a personal guarantee, but JJ said it was the only way. Another of JJ's referrals, Sal Abbott who was now a patient and helped with our tax returns, said there was no way the business alone could support the expansion. The only person at the practice with any business experience was Fran, and s/he kept assuring me that it would all work out it the end. If you build it, they will come, s/he would tell me. But, this was no field of dreams.

For a while, it seemed like Fran was right. I got married on Valentine's Day in 2012. In March 2012, our new building was finally ready, and for the first few months, business was booming. That summer, I even got invited to appear on *The Today Show* with Dr. Oz! From that interview, I got a call from Patricia Danica, who was suffering from some neck pain due to a NASCAR crash. We set her up in our best rooms for a weekend visit. The Friday treatment we gave her on August 10 went really well. Fran invited her back for more the following day, even though it was not really necessary. We should have left well enough alone. When I left the room to allow the treatment to take hold, Fran ended up messing around with my needle settings and pushed one in way too deep on Patricia's neck, causing a bit of paralysis in her left arm. While in rare cases paralysis is a side effect of electro-acupuncture, it is always temporary. However,

try telling that to the court of public opinion. Instead of a ringing endorsement, I was locked into a malpractice suit.

When Superstorm Sandy hit at the end of October 2012, everything got messy real quick. The entire clinic flooded, and all the money and effort I had poured into rebuilding the space was lost. To make matters worse, Fran told me after we surveyed the damage that our supposedly comprehensive insurance plan contained only $100,000 in flood protection. I was crushed. I ended up having to declare bankruptcy and close the clinic, which was a terrible feeling. Making things worse, Patricia blamed her lost 2013 race season on me and did interviews with numerous outlets preaching that Eastern medicine has no place in athlete treatment. So now I blamed myself for setting the practice of holistic medicine back a few decades.

Okay, I also placed some of the blame on JJ for not protecting me from financial ruin. S/He definitely should have told me about flood insurance. That pretty much ended our friendship. I started drinking alcohol a bit for the first time in my life. A few mixed drinks here and there or a glass of wine. Nothing too crazy. But it was hard to hold it together.

In April 2013, my personal physician mentioned that there was a small office open in her building. I decided to start over, promising myself I would keep things small and follow my instincts this time. Gone were my ideas of changing the world – I just wanted to practice medicine. My plan was pretty simple. When necessary, I would prescribe opioids to meet the needs of the local community. I could not afford to turn off patients who had heard my reputation was to rarely prescribe narcotics or only treat rich people. Then, when my funds were restored, and my credit was back to normal, I would keep pushing the holistic medicine. But even in our new incarnation, we followed the same holistic principles, and that meant that we never caved to the idea that we could not trust our patients, that we had to make them pee in cups. To show that we were still the same people, I kept the name of the business the same; I wanted redemption for our practice, even if additional flexibility was needed on the question of opioids.

No self-respecting nurse would agree to do business with me. I never wanted to see Fran Kelsey again, but s/he was a certified Nurse Practitioner, and s/he was available. I figured that if Fran could stick to what s/he was good at – nursing – everything could be alright.

I wanted to take things really slow this time, so we started off small, working on community members who had suffered workplace injuries. We weren't making a lot of money, but I was doing medicine again. Fran was getting impatient with the slow pace of business, though.

When JJ referred a friend in January 2014 – Hadley McAdoo – Fran and I had very different ideas about how to proceed. I wasn't sure Hadley was the type of patient we wanted. Fran had skimmed Hadley's chart and told me to prescribe her a low dose of Oxycodone and send him/her on his/her way. But something seemed off. I thought there was more to the story.

Over Fran's objections, I ordered a series of X-rays and CT scans. The tests proved what I had suspected all along – Hadley had no muscle or tendon damage. Instead, s/he was suffering from phantom pain, a pain that is quite real, but which does not have an identifiable physical cause. I started treating Hadley with a combination of acupuncture and lidocaine, both of which appeared to reduce Hadley's discomfort. I also gave her a script for a mild opioid, but that was more for the placebo effect.

Although the diagnosis was sound, and the treatment effective, Hadley didn't always seem all there. At times, she was lethargic and despondent, at others, she was upbeat and talkative. Like the time we were all at the Rotary Club gala in March 2015, when Hadley crashed the party

just to make fools out of the City Council. It was hilarious seeing her play 'When the Saints Go Marching In' on a bunch of half-full glasses of water with a dinner fork and a dessert spoon. The legend of that night has grown in the telling, but I honestly wasn't too concerned. If anything was seriously wrong with Hadley – anything that I should know about as his/her doctor – JJ or Sal would've said something even if Hadley was too proud to admit it. I certainly wasn't worried about Hadley's prescriptions. I had prescribed Hadley some opioids, but like I said – it was a super low dosage.

Then again, looking back, maybe Hadley's friends would not have told me anything anyway. In April 2014, I tried pressing JJ for more information about Hadley initially, but s/he said Hadley wouldn't want the whole town to know the details of his/her health. As Hadley's doctor, I was hardly "the whole town," but I didn't push the issue. The most JJ would say was that Hadley sometimes "got down" on himself/herself, but don't we all? I did ask JJ about getting me some additional money for the clinic. We sorely needed some new electro-acupuncture equipment. But JJ said was that I was toxic as far as the bank was concerned, and there was no way I was getting a new loan. Well, I wasn't going to get the cash betting on the ponies with Coach, so, yeah, that really upset me.

I know JJ's saying now that s/he later sent me a Facebook message right before Coach died saying… I don't know, something? I don't even have a Facebook page. I guess JJ must have sent something to the practice page that a marketer set up, but I have no idea. I certainly never checked the thing.

On February 15, 2016, the bank foreclosed on my house and took the textile factory, which I still harbored a fantasy of reopening. Sam filed for divorce, and I was left with nothing. I was rattled to my core. I'm sure my resolve to say "no" to Fran's demands to prioritize quantity over quality was no longer as strong. But I never allowed it to go too far. I was always in charge, even if I could no longer banter quite as light-heartedly.

A few weeks later, JJ came over to celebrate me hitting "rock bottom." I know JJ meant well, but I wasn't quite ready to laugh. I ended up saying some things to JJ that day that I really regret, blaming JJ for things that were my own fault. I know Fran is saying I said something about Hadley being an ATM or whatever, but I don't remember that.

With Fran micromanaging and JJ gone, I was shattered. It was all I could do to keep up with the practice and my professional reading. I know how important it is to keep up with the latest in practice techniques and stay on top of the latest science. But in mid-August, Fran left early to go to a doctor's appointment, and I went back to the room where I had been seeing patients all day. I had treated the last patient with hydromorphone, and the small bottle of it was still on the table. Without really knowing why, I reached for it and filled a syringe. I have no idea whether or not I would have used it, but luckily, it didn't come to that. Fran burst into the room, and I froze, syringe in hand. Fran asked me how long I had been using and I told him/her the truth – that I had never used and – thanks to Fran – never would. Despite the many ways Fran has wronged me, including spreading lies about me after Hadley's death, I will always be grateful to him/her for walking through that door and preventing me from doing the unspeakable.

Still, Fran began to take over. One day, s/he made an offhand comment about the Medical Licensing Board, so we both knew s/he could ruin me. That gave her the power she needed. S/he began bursting into the exam room after just 5 minutes, announcing that "time was up" and I had another patient waiting. The percentage of our patients receiving opioid prescriptions definitely went up around this time until it was above the national average – not because I was practicing differently, but because of the sheer volume of new patients with that need!

Our working relationship just got steadily worse and worse, finally culminating on December 16, 2016. At the very end of the day when I was getting ready to go home, Fran burst into our treatment room, practically dragging Hadley McAdoo with him/her. Hadley's pain was real; she was sweating and shaking and could barely speak.

I scanned the intake sheet and looked at Fran for an explanation, but s/he pulled the paper away, saying, "You need to give Hadley something strong, ASAP." I told Fran to tell me what was going on. I remember asking Fran if s/he had asked Hadley if s/he was taking any other drugs, since it looked to me like Hadley might be having an adverse reaction or in withdrawal. Fran said Hadley wasn't taking anything. I started to ask about whether Fran had checked the new database that Pennsylvania set up for doctors to check on a patient's prescriptions. It wasn't required, but it was helpful. I had delegated Fran with using the system and s/he had checked it a few times in the past year when I asked.

"We don't have time for this!" Fran screamed in response, and for once, I thought s/he was right. Hadley's face was twisting in a mask of agony. She even started pulling at her own hair, a clear diagnostic sign of overwhelming pain. I didn't think we had anything strong enough in the room, so I told Fran to grab something from the vault where our narcotics are kept.

While I anxiously waited for Fran with Hadley's ragged breathing in my ears, I started rifling through the cabinets in the room. My fingers closed on the hydromorphone. This was a very strong opioid, so I had Hadley sign one of our general release and waiver forms. Fran still wasn't back, and Hadley needed help, stat. I drew forth a 2mg dose, which is the high end of the FDA-approved dosing, and injected it into the muscles of Hadley's arm. Almost as soon as I depressed the plunger on the syringe, Hadley was all smiles. I gave her a script for a low oral dosage opioid to take when the effects of the shot wore off and she walked out.

As we all know, Coach died that night of an overdose. What I can't figure out is that the released toxicology report show that Coach had taken something much stronger than I prescribed. Coach must have been hoarding pills.

