

Defendants' motion to reconsider is governed by Local Rule 7.3(b), which states in pertinent part, "A motion to reconsider shall be based on (1) an intervening change in controlling law, (2) the availability of new evidence, or (3) the need to correct clear error or prevent manifest injustice." In Comeau v. Rupp, 810 F. Supp. 1172, 1174-75 (D. Kan. 1992), this court said,

The standards governing motions to reconsider are well established. A motion to reconsider is appropriate where the court has obviously misapprehended a party's position or the facts or applicable law, or where the party produces new evidence that could not have been obtained through the exercise of due diligence. Anderson v. United Auto Workers, 738 F. Supp. 441, 442 (D. Kan. 1990); Taliaferro v. City of Kansas City, 128 F.R.D. 675, 677 (D. Kan. 1989). "[R]evisiting the issues already addressed 'is not the purpose of a motion to reconsider,' and 'advanc[ing] new arguments or supporting facts which were otherwise available for presentation when the original summary judgment motion was briefed' is likewise inappropriate." Van Skiver v. United States, 952 F.2d 1241, 1243 (10th Cir.), cert. denied, 506 U.S. 828, 113 S. Ct. 89, 121 L. Ed.2d 51 (1992).

In introducing their motion, defendants state: "[t]his Motion to Reconsider is brought to urge the Court to reconsider its decision denying the exclusion of the government's proposed expert testimony and denying the request for a *Daubert* hearing. The defendants submit this motion to clarify certain points of fact and law in their original Motion. The Court noted that none of the authorities were attached as exhibits thereto. The Defendants therefore attach these authorities as exhibits to the instant motion." At no point do defendants identify the correct legal standard for motions to reconsider nor do they attempt to comply with that standard. Moreover, the government pointed out in its response that defendants did not comply with the standard and defendants' reply is again

silent. Nevertheless, the court has considered defendants' motion.

Defendants have attached nineteen exhibits to their motion to reconsider which allegedly support arguments that they raised in their initial motion. Defendants' failure to attach the exhibits to their initial motion is unexplained and inexplicable. The exhibits consist principally of articles published in medical literature. According to the addendum attached to the motion to reconsider, only one of the articles, exhibit 7, is available on the Internet. Another article, exhibit 4, is boldly stamped "Proof Copy Only - Do Not Distribute." Since defendants apparently assumed when they filed their initial motion that the court would independently search for and find the cited articles, the court wonders how it was supposed to locate a "proof copy." Similarly, if only one of the articles is available online, where did defendants expect the court to find the others?

Presumably, defendants now expect the court to read the articles. Yet defendants fail to point to the portions of the articles which support their positions. As the Tenth Circuit has observed in an analogous situation:

Sufficient evidence (pertinent to the material issue) must be identified by reference to an affidavit, a deposition transcript or a specific exhibit incorporated therein. Without a specific reference, we will not search the record in an effort to determine whether there exists dormant evidence which might require submission of the case to a jury. Thomas v. Wichita Coca-Cola Bottling Co., 968 F.2d 1022, 1024 (10th Cir.), cert. denied, 506 U.S. 1013, 113 S. Ct. 635, 121 L. Ed.2d 566 (1992); accord, United States v. Dunkel, 927 F.2d 955, 956 (7th Cir. 1991) ("Judges are not like pigs, hunting for truffles buried in briefs.").

Gross v. Burggraf Const. Co., 53 F.3d 1531, 1546 (10th Cir. 1995)(internal citations omitted). Moreover, the court is not

required to examine the articles because they are not "new." The articles were available at the time defendants filed their initial motion. Comeau, 810 F. Supp. at 1174-75.

Nevertheless, the court has reviewed the articles and will comment on a few of them.

Discussion

In the process of reviewing the articles, the court noted particularly J.C. Ballantyne & J. Mao, Medical Progress: Opioid Therapy for Chronic Pain, New Eng. J. Med. (2003) because it was published during the period when defendants' clinic was in operation and, more important, the New England Journal is the most widely read and influential medical journal in the world.