I know I will have to work even harder to restore my reputation when the trial is over and I am declared innocent. I think it speaks volumes already that Pain Away is still in business and we still have a loyal patient base. The fact of the matter is that I always practice with reasonable care and in the best interest of my patients, whether they are national celebrities or down-on-their-luck locals. No matter who I am treating or how, I live by the words of the modern Hippocratic Oath, the real one: "I will apply, for the benefit of the sick, all measures that are required, avoiding those twin traps of overtreatment and therapeutic nihilism. I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

Statement of Sal Abbott

Pucker Face. A double black diamond with double fall lines to match, off the Rendezvous Bowl in Jackson Hole, Wyoming. One of the fastest, toughest ski trails on one of America's toughest mountains. They don't even run a lift there. You have to hike up for the privilege of skiing it. I took that hike in 2008. All day long, hike up, ski down. Around 2 PM, snow blew in. Cloud cover flattened the light, making it hard to see the contours in the snow. Tired eyes, tired legs, flat light: a skier's nightmare. I was at my top speed when I went down. Never had a chance. Broke my collarbone, separated my shoulder, even tore my rotator cuff as I went tails over teeth. They had to bring me down in the burrito… that's what they call the sled that ski patrol hauls.

Shouldn't have been all that bad. Coach Mac – that's Hadley McAdoo if you're not from Wisawe – taught us to be tough. Sprints until we puked, shaking off an injury. Boys, girls, it didn't matter. Mac coached the Homecoming Queen the same as the hardest guy in town. Coach set an example; she ran the sidelines for the whole '02 season with a torn ACL. No painkillers. That kind of example sticks with you. I once saw Kelly Simon take an elbow on the blocks, walk to the sidelines with a handful of her teeth, like Chiclets or something, hand 'em to coach, then take her own free throws. You work hard, you play hard. Pain is weakness leaving the body. So, when I went down on Jackson, I figured I'd be back on my feet and droppin' dimes by the time summer league came around.

I got amazing care at Kalmia University Medical Center. Thing was, hard as they tried, something just never got right. And I don't mean "you're old, Sal, it ain't gonna be like it was"; I mean "take a trey and your eyes flash blind from the pain." For three years, nothing worked: PT couldn't get my range of motion back, the doctors could not find anything wrong, and Advil stopped helping after a month or two.

I couldn't afford to take time for exploratory surgery, and I sure can't have my brain fogged by painkillers. I am a Certified Public Accountant, a certified actuary, and a certified financial planner. If you're going to work in Wisawe, you don't have the luxury to specialize. I'm proud to be an Elizabethtown alum, just like Coach Mac, but it's hard to punch a ticket to Wall Street from there. So I make every dollar I can, and I pay most of it in property taxes in Laurel Bluff! I'd rather have my girl at Wisawe High, of course, but not without Coach on the bench. And I'd rather cut off my right hand than have her at Crownvetch.

Oh, yeah, back to my shoulder. So, I was in an ocean of pain, the wrong side of thirty, with two kids under the age of six and one on the way. I was doing whatever work I could from home and sleeping at my desk. I had almost given in to the pressure for more surgery – with another year or more of recovery and PT to follow! – when my good friend JJ Teva introduced me to Dr. Rae. I wasn't happy to have a bunch of needles hooked up to a car battery jabbed in me or whatever, but what did I have to lose, right?

Best decision I ever made, I'll tell you that. My shoulder burned like fire, and that stuff Doc smeared on it smelled like yak dung. The kids wouldn't even give me a hug! After two weeks of treatment, though, I was able to lift Grace upseey-daisy, and after a month, I had my life back!

It took six sessions over four months to be pain free, and to be honest, I think the opioids did some of that. Whatever they were did it. I was back on the YMCA League court that winter, kids and all! The first time I went behind the back, cross-court, my depression lifted, and I was *me* again. Ball is life.

Needless to say, I know a bunch of former athletes, between E-Town's Blue Jay Athletic Club and the Wisawe High alumni association. Plus, Wisawe ain't exactly Harrisburg; it's hard *not* to know everybody here, especially when you've got two state titles to your name! If there's one thing old athletes like, it's talking about how great we used to be. But if there's another, it's yakking about the price we're paying, the knees that tell you when it's gonna snow, the fingers that you can't fit rings on, the shoulder that clicks like a model train. And now I knew what to tell them: before you get on that Oxy train, ya gotta see Dr. Rae.

I mean, I would have anyway, but Doc also needed the help. No head for business. A hand-painted sign? I mean, wow. S/He didn't even take my easy suggestions, like getting active in the Chamber of Commerce, or donating to Coach Mac's campaign. I mean, Mac was running unopposed; can you think of a safer bet for some easy referrals than the Genie of Elizabethtown and the head of City Council? Thank God I was able to convince Fran to send in a check in the practice's name, and at least someone there was thinking about expanding the patient base and upgrading the facilities. But what really did it for Doc was the appearance on *Today*. Nothing like a bit of press to make a business pop. I made it a point to push Doc to capitalize.

I guess it must have worked, because Doc went out on the limb and mortgaged it all for that gorgeous joint down by the river. Of course, I'm sure JJ had something to do with that. JJ could sell sand to the Pharaoh, and s/he always has two goals: (1) get promoted at the bank and (2) get control over some other aspect of Wisawe. Shafer was a perfect "twofer": a big investment that could pay off handsomely and a new business in town that JJ could capture. JJ wants it all. Always has, from Class President onward. S/He is not the brightest, necessarily, or wildly good looking or whatever, but s/he cares more about being liked than anyone I've ever met, and s/he is willing to go to lengths to get that affection. S/He's the kind of person who hits a full second serve, you know? Go big or go home.

But it's not always a happy ending. Sure, Bill Gates leaves Harvard to start his own little company, or Sara Blakely dumps every dime she has to bet on panty hose and winds up a billionaire. The American Dream. But about a third of all small businesses fail in their first two years, and another third are dead by the time they would turn ten.

And some get flooded out in six months. It's a bad beat for a good doctor. Wish I would have noticed that the insurance did not cover floods, but I didn't. I mean, it's not entirely my fault, right? That was a hundred-year flood, and I wasn't even forty! I would say that I regret it, but that wouldn't exactly be true. Coach taught that you have no regrets, ever. You move forward, work harder, and work better. So, no tears; now I know. Won't make the mistake next time.

Anyway, what really did in Doc was not the weather but the fallout from the whole Patricia Danica thing. Bad luck there, too. Everyone knows that Patricia was a fine Indy car driver who could never adjust to the stock car scene. Indy cars have a wide base, with a lower roll center.

They don't sway the same in the corners. And don't get me started on the differences in passing. There's no shame in that. Heck, look at Sam Hornish, Jr. Won everything on earth in IndyCar, couldn't stick in Sprint Cup. I guess Patricia figured there was no better way to keep your sponsors on board than to blame an injury. But to kick Doc when s/he was down – well that is about the lowest of the low.

People blaming Doc for Coach's death are just silly. Nobody wants to say it about the Genie, but by '14, she was on the way downhill. I think things started around 2010 or 2011. Coach had been in pain forever, of course, from that flagrant foul she took from Allie Gorman at Messiah. And she for sure wasn't the same ever since she left Wisawe High at the end of '13. It might have been just age, or losing her husband to cancer, or maybe just not having anything else to do, but she started complaining a lot more about the pain, replaying that play against Messiah again and again. She was a hero, and we respect our elders, so nobody said anything, but it was a different person, sadder, almost morose. Nothing like the Coach we knew.

When I heard that Coach was seeing Dr. Lefu Harrison, I knew things had gotten bad. First off, Lefu was the 5 for Crownvetch, and those pampered idiots were our bitterest rival. Second off, everybody knew that Lefu was the loosest doc in town. People even said that Lefu was in with the 5th Street Irregulars – you know, the motorcycle gang? – but I think sometimes folks just say that about anyone with a Harley and tats. Anyway, Lefu was raking in the cash. I know that he bought up a couple laundromats, has interests in two or three restaurants, and bought out the Park'n'Polish car washes. Sports medicine can be good money, but with our economy, the fastest way to that kind of cheddar is being willing to take your patients at their word about how much medication they need, if you get my drift. When my shoulder was aching, folks told me to go on over, that I could get Oxys or Percs on the first visit, no question. A couple even offered me extra pills he'd prescribed, like he'd told them he could take eight or ten a day and they only needed four. I can't say I was shocked when I heard about them losing jobs or going into rehab.

You gotta know, that's why I wanted Coach at Doctor Rae's. I knew that Doc's methods worked, *and* I knew that Doc would not just throw pills at the problem to try and make it go away. I drove Coach myself, right after Christmas 2013, when she was found sitting outside Johnson's Tap House, half-asleep, with the motor running. No charges were filed, of course. It's Coach, and the Wisawe PD knows how to run someone home and tuck 'em in, with no paperwork. But that don't mean you don't hear about it at the Cup o'Joe the next morning.

We all knew that Coach would never go into rehab of any kind– showing mental weakness? C'mon, man! – so I thought Doc would be the next best thing. JJ totally agreed. The only issue was that Coach was private when it came to pain – and JJ and I didn't think it was a good idea to tell Doc Coach was seeing Lefu. If Coach wanted to share, s/he should have herself. And really, we all figured that Doc would know what was going on. I mean, Coach passed out in a car!

I guess it didn't work as well as I had hoped, because Coach kept seeing other docs, too. Sometimes I would see her around town, and she looked rough, still complaining about pain, still not even able to raise her shoulder to wave. She even took to using a walker from time to time, or one of those motor scooter things you see on TV. We all thought it was a bit cray-cray,

because she could still walk, but you never know what's in someone's head. And, unfortunately, I would still see her from time to time over on the East Side of town, where I'm guessing she was seeing Lefu. Sometimes, I would take her to the pharmacy and maybe out for a bite or whatever. I got the impression that Coach would really say or do whatever to make sure she got the drugs she needed to make it to the next day.

I should say, though, that Coach wasn't that way every day. Not even close. When we played Crownvetch for the Regional Championship in March 2016, she walked proudly to her spot in the front row, screaming at each player by name. She even went into the huddle and diagrammed the out-of-bounds play that won the whole thing. For every day you saw her looking not right, there were three she looked alright, and one where you would never know it wasn't '03 again. Maybe it was Doctor Rae having a positive effect on her pain levels. Maybe it was the phase of the moon. Who can say? You just never knew which Coach would be there. If you didn't know her like we did, you'd probably think it was more like 75-25 good days and bad. But when you knew her back in the '90s, when she would rather lose a hand than admit she was hurting, you knew how bad things had gotten. The Rotary Club incident was probably one of the best examples. We all thought it was a revenge ploy to get back at those City Council folks who scapegoated her. It was funny, it was rude, it was pure Coach. I thought it was hilarious. JJ thought it was a drug fueled rampage. With Coach, I guess you never really knew.

JJ was a big advocate for Doctor Rae as well, at least until they had that falling out. I guess things that are said can't be unsaid. But after that point, JJ made a big point of how we could not trust Doctor Rae with Coach anymore. JJ also said something about Doctor Rae's injecting practices, but none of it made any sense. I mean, what does JJ know about medicine? For all JJ can say, Doctor Rae was injecting a steroid for an allergic reaction or whatever. They did that for me once. I'm crazy allergic to milkweed. I thought that was crazy, especially with the choice being Lefu, but JJ was insistent. S/He got all worked up and told me that Doctor Rae had been talking with other bankers and was looking to refinance the loan out from under First Wisawe. JJ called Doc a "Judas," and s/he said that Doc would not even give to Coach's campaign, which I thought was really strange. I mean, Coach had no chance of winning re-election in her condition, no matter how many trophies she put in the case, and I never saw campaign signs for her or anything. I don't know where that money was going. But JJ was really worked up about it, saying that s/he had promised Coach the contributions would come through and that Doc was risking her/his relationship with Coach. It was way over the top. If you ask me, JJ was upset that Doc and s/he weren't friends anymore. I mean, what did JJ expect, her/his bank was foreclosing on Doc!

As the de facto accountant for Pain Away, I was always looking at the books. Yes, after the business was reborn after Sandy, Doc's clientele changed. It was natural. The business was focused on the local community. And when the local community is blue color workers, there are bound to be more workplace injuries and more people who need relief from them to work, meaning more of a need to prescribe opioids. Sure, the volume of patients increased, but that was really because Doc is good at what s/he does. I saw the numbers – Doc was not running a pill mill – just practicing good medicine.

If anything, the problem with that practice was never Doc, but her/his assistant Fran. She was just about the worst person in Doc's life. You could tell Fran really wanted to run the place, and they fought like crazy. I don't know why Doc kept that vampire around. But Doc and I had good meetings when I came in for treatment, and I never felt as if I was being rushed. S/He spent time with me, got to know what was going on in my life. For all of Fran's pushing to make the place a factory for pain sufferers, Doc treated me with concierge-like personal service.

So, business was improving, as was Doc's standing in the community. S/He was invited to the high school to talk about the dangers of painkillers and addiction, s/he started coming out to Dhillon's for a beer now and then, and s/he got invited to join the Rotary as a permanent member. Doc was on the road to reputation recovery.

I have never told anyone this, but I saw Coach a couple days before she died. I was bringing her back from a pharmacy visit that didn't go well; she said something about the CVS computer being screwed up. I walked her inside, and it was a mess. Pill bottles were everywhere, most or all of them empty, different drugs from different docs from the looks of it. Half her personal trophy case was scattered around, and there were dirty dishes in the sink. Coach just kicked the mess on the floor aside, collapsed into the chair next to the TV, and tuned me out. I hate that that's my last memory of her.

Anyway, Doctor Rae did her/his best, and we all knew that Coach wasn't right. You make the best choices you can, in the moment. That's all Coach demanded from any of us, and it's all she would have demanded from Doc. Do I wish things were different? Yeah, no doubt. But it ain't like she was gonna get better with Lefu. Hell, she would'na wanted to be alive in pain *or* lit on painkillers, living in filth. So, I'd do it again the same way. 'Course I would. No regrets.

Statement of Ry Haight

The thing about pain that makes it really funny, from a medical perspective, is that it's so *un*-scientific. Medical professionals are trained to take the subjective and make it objective, to test it and figure out how big it is, what caused it, and what will make it shrink or grow.

Pain isn't like that. There is no objective way to measure pain; not only can we not tell what level of pain you're experiencing, but we cannot tell whether that pain is greater than the pain someone else is experiencing. And we often can't tell where it comes from, how it got there, or how to get rid of it. A patient may wake up one day and feel like his leg is literally on fire, and we won't know why. We can label it – "neuropathic pain" – but the name carries no power. Western medicine has discovered ways to suppress pain, meditation can control it to a degree, and acupuncture can be extremely effective in some individuals… and we don't fully know why. At different times, pain has been an inevitability, a symptom, and even the disease itself. That's why it's fascinating. That's also why Rae Shafer is no guiltier of a crime than you or I.

As a professor, I study pain. I know, I know, it sounds like the lead-in to a joke, and believe me, I have heard them all. But there are not many frontiers left in medicine, and pain is one of them. I have dedicated four decades of my life – alongside countless other innovators – to fighting it.

The ambiguity of pain is at the heart of this case. It is easy to sit on the sidelines, as High Priest Royal Copeland of the Church of Drug Diversion does, and criticize those who treat pain as fools, suckers, or crooks. But it is another to sit with a patient who is weeping and place yourself as arbiter of that person's truth. Someone says they have a fracture? You x-ray it. Cancer? A CT scan or a PET scan, and there's the mass… or not. But pain is different. When you tell someone they do not have cancer, it is because you can determine that there is no cluster of cells multiplying in an uncontrolled fashion. If you decide that they do not have pain, or that their pain is not that bad, really, you are simply playing God.

Make no mistake about it: opioids are powerful, but sometimes power is needed. I would no more give an opioid to someone with a headache than you would, but what are you going to say to an athlete with a shattered leg? Tough it out? Take a couple ibuprofen? Maybe thirty years ago. But with the creation of oxycodone and its formulation with acetaminophen – what you probably know as Percocet – we had a solution. And what about the end-stage cancer patient? Must we make them inpatients to give them a constant morphine drip, so they're half-conscious for their last weeks or months, wasting away in a bleached room away from their home and family? As much as Copeland derides it, that's why we made fentanyl. And I suspect that many of those who rail in the newspapers against drug companies have never seen the gratitude fill a patient's eyes when the pain goes from suicide-inducing to manageable, when they get "normal" back in their lives after living in a haze of pain.

So, how then does one determine how to treat pain? How does one say with confidence that this patient needs acupuncture, this one a small dose of opioids, and this other a heavier dose?

Yes, these medicines are addictive. Yes, they can be lethal in the wrong combinations. Yes, in the wrong hands these are as dangerous as a loaded gun. And yes, the medical profession has

made mistakes with them at times. But of course, so did the government! I doubt Copeland is eager to mention it, but did you know that the Department of Health and Human Services treated pain like a *vital sign* as recently as 2015? Pain was thought of like blood pressure, or respiration, something to be corrected if abnormal using medication. In fact, HHS reimburses doctors and hospitals based in part on scores on patient surveys, and one of the major questions for years was how well they managed pain *with these very medications*! In the last decade, the government has pushed these drugs as hard as anyone!

So, I respect Royal Copeland's mission, and one cannot help but join the efforts to seek the end of the opioid epidemic. But bias cannot substitute for data. It is irresponsible to reject any explanations that do not fit a predetermined narrative. Every fact upon which Copeland relies can be explained equally plausibly as proper practice or a minor deviation from it.

Let's take the facts in turn.

Hadley McAdoo presented to the Pain Away clinic – excellent goal, but a ghastly name – on January 12, 2014, in extreme pain. McAdoo was one of a category of patients with what we call idiopathic pain, that is to say pain for which we cannot find a precise cause. But as in the case of neuropathic pain, above, that does *not* mean that it is not real. It is all too real, and all too frustrating. What Copeland insists is evidence of drug-seeking is equally explained as evidence of relief-seeking. There is no basis, medically, to say that someone is not experiencing pain, just because we cannot locate a specific physiological cause. Someday, when the science has advanced, perhaps pain will be like cancer, detectable and measurable. But today, there are patients with very genuine pain without any physical marker. Copeland can no more assess whether McAdoo was faking pain than s/he can give you next week's lottery number.

Similarly, it is true that Pain Away's patient base grew over time. That's what one would expect from a good doctor! Especially for young physicians, word of mouth advertising is some of the most effective kind. As I tell my students, it takes years to build a reputation, but minutes to destroy one. It's only natural that after years of building, a quality physician's practice will grow.

The increase in opioid prescriptions is also predictable, at least to a point. Many young physicians have a crusader mentality. It is natural that a physician like Rae Shafer, coming from an experience that soured her/him on opioids, would eschew them. But over time, young doctors learn that things are not so cut and dry. They trend toward the mean, gradually joining the majority position on most things. Including prescribing habits.

Of course, this does not explain entirely why Shafer would be somewhat above the mean in opioid prescriptions per patient for a physician at a pain clinic. Additional study would be needed to determine that. But one can imagine it could be because patients in more severe pain were coming to Pain Away as its reputation grew. There are, of course, less savory explanations. I must be forthright; just as Copeland cannot rule out the positive possibilities, I cannot rule out ones that are problematic. Or even criminal.

But patient mix explains much. Those in the Wisawe community with the means to do so come to the Sackler Clinic of Medical Pain Management at Kalmia University, where they receive care

from the leading specialists in the world. No middle manager at Xenopharma can afford that kind of treatment, much less the general population. For these citizens, Medicaid is the safety net on which they survive. And Medicaid reimbursement is pitiful, which is why the Sackler Clinic is not a Medicaid provider.

But being poor and being in pain are not mutually exclusive. So where can these individuals go? Many physicians now shy away from opioid painkillers – Copeland is succeeding in chilling the community! – and lack the specialized knowledge to assess and treat chronic pain. So, these poor souls must find a pain management specialist. In Wisawe and the immediate surrounding communities, that means Rae Shafer. So, *of course* you do not mind rushed visits and a bit of lip service from an overtly aggressive nurse. *Of course* they line up all morning; Shafer is the only person who is willing to help them manage their agony!