In their initial motion, defendants made the following statement: "The government's experts also fault Dr. Schneider for prescribing to 'known' addicts, but it is not clear on what basis they have concluded that Dr. Schneider 'knew' that they were addicts." In a footnote, defendants went on to say: "As the Indictment itself acknowledges, addiction is not common in treatment with opioids. Overwhelmingly, research has failed to show that chronic opioid therapy is associated with any significant level of addiction outcomes." (Doc. 188 at 18, n. 13). The New England Journal is cited as support for this statement.

Two sentences in the 6997 word article may (or may not) support the statement: "Most of the literature on opioid therapy consists of reports of surveys and uncontrolled case series. The general finding is that patients with chronic pain not associated with a terminal disease can achieve satisfactory analgesia by using a stable

(nonescalating) dose of opioids, with a minimal risk of addiction.”

(Doc. 215, exh. 11 at 2). However, the article also states:

The recognition that opioid therapy can relieve pain and improve mood and functioning in many patients with chronic pain has led experts on pain to recommend that such patients not be denied opioids. Despite this recommendation, many physicians remain uncertain about prescribing opioids to treat chronic pain and do not prescribe them. Some physicians argue that opioids are only marginally useful in the treatment of chronic pain, have a minimal effect on functioning, and may even worsen the outcome. However, this seems to be a minority view. Key organizations that strongly support the use of opioids to treat chronic pain have published consensus statements to guide physicians in prescribing these drugs. These consensus statements emphasize the importance of a standardized approach.

Such an approach should include an initial, comprehensive medical history and physical examination, establish firmly that nonopioid therapy has failed, establish agreed-on goals for treatment, develop an understanding between physician and patient of the true benefits and pitfalls of the long-term use of opioids, involve a single physician and pharmacy whenever possible, and ensure comprehensive follow-up. The follow-up should comprise regular assessment of whether the goals are being achieved, careful monitoring for signs of opioid abuse (including toxicologic screening in some cases), the use of adjunctive treatments whenever possible, and a willingness to end opioid treatment if the goals are not met. This necessarily elaborate process should be fully documented. More detail is provided in the consensus documents and in the standard references.

(Doc. 215, exh. 11 at 1-2; emphasis added).

The government alleges, and of course must prove, that Dr. Schneider did not follow the recommended, standardized approach but instead prescribed drugs with a potential for severe psychological or physical dependence without first taking a patient's thorough history and conducting a medical examination or employing any of the other facets of the recommended approach.

The article goes on to observe:

PROLONGED, HIGH-DOSE OPIOID THERAPY

The published trials leave two important questions unanswered: Is opioid therapy beneficial in the long term (over a period of years rather than months)? Does the dose have an effect on the efficacy and the safety of long-term therapy? One of the fundamental principles of pain management is that the dose of an opioid should be increased until maximal analgesia is achieved with minimal side effects. Experts advise that in the treatment of chronic pain the initial dose increases should be achieved within weeks, doses should be moderate, and further increases in the dose should be introduced with extreme caution. However, our clinical experience suggests that many physicians take a much more liberal approach to dose increases. Some patients with chronic pain receive doses as high as 1 g or more of morphine (or a morphine equivalent) per day, which may be five or more times the doses validated by the literature (see Supplementary Appendix 1). Anecdotal evidence suggests that patients receiving opioid doses of this magnitude rarely report satisfactory analgesia or improved function. Although the clinical trials carried out to date have not examined the efficacy and safety of prolonged, high-dose opioid therapy, evidence is rapidly accumulating that, in the treatment of patients with chronic pain, opioid doses should be limited in order to maintain both efficacy and safety.

(Doc. 215, exh. 11 at 2)(emphasis added). The indictment alleges that Dr. Schneider did not follow this "rapidly accumulating" evidence and, instead, did just the opposite.

Finally, the article speaks to clinical implications which presumably would be of concern to a physician who sees and treats patients complaining of chronic pain:

Two important concepts arise from our improved understanding of how opioids act: first, that apparent opioid tolerance does not equal pharmacologic opioid tolerance; and, second, that prolonged, high-dose opioid therapy may have serious adverse consequences.