The same logic can be applied to the suggestion that polydrug consumption suggests that McAdoo was drug-seeking. That's absurd. Place yourself in the position of someone with chronic pain. You never know when you wake up if you will feel good or bad, if you will be your best self or unable to move your limbs, trapped in an agonized haze. And you know that relief is temporary and fleeting; whatever you do next could cripple you, and there's no way of predicting what will set off your pain. Over time, would that not make you anxious? It is hardly surprising that many chronic pain patients eventually need medication to sustain their mental health.

Now we get to the heart of the situation: what happened when a lapsed patient returned to the clinic. First, there ought to have been some kind of paperwork completed about the individual's medical condition. We see that there was; an intake sheet was completed with McAdoo upon arrival. Note that it does not show a prescription for any benzodiazepine. So right from the jump, Dr. Shafer was disadvantaged.

Now why would a patient not mention a medication? There could be many reasons. Copeland only looks at one: drug-seeking. But just as likely is that the patient forgot. Keep in mind that McAdoo had only been on Xanax for a few weeks at that point and was in intense pain.

Which does lead to one area in which I find the records lacking. There is no indication in the progress note – at least as recorded before McAdoo's death – that Shafer specifically asked about benzodiazepines. However, my review of the record shows Dr. Shafer did ask the intake nurse if the patient reported taking any other drugs and the nurse said the patient had not. Nevertheless, it is a best practice before administering an opioid to ask specifically about benzodiazepines; given the well-known interaction between the classes of drugs, it is far better to be safe than sorry in this regard. That's what I teach my students.

I suppose that this is where I must clarify the difference between "best practice" and "required;" I know you attorneys get caught up in such things. I teach what I think the very best physicians are doing and what all physicians ought to be doing. That is, I say with a mix of regret and understanding, not how the "real world" works. The "usual course" of professional practice is *much* broader than that, and many pain management specialists – even good ones! – do not adhere to the practices I teach. Frankly, many cannot do so, given the volume of patients they see. If you are seeing more patients, you necessarily have less time with each one, and even

less time still to complete administrative tasks. This can lead to some omissions of what would otherwise be desirable. The "usual practice" of medicine is not negligent, but the standards at Sackler are far above those of lesser offices. Were I to make a mistake like failing to ask about benzodiazepines, I would be horrified.

This leads to what I consider a key question here, that of the PDMP. The state DMPs are one of the most significant innovations of the last ten years. They give doctors a real-time ability to verify what they are being told and to avoid the most problematic of drug-seeking patients. It is natural for Copeland to fault Dr. Shafer for failing to check the database, which would have revealed the fact that McAdoo had filled a prescription for Xanax only a couple weeks before. However, this "best practice" was not a legal requirement. Pennsylvania rules absolutely did *not* require that the PDMP be searched for each prescription.

Nor did Pennsylvania rules require urine screening. They still don't today. Of course, today routine drug screening is strongly recommended by both the CDC and the Pennsylvania Department of Health for any opioid patient with risk factors, like a family history of addiction or mental health issues. And it is recommended for all patients receiving opioids long term. But that recommendation is only in the last year or two. At the Sackler Clinic, we started testing in 2009, after an article was published by Roger Chou and others in the *Journal of Pain* recommending it.

But while that was the practice at Kalmia, and the practice that I taught, I know many community practitioners did not, although fewer and fewer did not at least urine test over time, as the opioid epidemic developed. Urine testing has become quite common, because you want to know about the metabolic effects that your prescription is having, but I still think not universal, at least for patients without other mental health issues or history of addiction. Thus, I suppose was within the spectrum of professional practice – regrettably – for Dr. Shafer to fail to check the PDMP or urine test. It was not good practice, but if we started handing criminal penalties to anyone who did not meet the standards of my Sackler Clinic, there would be no doctors left to treat patients.

Was Dr. Shafer's professional practice to the same standards as mine? No. Was it to the standards I wish s/he had been able to maintain? I have to say I question some of Dr. Shafer's decisions about practice. But was it criminal? I think not.

And now the final question: should Dr. Shafer have suspected that Hadley McAdoo was abusing drugs? The answer is, again, not necessarily. Yes, there were some risk factors: a long-term opioid user paying in cash for the service absolutely can be an eyebrow-raiser. And there may have been other warning signs in behavior or presentation. But whether one ought to have suspected opioid abuse depends principally on the physical exam and the mental status assessment. None of us – not me, not Copeland, not even the nurse – is as qualified as Dr. Shafer to make that assessment.

The signs and symptoms of addiction are not immediately differentiable from the symptoms of severe pain. Think about the worst pain you've ever felt. Remember how it made you act. Maybe you walked with a halting gait or a hunch, because you couldn't focus? Maybe your

eyes teared from the pain. Maybe you were distracted, couldn't quite push through the pain to follow what was going on? Now think of a time you have seen someone highly intoxicated. Consider how they looked and acted. The same, right?

And this is to say nothing of the fact that those in chronic pain have trouble sleeping. Imagine everything I've just said, but now you're only getting three or four good hours of sleep for weeks on end. You would be woozy, unbalanced, and unable to concentrate. To an untrained or undertrained observer, you would appear intoxicated. That's why this must be a matter of clinical judgment, to be made in the moment by a trained, experienced professional, not a question to be revisited months later by others who are not there. You have to trust the doctor in these situations.

That is why the Pennsylvania Code allows for a wide range of "usual courses" of "professional practice." No physician should go to jail for not meeting my personal desires for the profession, or anyone else's.

Everyone actually present agrees that Coach was in worse pain than ever before. So the injection could be used as a logical treatment for an acute pain and the extra pills a means of controlling that pain, so it does not become acute again. Hydromorphone is a common medication for opioid-tolerant individuals experiencing new or breakthrough pain, i.e. pain that is "breaking through" their other painkillers. Injecting Hadley McAdoo may have been a mistake, particularly since Dr. Shafer chose a high dose intramuscular injection. In many cases, it is better to use a slow dose intravenous method instead. But even giving the maximum dose intramuscularly was absolutely legal and FDA-approved. Physicians must accept that their mistakes may be fatal; it is a fundamental reality of the profession.

It is understandable to want to say, "We did something about opioids." But scapegoating a good doctor will not solve America's problems. As Teddy Roosevelt famously said, "It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena… who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming…"

I have been told that it is necessary that I discuss my compensation. I have formed my opinion after a thorough review of the records in this matter, and my opinion is based on my years of experience in this field. I was paid $12,300 to review the records and prepare for testimony, and I will be paid an additional $7,000 should there be a trial of this action, in compensation for the time I am required to leave my clinical, teaching, and administrative duties. The rate I am charging for this matter is consistent with my rate in other cases, and I have testified as an expert on numerous occasions in court, legislative bodies, and administrative tribunals. My understanding is that Dr. Shafer is quite destitute. Accordingly, in this case, I am accepting payment through Dr. Shafer's counsel from a third party who supports Dr. Shafer but who wishes to remain anonymous, even to me.

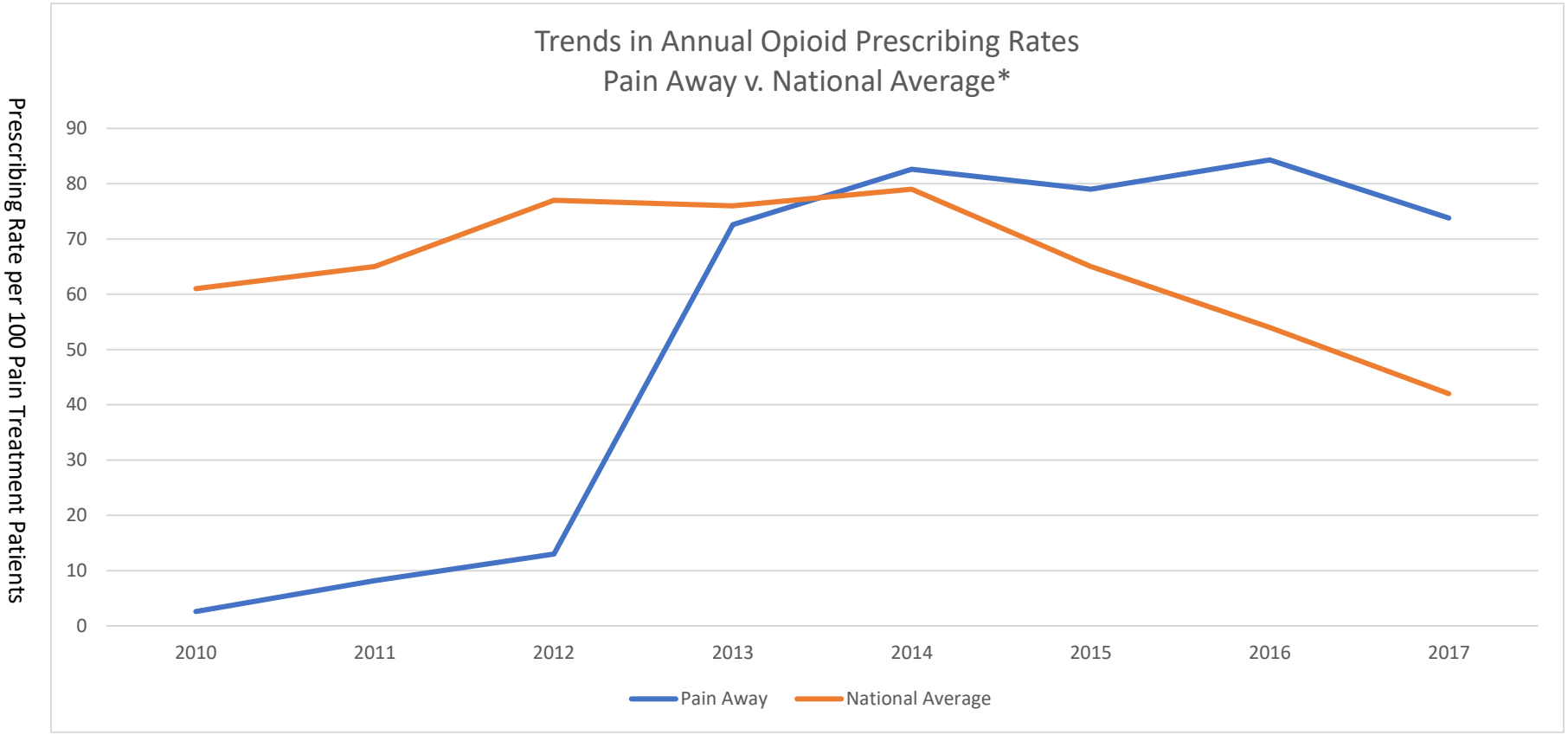
Exhibit List

Exhibit 1	Pain Away Historic Holistic Prescription Chart
Exhibit 2	Email Exchange between Sal Abbott and JJ Teva
Exhibit 3	Pain Away Intake Sheet
Exhibit 4	Facebook Messenger Message
Exhibit 5	CBS Sportsline Article
Exhibit 6	CDC Guideline for Prescribing Opioids for Chronic Pain
Exhibit 7	CDC/AHA Pamphlet: Prescription Opioids: What You Need to Know
Exhibit 8	Training Record – Royal Copeland
Exhibit 9	Curriculum Vitae – Ry Haight
Exhibit 10	Dispensing Record – Wisawe Pharmacy and Topiary Shoppe
Exhibit 11	PDMP Printout – Hadley McAdoo – 10/1/2016 through 12/13/2017
Exhibit 12	Ambulance Trip Sheet
Exhibit 13	DEA/WDOH Bulletin 123-55: Topic: Benzodiazepines

Exhibit 1

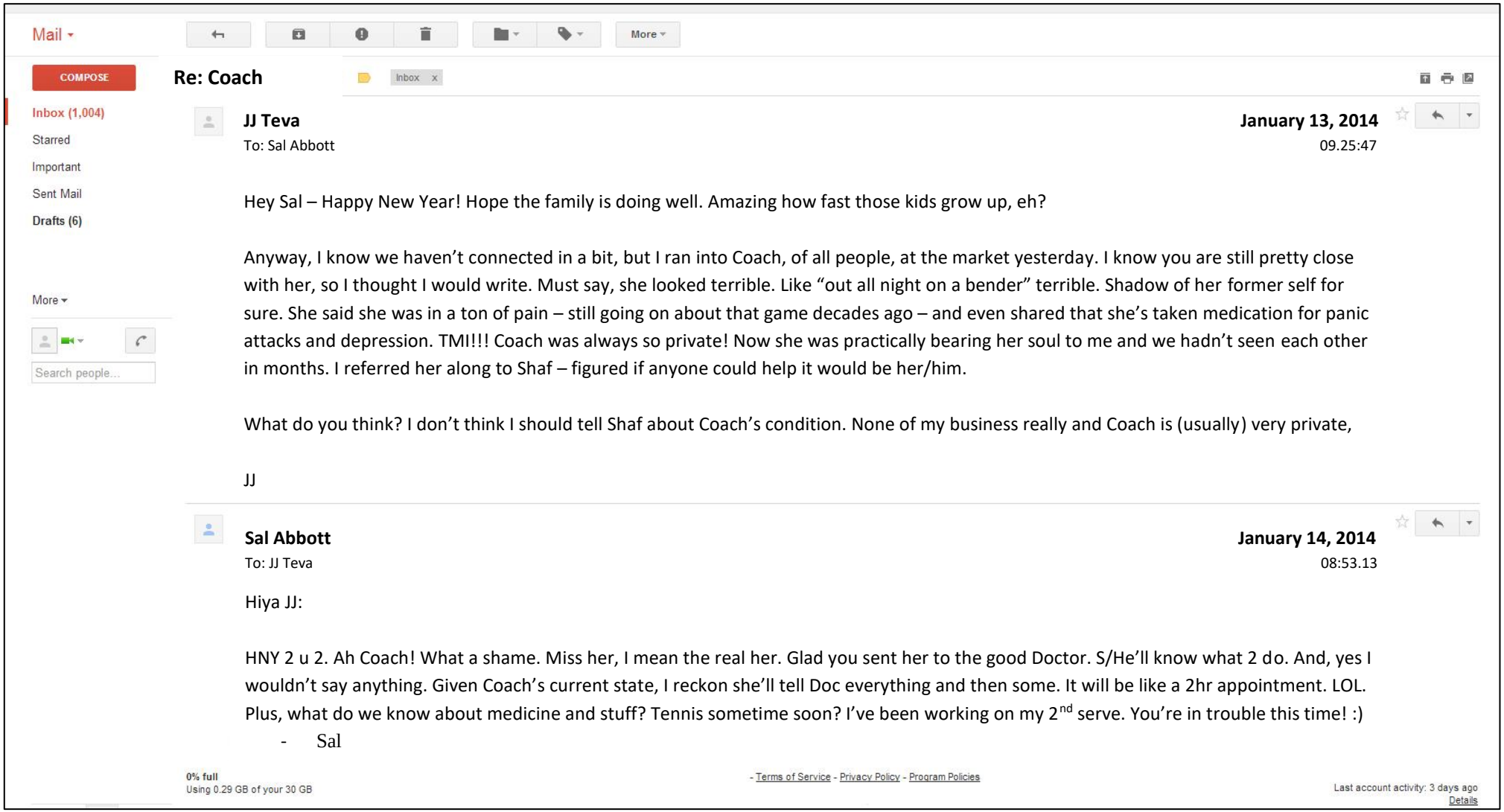
Historic Holistic Prescription Chart

Year	# of unique patients	# of patients prescribed opioids	Pain Away Prescribing rate per 100 patients	National Average prescribing rate per 100 pain medicine*	Average Dosage Morphine milligram equivalent (MME)	National Average MME*	Average # of days per prescription	National Average # of days per prescription*
2010	76	2	2.6%	61%	25.1	45.3	7	14
2011	159	13	8.2%	65%	37.8	47.1	5	14
2012	921	120	13%	77%	35.1	44.8	3	16
2013	84	61	72.6%	76%	45.2	45.7	15	15
2014	190	157	82.6%	79%	50.1	45.2	21	15
2015	704	556	79%	65%	52.2	46.7	27	16
2016	1205	1017	84.3%	54%	46.9	44.2	23	18
2017	1376	1016	73.8%	42%	52.6	45.3	30	17



* National data taken from United States Centers for Disease Control public website

Exhibit 2



Mail

More

COMPOSE

Inbox (1,004)

Starred

Important

Sent Mail

Drafts (6)

More

Search people...

Re: Coach

Inbox x

JJ Teva
To: Sal Abbott

January 13, 2014
09.25:47

Hey Sal – Happy New Year! Hope the family is doing well. Amazing how fast those kids grow up, eh?

Anyway, I know we haven't connected in a bit, but I ran into Coach, of all people, at the market yesterday. I know you are still pretty close with her, so I thought I would write. Must say, she looked terrible. Like "out all night on a bender" terrible. Shadow of her former self for sure. She said she was in a ton of pain – still going on about that game decades ago – and even shared that she's taken medication for panic attacks and depression. TMI!!! Coach was always so private! Now she was practically bearing her soul to me and we hadn't seen each other in months. I referred her along to Shaf – figured if anyone could help it would be her/him.

What do you think? I don't think I should tell Shaf about Coach's condition. None of my business really and Coach is (usually) very private,

JJ

Sal Abbott
To: JJ Teva

January 14, 2014
08:53.13

Hiya JJ:

HNY 2 u 2. Ah Coach! What a shame. Miss her, I mean the real her. Glad you sent her to the good Doctor. S/He'll know what 2 do. And, yes I wouldn't say anything. Given Coach's current state, I reckon she'll tell Doc everything and then some. It will be like a 2hr appointment. LOL. Plus, what do we know about medicine and stuff? Tennis sometime soon? I've been working on my 2nd serve. You're in trouble this time! :)

- Sal

0% full
Using 0.29 GB of your 30 GB

- Terms of Service - Privacy Policy - Program Policies

Last account activity: 3 days ago
Details

Exhibit 3

INTAKE SHEET

Patient Name: H. McAdoo Gender: F

Date of Birth: DNR Race: Wh

Occupation: Retired Marital Status: S M D (W) (circle one)

Insurance Carrier: NA Plan/Group ID: NA Primary Care Physician: Hanson

Do you smoke?: No How often?: ———

Do you drink alcohol?: Y How often?: 6-pack/wk

Have you been treated for any of the following?