RELATION OF APPARENT TOLERANCE TO PHARMACOLOGIC TOLERANCE
Pharmacologic tolerance to opioids has defined cellular mechanisms. The clinical hallmark of pharmacologic tolerance is the need for increasing doses to maintain the same level of analgesia. However, there is evidence that opioids can induce abnormal pain sensitivity or hyperalgesia, which is also manifested clinically as the need for increasing doses of opioids to maintain the same level of analgesia. Although sophisticated testing can

identify hyperalgesia (to distinguish it from pharmacologic tolerance), it may not distinguish the hyperalgesia due to opioid treatment from the hyperalgesia due to worsening neuropathic pain. Furthermore, in everyday clinical practice (without testing), it is impossible to distinguish between pharmacologic tolerance and abnormal pain sensitivity. Whether opioid-induced abnormal pain sensitivity is related to the dose, the particular opioid, the route of administration, the duration of use, or other factors remains unclear. Nevertheless, abnormal pain sensitivity may, at least in part, explain the failure to relieve pain in some patients, despite increases in the opioid dose. Thus, in some instances, treating increasing pain with increasing doses of opioids may be futile.

ADVERSE CONSEQUENCES OF PROLONGED, HIGH-DOSE OPIOID THERAPY

Clinical and preclinical studies indicate that prolonged use of opioids may have adverse consequences, including opioid tolerance with the need for dose escalation, and opioid-induced abnormal pain sensitivity. Prolonged opioid use may have hormonal effects that result in reduced fertility, libido, and drive. Prolonged use may also result in immunosuppression, especially in susceptible persons. We do not yet know to what extent these effects are clinically relevant. However, prolonged use of high doses of opioids is likely to be more toxic than short-term use of low doses, so hormonal effects are most likely to occur in patients with chronic pain who receive high-dose opioid therapy. The aim of current guidelines is to protect patients from the adverse effects of opioid therapy and to ensure careful follow-up and cessation of therapy if the treatment goals are not being met.

(Doc. 215, exh. 11 at 4-5).

The indictment alleges, in substantial detail, that defendants' clinic was operated contrary to these clinical implications. The government must prove the allegations but two points are clear: (1) just as with citation to case authority, it is unwise to cite snippets of an article in support of a proposition when the majority of the article is contrary to the parties' interest and (2) there is nothing in the New England Journal article which supports defendants' claim that the court erred by failing to agree with their contention that Daubert hearings will demonstrate that the governments' expert

witnesses should not be permitted to testify.

Defendants seek reconsideration of the court's rejection of their arguments regarding "red flags." They assert that the "scientific literature makes clear that the red flags are simply a set of ambiguous factors." (Doc. 215 at 5). Defendants then cite to three articles which were written or co-written by Dr. Passik, one of defendants' experts. In the first article, Dr. Passik and five other authors conducted a "pilot study" to examine the perceptions of aberrant drug taking behaviors. The "study" was based on a short survey of physicians' perceptions of drug-taking behaviors. The survey was completed during a pain experts meeting in March 2001. Dr. Passik determined that "there is some consensus among physicians in their views of aberrant behavior with illegal behaviors topping the list. It is also interesting to note the large amount of individual variation in how these behaviors are viewed." Importantly, the article noted that the study has limitations: "The conclusions drawn from these results need to be made somewhat cautiously due to the small convenience sample employed and the fact that while all of these clinicians have an active interest in pain . . . this does not necessarily suggest a particular expertise in aberrant behavior or generalizability to other pain clinicians." (Doc. 215, exh. 3 at 46-47).

The second "article" pertains to monitoring outcomes during long-term opioid therapy for noncancer pain.¹ This article follows twenty-

¹ This is the article marked "proof copy only - do not distribute." Defendants have not submitted any evidence that this was the article was published, much less that it was peer-reviewed.

seven physicians who treated 388 patients. The patients were interviewed and rated by the physicians. The results suggested that "aberrant behaviors were common but viewed as an indicator of a problem in only approximately 10 percent of cases." At no point do the authors suggest that "red flags" or aberrant behaviors are not an indicator of addiction. In fact, the article indicates that "if this observation is replicated in larger epidemiologic surveys, it suggests that the subgroup of patients expected to be problematic on opioids could have been predicted from the baseline population norms." (Doc. 215, exh. 4 at 9).