☐ Diabetes	☐ Stroke	☐ HIV/AIDS	☐ Kidney Problems
☐ Breathing Issues	☐ Hepatitis	☐ Heart Attack	☐ Liver Problems
☑ High Blood Pressure	☐ Anxiety	☑ Ulcers	☑ High Cholesterol
☐ Anemia	☐ Cancer	☑ Depression	☐ Thyroid Problems

Do you have any of the following symptoms:

☐ Weight Loss	☐ Nausea/Vomiting	☐ Difficulty Breathing
☐ Chest Pain	☐ Painful Urination	☑ Headaches
☐ Seizures	☑ Numbness	☐ Changes in Bowel Habits
☑ Pain	Specify Pain: Shoulder/Arm	

Current Medications (Prescriber):

Lipitor 10 mg (Alsberg)

Ry Cadura 15mg (Shafer)

Lopressor 100mg (Alsberg)

Primary Complaint: ↑ Arm Pain, crippling

History of Present Illness: Sudden onset overnight

Auto Collision?: Y or (N) (circle one) Is Your Illness Job-Related: Y or (N) (circle one)

Were You Referred By an Attorney: Y or (N) (circle one)

Completed By: FK CMP

INTAKE EXAM

Patient Name: H McAdoo Date of Service: 12/16/16

Vital Signs:

Temp: 98 Elevated?: Y or (N) (circle one)

HR: 110 Elevated?: (Y) or N (circle one)

BP: 140/90 Elevated?: (Y) or N (circle one)

Resp. Rate: 19 Elevated?: (Y) or N (circle one)

Observations:

Skin – Normal?: Y or (N) (circle one) If no: Sweaty

Pupils – Normal?: (Y) or N (circle one) If no: _____

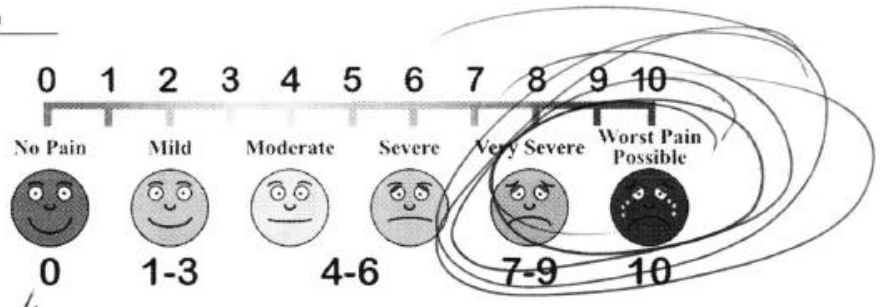
Affect – Normal?: Y or (N) (circle one) If no: Panicked

Gait – Normal?: (Y or N) (circle one) If no: Hitty

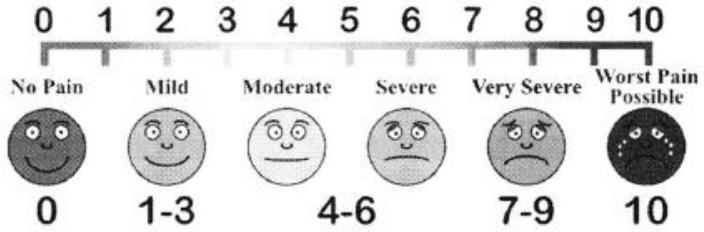
Speech – Normal?: (Y) or N (circle one) If no: _____

Pain Levels:

Location: Arm



Location: N/A



Completed By: FK CMA

Exhibit 4

Search JJ Home Create

Pain Away | Rae Shafer, MD
Active 6h ago

Pain Away | Rae Shafer, M.D.
You're friends on Facebook

12/02/2016 10:04AM

Hey Shaf.

I wouldn't normally blast your busienss FB, but you dont return calls or texts. Listen, I know you hate me and I know that you feel that I betrayed you. It is hard for me to admit that I was wrong, but I was wrong. I should never have let you think the bank would give you more money. Please do not hold a grudge. Seriously. You know how I feel about you and our friendship. Dont throw it away. I am more than willing to forget that entire incident at your office with the Rock Bottom Party. Anyway, I hear you are doing better these days - with the finances and patients.

Look here's the deal. I am not one to spread rumors or suggest medical care - but I saw Coach the other days and she is not good. I think she is on prescription drugs all day. She was popping Xanax like after dinner mints. No one is that anxious. She says she is depressed andin constant pain. She does not need more drugs. She needs rehab.

Once upon a time you were part of the solution. Now you are part of the problem and we all know it. Stop being part of the problem. Help us help Coach. If you can redeem yourself, the practice will follow. THX!

JJ

Type a message...

Pain Away | Rae Shafter, MD
Active 6h ago

Options

Search in Conversation

Edit Nicknames

Change Color

Change Emoji

Notifications

Shared Photos

Exhibit 5

Patricia Danica not racing in 2013 NASCAR season - blames accupuncture

by Legan Arabach

It wasn't that long ago that Patricia Danica had her eyes set on winning the NASCAR Sprint Cup Championship. Now that dream seems as if it has never been further away.

On November 21, 2012, Danica officially bowed out of the 2013 NASCAR season. The culprit: acupuncture. Yes, that's right, acupuncture.

Danica's chronic neck pain has been well-documented ever since her infamous crash in turn 3 at Pocono Raceway back in 2009. She has had surgeries two of the last three off-seasons and was rumored to have tried a variety of alternative medicines. Well, wonder no longer. Apparently one of those was "electro-acupuncture" at the now defunct Pain Away clinic in Wisawe, Pennsylvania, and it went horribly wrong. Danica's public statement read:

"I made a terrible mistake in my pursuit of greatness and trusted this quack doctor, Rae Shafer, to treat my neck. S/He had no clue what s/he was doing and ended up causing paralysis in my arm. I have experienced extensive nerve damage that prevents me from gripping the wheel. Full recovery will take a long time. No one should trust this so-called medical procedure."

If that sounds a tad defensive, that's because it is; skeptics on social media have suggested Danica is using her injury as an excuse for a dwindling sponsorship and a decreasing fan base. Still, with a strong performance this year at Dover, there was hope for a rebound in 2013. The entire NASCAR world hopes for Danica to have a speedy recovery in her quest for the podium in 2014.

Exhibit 6

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Promoting Patient Care and Safety

THE US OPIOID OVERDOSE EPIDEMIC

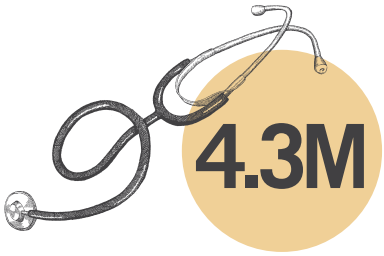
The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

40

More than 40 people die every day from overdoses involving prescription opioids.[1]

165K

Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.[1]



4.3M

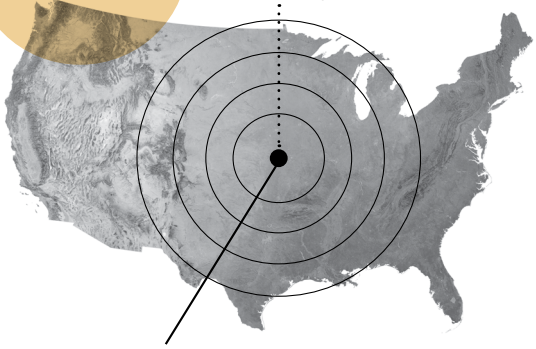
4.3 million Americans engaged in non-medical use of prescription opioids in the last month.[2]

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.

249M

prescriptions for opioid pain medication were written by healthcare providers in 2013



enough prescriptions were written for every American adult to have a bottle of pills

[1] Includes overdose deaths related to methadone but does not include overdose deaths related to other synthetic prescription opioids such as fentanyl.

[2] National Survey on Drug Use and Health (NSDUH), 2014

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

NEW CDC GUIDELINE WILL HELP IMPROVE CARE, REDUCE RISKS

The Centers for Disease Control and Prevention (CDC) developed the *CDC Guideline for Prescribing Opioids for Chronic Pain* (Guideline) for primary care clinicians treating adult patients for chronic pain in outpatient settings. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. The Guideline was developed to:

- Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain
- Provide safer, more effective care for patients with chronic pain
- Help reduce opioid use disorder and overdose

The Guideline provides recommendations to primary care clinicians about the appropriate prescribing of opioids to improve pain management and patient safety. It will:

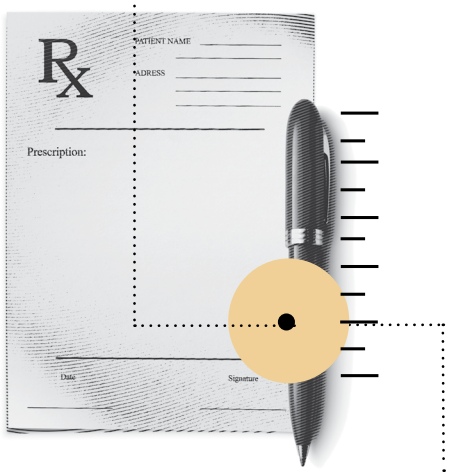
- Help clinicians determine if and when to start prescription opioids for chronic pain
- Give guidance about medication selection, dose, and duration, and when and how to reassess progress, and discontinue medication if needed
- Help clinicians and patients—together—assess the benefits and risks of prescription opioid use

Among the 12 recommendations in the Guideline, there are three principles that are especially important to improving patient care and safety:

- ☑ Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- ☑ When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- ☑ Clinicians should always exercise caution when prescribing opioids and monitor all patients closely.

To develop the Guideline, CDC followed a transparent and rigorous scientific process using the best available scientific evidence, consulting with experts, and listening to comments from the public and partners.

patients receiving long-term **opioid therapy** in primary care settings



struggle with **opioid use disorder.**

PATIENT CARE AND SAFETY IS CENTRAL TO THE GUIDELINE

Before starting opioids to treat chronic pain, patients should:

- Make the most informed decision with their doctors
- Learn about prescription opioids and know the risks
- Consider ways to manage pain that do not include opioids, such as:
  - Physical therapy
  - Exercise
  - Nonopioid medications, such as acetaminophen or ibuprofen
  - Cognitive behavioral therapy (CBT)

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC RECOMMENDATIONS

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 OPIOIDS ARE NOT FIRST-LINE THERAPY

Nonpharmacologic therapy and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

2 ESTABLISH GOALS FOR PAIN AND FUNCTION

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 DISCUSS RISKS AND BENEFITS

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING

When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

Immediate-release opioids: faster acting medication with a shorter duration of pain-relieving action

Extended release opioids: slower acting medication with a longer duration of pain-relieving action

5 USE THE LOWEST EFFECTIVE DOSE

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 **morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

7 EVALUATE BENEFITS AND HARMS FREQUENTLY

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS

8 USE STRATEGIES TO MITIGATE RISK

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent **benzodiazepine** use, are present.

9 REVIEW PDMP DATA

Clinicians should review the patient's history of controlled substance prescriptions using state **prescription drug monitoring program (PDMP)** data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 USE URINE DRUG TESTING

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

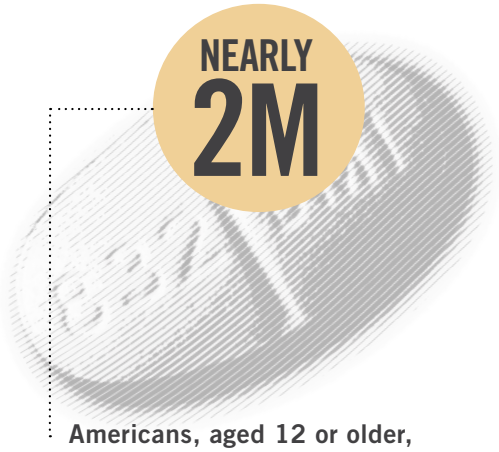
12 OFFER TREATMENT FOR OPIOID USE DISORDER

Clinicians should offer or arrange evidence-based treatment (usually **medication-assisted treatment** with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Naloxone: a drug that can reverse the effects of opioid overdose

Benzodiazepine: sometimes called "benzo," is a sedative often used to treat anxiety, insomnia, and other conditions

PDMP: a prescription drug monitoring program is a statewide electronic database that tracks all controlled substance prescriptions



Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

Medication-assisted treatment: treatment for opioid use disorder including medications such as buprenorphine or methadone

Exhibit 7

PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as **1 in 4** PEOPLE*

receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

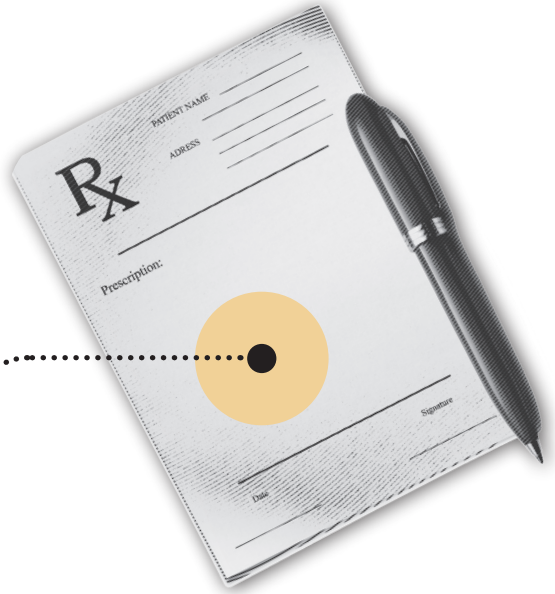
American Hospital Association®

CS264107C May 9, 2016

KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- Pain relievers such as acetaminophen, ibuprofen, and naproxen
- Some medications that are also used for depression or seizures
- Physical therapy and exercise
- Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- Never take opioids in greater amounts or more often than prescribed.
- Follow up with your primary health care provider within ____ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

Exhibit 8

DEPARTMENT OF JUSTICE CENTRAL TRAINING RECORD

Employee: Copeland, Royal — Employee ID No.: 91513
Entrance on Duty: 10.27.2013 — Record Created: 10.27.2013
Position: Diversion Investigator

Prior Training (Credited):

Police Academy - CHI PD

Firearms (Basic)	Narcotics (Basic)	CPR/First Aid
Procedures (Basic)	Fingerprints (Basic)	Driving (Basic)
Crime Scene (Basic)	Organized Crime/Drug Gang (Basic)	
Use of Force (Basic)	Law Enforcement Documentation (Basic)	
Covert/Undercover Operations (Basic)		
Covert/Undercover Operations (ADV)		

Bachelor/Equivalent: Criminal Justice I
Associate/Equivalent: Auto Repair
GED/Equivalent

Entrance on Duty Training (Federal Law Enforcement Training Center):

Federal Law (Basic)	Narcotics Identification (ADV)
Close quarters combat (Basic)	Narcotics Investigation (ADV)
Firearms (Basic)	Counterintelligence (Basic)
Use of Force (Basic)	Sexual Harassment/EEO (Basic)
Responsible Computer Use (Basic)	Covert/UC Ops. (Basic)
Tactical Driving (Basic)	Documentation (Basic)
Welcome to the DOJ! (Basic)	Crime Scene (Basic)
Covert/UC Ops. (ADV)	Criminal Discovery (Basic)
Hatch Act/Professional Responsibility (Basic)	
Controlled Substance Diversion (ADV)	

Additional Training:

- Pharmacy Audit Certification (ADV)
- Physician Office Audit Certification (ADV)
- Hospital Audit Certification (ADV) (FAILED - NO CREDIT)
- Controlled Substance Chemistry (ADV)
- Controlled Substance Diversion (Opioid Focus) (ADH)
- Prescription Drug Monitoring Program - Data Query Certification (Basic)
- Controlled Substance Diversion (Other) (ADH)
- Financial Crimes (Basic) (FAILED - NO CREDIT)
- Narcotics Investigation (Basic) (INS)
- Developing Confidential Sources (Basic)
- EOD/New Agent Training - Chicago (Basic) (INS)

ADDL EDU CREDIT: MPH (UNIV PHX)

ADV: Advanced ADH: Advanced, High Level INS: Instructor

Exhibit 9

RY HAIGHT, M.D., Ph.D.

EDUCATION

Kalmia University
Fellowship, Neurology and Pain Management, completed 2001
Residency, Internal Medicine, completed 1999
Internship
University of Pennsylvania, M.D./Ph.D. (Neurobiology), 1995
Harvard University, B.S., Integrative Biology, 1989

EMPLOYMENT EXPERIENCE

Kalmia University School of Medicine, Department of Neurology
Janssen Clinical Professor of Medicine, 2010-Present
Founder, Director, Sackler Clinic of Medical Pain Management, 2003-Present
Associate Clinical Professor of Medicine, 2001-Present

Clinician, professor, and preceptor in the pain management program. Responsibilities include clinical patient care, training and mentoring medical students and residents, obtaining research funding and grants for expansion and operation of Sackler Clinic.

OTHER RELEVANT EXPERIENCE

American Neurological Association, Member, 2001-Present

American Academy of Pain Medicine, Member, 2003-Present

Board certified in Internal Medicine, 1999-Present

Board certified in Neurology, 2004-Present

SELECTED RECENT RESEARCH, SPEECHES, AND PUBLICATIONS

With JR. Bartels and F. Rody, *Pain Mediation Methodologies in a Clinical Setting: A Differential Analysis*, Annals of Internal Medicine, Oct. 17, 2017

Unrelenting, Unending Pain: The Case Against Restricting Prescription of Fentanyl, American Academy of Pain Management, sponsored talk (Purdue Pharmaceuticals), Spring 2017

Pain as a Vital Sign: Steps and Mis-Steps of a Movement, Science, Oct. 27, 2016

Drug Diversion and the DEA: An Important Step Forward or an Unholy War on Patients?, Time, June 30, 2016

Opioid Painkillers: A Study of a Powerful Tool Maligned Unfairly, American Academy of Pain Management, sponsored talk (Purdue Pharmaceuticals), Spring 2016

Principal Investigator: Phase III Clinical Trial for Fentasynol, experimental hydrocodone analogue; double-blind study of use in 250 patient cohort (sponsor: Purdue Pharmaceuticals)

Your Medicine Cabinet: A Box of Death?, Segment, Good Morning, America, May 1, 2015

PDMP Now: Moving Toward Ending the Opioid Epidemic in Pennsylvania, testimony before Pennsylvania Legislature regarding proposed Prescription Drug Management Program, Sept. 2014

Instructor, Controlled Substance Chemistry, Federal Law Enforcement Training Center, 2014-15

Polydrug Abuse in the Modern Practice: The Risks of Street Drug Abuse for Practitioners, Journal of American Board of Family Medicine, July-August 2014

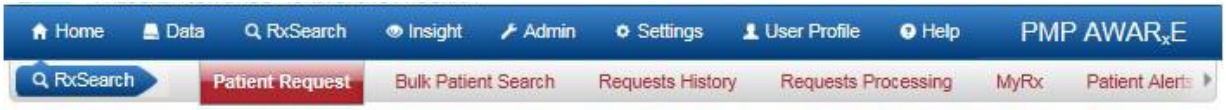
Exhibit 10

Physician to Patient Prescription Records 2016

Physician: **Rae Shafer, M.D.** | Patient: **Hadley McAdoo**

Date	Medication	Dosage	Amount
01.12.2016	Oxycodone	20 Mg	60
02.10.2016	Oxycodone	20 Mg	60
03.14.2016	Oxycodone	20 Mg	90
04.09.2016	Oxycodone	20 Mg	90
05.05.2016	Oxycodone	20 Mg	90
06.08.2016	Oxycodone	20 Mg	90
07.10.2016	Oxycodone	20 Mg	90
08.12.2016	Oxycodone	20 Mg	90
09.11.2016	Oxycodone	20 Mg	120
10.10.2016	Oxycodone	20 Mg	120
11.11.2016	Oxycodone	20 Mg	120
12.16.2016	Oxycodone	30 Mg	120

Exhibit 11



Patient Report
Report Prepared: 12.17.2016 **Date Range:** 10.1.2016 – 12.17.2016