Finally, in the third article, Dr. Passik suggests that the behaviors termed "red flags" should instead be called "yellow flags" because the term red suggests that a physician should discontinue pain treatment. Dr. Passik opines that upon an indication of "yellow flags," a physician should react therapeutically, not punitively, and change the pain management treatment for the patient. (Doc. 215, exh. 5).

After reviewing the Passik articles, there is no indication that the general medical community views red flags as an unreliable tool in identifying addiction. The first article clearly states that the survey is not reliable and should be limited in use. The second article suggests that the most severe red flag factors are indicative of a problem. The third article in no way can be interpreted as supporting a universally-recognized conclusion that "red flags" or "yellow flags" are not indicative of an addiction. The court is left to wonder whether defendants' counsel even read the articles they claim will require exclusion of the government's experts' testimony

(Doc. 188 at 21-22).

Finally, defendants again argue that the government's forensic experts' opinions are flawed because "it is impossible to determine whether the cause of death was the heart disease itself or some other cause, such as drug overdose." (Doc. 215 at 2). Instead of citing to one of the belatedly-attached articles, defendants refer back to their original motion. Defendants fail to point to any of the language in any articles which supports their argument that the cause of death cannot be determined.²

In summary, the court finds that defendants have failed to demonstrate that any of the articles support reconsideration of the court's prior order and, in particular, the holding of expensive, time-consuming Daubert hearings. It is painfully apparent that any attempt to discredit the government's experts' opinions using the articles at a Daubert hearing would be ineffectual.

Burden-Shifting

Defendants assert that the court has shifted the burden to them to "disprove reliability, rather than on the government to show reliability." (Doc. 215 at 6). Defendants seem to be referring to

² In a footnote, defendants cite exhibit 2 for the proposition that Dr. Rohrig's "own articles" state that post-mortem drug levels do not accurately reflect the levels in living subjects. (Doc. 215 at 4). Curiously, exhibit 2 is not an article authored by Dr. Rohrig, but instead authored by R.E. Ferner. Exhibit 1 is an article authored by Dr. Rohrig entitled "Fluoxetine Overdose: A case Report." The court has read the article, whose conclusion is: "In consideration of the circumstances surrounding the death and the absence of any anatomical or histological evidence as to the cause of death, the death was certified as combined toxicity of fluoxetine and ethanol; the manner of death, accidental." The court cannot identify anything in the report which supports either defendants' characterization or criticism of Dr. Rohrig's work.

the court's earlier observation that other federal courts have permitted some of the government's experts to offer opinions in similar cases. How this observation amounts to improper burden-shifting is unclear, to say the least. The court firmly established in an earlier status hearing that all parties seeking a Daubert hearing would have to state reasons why a hearing is necessary. This is not burden-shifting. As stated in its prior order, the court is not required to have a Daubert hearing if the court has a sufficient basis to determine the reliability of the experts' opinions. United States v. Charley, 189 F.3d 1251, 1266 (10th Cir. 1999)(district court is granted great latitude in "deciding whether to hold a formal hearing.") In this case, the government's experts are all qualified in their field of expertise and the court has found that the methodology utilized by the experts is consistent throughout their fields and reliable. In seeking reconsideration, defendants have failed to provide any basis to challenge that conclusion.

Admonition

In all aspects of this case, counsel for the parties are expected to know and apply applicable rules regarding motion practice. For future reference, the following applies to motions in limine. To the extent it can with the information before it, the court will briefly rule on each motion. The court cautions the parties, however, that a ruling against admissibility will not preclude the admissibility of the excluded evidence if it otherwise becomes relevant at trial. See Turley v. State Farm Mut. Ins. Co., 944 F.2d 669, 673 (10th Cir. 1991) ("The better practice would seem to be that evidence of this nature . . . should await development of the trial itself."). In other

words, the parties should not expect to try this case by way of motions in limine.

Defendant's motion for reconsideration is denied. (Doc. 209).

IT IS SO ORDERED.

Dated this 3rd day of December 2008, at Wichita, Kansas.

s/ Monti Belot

Monti L. Belot

UNITED STATES DISTRICT JUDGE