Hadley McAdoo

Summary Prescriptions: 9 Prescribers: 3 Pharmacies: 3 Private Pay: 4

Prescriptions

Filled	ID	Written	Drug	QTY	Prescriber	Pharmacy	Refills	Payer
10.1	1	9.30	Xanax .5 mg	60	Margaret Hamburg	Walg (427)	0	BC/BS
10.1	2	9.30	Oxycodone – Acetaminophen 5-325 30 MG	120	Lefu Harrison	Rite Aid (555)	0	Private Pay
10.10	3	10.10	Oxycodone HCL 20 MG	120	Rae Shafer	WPharm (001)	0	BC/BS
11.1	2	10.30	Oxycodone – Acetaminophen 5-325 30 MG	120	Lefu Harrison	Rite Aid (555)	0	BC/BS
11.1	1	10.30	Xanax 1 mg	90	Margaret Hamburg	Walg (427)	0	BC/BS
11.11	3	11.10	Oxycodone HCL 20 MG	120	Rae Shafer	WPharm (001)	0	Private Pay
11.30	1	11.30	Xanax 1 MG	60	Margaret Hamburg	Walg (427)	0	BC/BS
12.16	3	12.16	Oxycodone HCL 30 MG	120	Rae Shafer	WPharm (001)	0	Private Pay
N/A	3	12.16	Hydromorphone 2MG	1	Rae Shafer	N/A	N/A	Private Pay

Exhibit 12

Ambulance Trip Sheet

Call Number	Date	Dispatch#	Patient Name SSN#	Page: History ID Issued on:
2016-72414	12-16-2016	8715	000-00-0000	

PCR# **Patient Information**

Name: Hadley McAdoo **Gender:** Female **Title:** **SSN:** 000-00-0000 **Phone:** 215.555.5555	**Provider Impression:** Dead on Arrival
Address: 8701 MORRISETTE DRIVE	**Chief Complaint:** Cardiac/Respiratory/Total Arrest

Gender:	Weight:	Date of Birth:	Age:	Secondary Complaint:
Female	170		73	Possible Drug Overdose

Incident#	Medical Record #	Family Physician:	Phone #

Call Information

Provider: W. CAMPBELL (EMT); P. DUNBAR (EMT)	**Pickup Location:**
Unit # 2	**Address 1:** 8701 MORRISETTE DRIVE
Onset Time: 20:40	**Address 2:**
Patient Disposition: DEAD	**City, ST, Zip:** WISAWE, PA
Disp: Urgency: LOW	**Latitude:** **Longitude:**
Mode to Scene: AMBULANCE	**Drop off Location:** N/A
Mode From Scene: AMBULANCE	**Destination Determination:**
Transportation Agency:	**Loaded Mileage:** 0 **Total Mileage:** 0
Transporting Unit:	**Starting:** 20:43 **Pick Up:** N/A
Ord/Ref Doctor:	**Drop off Patient:** N/A **Ending:** 21:52
Dispatch Reason: CALL FROM RELATIVE	**How Patient Moved To Ambulance:** N/A
Patient Pos During Tran: N/A	**How Patient Moved From Ambulance:** N/A
Mutual Aide: No	**Patient Condition at Destination:** N/A

Pertinent Findings

Level of Care: ASSESSMENT ONLY	**Cause of Injury:** POSSIBLE DRUG OVERDOSE

Alcohol/Drug Use Indicators: PILLS FOUND NEAR BODY; MULTIPLE BOTTLES; EVIDENCE OF OPIATE + BENZO USE

Special Scene Factors: DOOR UNLOCKED

Primary Signs and Symptoms: NO PULSE, NO RESPIRATION

Current Medications: LIPITOR 10mg; LOPRESSOR 100mg; OXYCODONE 15mg; XANAX 1mg

List with Patient:

Envir./Food Allergies: UNKNOWN
Medication Allergies: UNKNOWN

NKDA:

Past Medical History: HYPERTENSION; PAIN
Medical/Surgical

AMS GERD HTN ANEMIA HYPERGLYCEMIA

Event Chronology

TIME	EVENT	ATTENDANT	EVENT
20:40	INITIAL CALL	GOYAN, DISPATCHER	
20:43	UNIT 2 DISPATCHED	CAMPBELL (EMT)	
21:03	AMBULANCE ARRIVED	CAMPBELL (EMT	
21:04	PATIENT LOCATED	CAMPBELL (EMT)	
21:05	RESUSCITATION STARTED	CAMPBELL (EMT)	
21:12	PATIENT PRONOUNCED DEAD	DUNBAR (EMT)	
21:14	POLICE ARRIVE	CAMPBELL (EMT)	
21:52	UNIT 2 RETURN TO SERVICE	CAMPBELL (EMT	

Call Number:	Date:	Dispatch #	Patient Name:	Page
2016-72414	12-16-2016	8715	SSN# 000-00-0000	History ID

Ambulance Trip Sheet

				Issued On
Narrative: Unit 2 responded to residence. Found owner unconscious, unresponsive in chair, watching television. Empty bottle of alcohol, multiple pill bottles (several prescribers), and trophy found near body. Pills included Oxycontin, Oxycodone, and Alprazolam. Naloxone injected. CPR/AED attempted. Attempts failed. Police called re: narcotic pain relievers found with body. Police responded. P/O J. Goyan took custody of body. Medical Examiner contacted. Unit 2 returned to duty.				
Additional Crew Members:				
Driver	**Primary Patient Caregiver**		**Transfer Care to**	
PAUL DUNBAR (EMT)	WALTER CAMPBELL (EMT)		N/A	
EMT Paramedic NONE	EMT Paramedic NONE		I certify the above name patient was received by our facility on this date and time set forth in this report.	
Patient Signature	Med. Direction Authorized by:			
	None			

Please note: Completion of this form, in its entirety, is required upon submission to BCBSNC. Incomplete forms will result in delayed processing.

Exhibit 13

United States Drug Enforcement Administration *and* Wisawe Department of Health
Bulletin 123-55
Topic: Benzodiazepines

This bulletin is being issued by the Wisawe Department of Health (DOH) and the United States Drug Enforcement Administration (DEA) regarding the health risks associated with benzodiazepines. Due to an increase in injury and death resulting from abuse or overdosing on these drugs, the DOH and DEA are issuing this bulletin to all citizens and health professionals in Wisawe and its environs.

Benzodiazepines (which have a street name of "benzos," "blues," "tranks," or "downers") are a prescription medication indicated to relieve anxiety and sleep issues. They slow down the activity of the central nervous system and the messages going between the brain and the body. Specifically, they can produce sedation and hypnosis, relieve anxiety and spasms, and can reduce seizures. **Currently, benzodiazepines are controlled in Schedule IV of the federal Controlled Substances Act**.

Between 1996-2013, benzodiazepine medications filled in the United States increased by 320 percent. During that timeframe, there were 46 prescriptions for benzodiazepines per 100 adults in Pennsylvania.

Examples of benzodiazepines are as follows:

Generic Name	Brand Name	Generic Name	Brand Name
Alprazolam	Xanax®	Diazepam	Valium®
Chlordiazepoxide	Librium®	Lorazepam	Ativan®
Clonazepam	Klonopin®	Temazepam	Restoril®

The most common benzodiazepines are the prescription drugs Valium, Xanax, Halcion, Ativan, and Klonopin. Tolerance can develop to benzodiazepines, although at variable rates and to different degrees. Shorter-acting benzodiazepines used to manage insomnia include estazolam (ProSom), flurazepam (Dalmane), temazepam (Restoril), and triazolam (Halcion). Midazolam (Versed), a short-acting benzodiazepine, is utilized for sedation, anxiety, and amnesia in critical care settings and prior to anesthesia. It is available in the United States as an injectable preparation and as a syrup (primarily for pediatric patients).

Benzodiazepines with a longer duration of action are utilized to treat insomnia in patients with daytime anxiety. These benzodiazepines include alprazolam (Xanax), chlordiazepoxide (Librium), clorazepate (Tranxene), diazepam (Valium), halazepam (Paxipam), lorzepam (Ativan), oxazepam (Serax), prazepam (Centrax), and quazepam (Doral).
Clonazepam (Klonopin), diazepam, and clorazepate are also used as anticonvulsants.

Side Effects of Use

Side effects that are associated with taking benzodiazepines are drowsiness or sleepiness and dizziness. They can result in irritability and vivid or disturbing dreams.

Although rare, some side effects include headache; confusion; low blood pressure such as feeling dizzy when standing up; problems remembering things; feeling aggressive; feeling excitable and talkative; feeling unfriendly; and feeling impulsive.

Abuse

Long-term use of benzodiazepines can be physically and psychologically addicting. Tolerance often develops after long-term use acquiring larger doses to achieve the desired effect. Physical dependence occurs when a person's body adapts to a drug and can function when the drug is present. In 2016, benzodiazepines were the second leading substance in decedents in Pennsylvania (33% of deaths), surpassed only by heroin. Abuse is frequently associated with adolescents and young adults who take the drug orally or crush it them and snort it to get high. Abuse is particularly high among heroin and cocaine users and among abusers of opioid prescription narcotics.

Effects of overdoes include the following:

- Shallow respiration
- Clammy skin
- Dilated pupils
- Weak and rapid pulse
- Respiratory difficulty
- Coma
- Possible death

The likelihood of overdoses increases if benzodiazepines are taken with other depressant drugs such as alcohol, or other opioids such as Vicodin, Percocet, or heroin. Benzodiazepine abusers often suffer an adverse sympathetic reaction between such depressants, increasing the likelihood that they will experience the most serious side effects of each of these drugs, particularly respiratory difficulty. These respiratory difficulties can be fatal.

The DOH and DEA are your partners in preventing these overdoses. Because they are commonly diverted and abused, and because they can have lethal effects when combined, careful monitoring of patients is an essential task for anyone prescribing opioids or benzodiazepines. Be careful when prescribing benzodiazepines or opioids, and be aware of indicators of diversion, such as negative urine tests for prescribed drugs; patients offering to pay substantial sums in cash for prescriptions or office visits; patients requesting particular shapes or colors of pill; and/or patients demanding branded pills when less expensive, generic options are available, without a reasonable explanation for that demand.