Rory Thomas

v.

Arya Davis, M.D.

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CAROLINA CENTER FOR CIVIC EDUCATION

The Carolina Center for Civic Education wishes to thank those involved in the creation of this year's civil case. The case was authored by CCCE State Coordinator Susan H. Johnson with contributions from Carolina Mock Trial alumni Ben Dolder, Arvind Krishnamurthy, Brandon Morrissey, and Logan Spaller. Many thanks also to Adam Kaufman, M.D., for reviewing the medical information and to Michael D'Ippolito, Elizabeth Ertle, Ben Felder, Samuel Johnson, Sarah Stebbins, Elise Wilson, David Yasinovsky, and CCCE Case Committee Chair Gordon Widenhouse for their expertise and insights in refining and improving this mock trial case.

AVAILABLE WITNESSES

Plaintiff Witnesses	Defense Witnesses
Rory Thomas, plaintiff, parent of deceased	Arya Davis, M.D., defendant
Dallas Sanchez, student at Utopia University	Finn Morrissey, M.D., former medical liaison
Blake Spaller, M.D., orthopedic surgeon	Dorian Wilson, director, Four Seasons Center

CASE DOCUMENTS

Legal Documents

1. Statutes
2. Stipulations
3. Available Case Law
4. Order on Motions in Limine
5. Complaint
6. Answer
7. Jury Instructions

Affidavits and Reports

Plaintiff

1. Affidavit of Rory Thomas
2. Affidavit of Dallas Sanchez
3. Report of Blake Spaller, M.D.

Defense

6. Affidavit of Arya Davis, M.D.
7. Affidavit of Finn Morrissey, M.D.
8. Affidavit of Dorian Wilson

Exhibits

1. Photo of Vicodin HP pills and bottle, showing warning labels
2. 2017 Physicians' Desk Reference
    A. Physician Fact Sheets: Vicodin HP
    B. Medication Guide: Vicodin HP
3. Text messages between Dallas Sanchez and Sloane Thomas
4. Curriculum Vitae of Blake Spaller, M.D.
5. Davis's medical chart notes re: Sloane Thomas
    A. 2013: Right Ankle Injury Intake Form and Chart Notes
    B. Spring 2017: Left Rotator Cuff Injury Intake Form and Chart Notes
    C. December 2017: Ankle/Shoulder Injury Chart Notes
6. Autopsy of Sloane Thomas
7. Empower Pharma Marketing Handout
8. Wilson's rehabilitation therapy chart notes re: Sloane Thomas

UTOPIA GENERAL STATUTES

(Selected Provisions)

Article 1B. Medical Malpractice Actions.

SECTION 90-21.11. Definitions.

The following definitions apply in this Article (*selected sections*):

(1) Health care provider. – Without limitation, any of the following:

a. A person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed in the practice of any of the following: medicine, surgery, physiotherapy, anesthesia, laboratory analysis, radiology, or psychology.

(2) Medical malpractice action. – Either of the following:

a. A civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider.

(8) Addict. – Without limitation, the following:

a. Any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction.

(9) Opiate, opioid. – Without limitation, the following:

a. Any drug or other substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

SECTION 90-21.12. Standard of health care.

(a) In any medical malpractice action as defined in G.S. § 90-21.11(2)(a), the defendant health care provider shall not be liable for the payment of damages unless the trier of fact finds by the preponderance of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities under the same or similar circumstances at the time of the alleged act giving rise to the cause of action.

SUPERIOR COURT FOR THE STATE OF UTOPIA
ST. THOMAS MORE COUNTY

RORY THOMAS, as Surviving Parent of SLOANE THOMAS, Deceased, **Plaintiff**, **v.** **ARYA DAVIS, M.D.**, **Defendant**.	**CIVIL ACTION** **DOCKET NO. 18-CIV-0803** Judge Lucy Ridgeway **STIPULATIONS**

COME NOW the parties and agree to the following stipulations:

1. Both parties waive all objections arising under the Constitution of the United States.

2. Both parties waive all objections based on privilege.

3. Chain of custody of all evidence is proper and may not be challenged.

4. All witnesses were instructed to include all relevant testimony in their sworn statements. All witnesses reviewed their statements immediately prior to trial and were given an opportunity to revise them. None did so. All witnesses affirm the truthfulness of all information contained in their statements.

5. All documents, signatures, and exhibits included in the case materials are authentic. Both parties must lay proper foundation prior to entering evidence, and both parties reserve the right to dispute any legal or factual conclusions based on these items and to make objections other than to authenticity.

6. Sloane Thomas died at 4:16 a.m. on January 1, 2018.

7. Exhibit 6, the autopsy report, is a public record per Rule 803(8) of the Rules of Evidence and may be admitted without further foundation at any time once the record is open.

DATED: AUGUST 22, 2018

IT IS SO ORDERED

Lucy Ridgeway

LUCY RIDGEWAY
Superior Court Judge

APPLICABLE CASE LAW

All decisions were rendered by the Utopia Supreme Court

Civil Trials

Ada's Lasagna Cafe v. Logan Cake Factory

A plaintiff must establish all of the elements of its claim by a preponderance of the evidence, meaning that it must establish every element to be more likely true than not. Likewise, an affirmative defense must be proven by the defendant by a preponderance of the evidence.

Ertle v. Tidball

Utopia has adopted a "partial comparative negligence" rule for civil suits advancing a theory of negligence. Under this doctrine, a plaintiff may recover from a defendant who has acted negligently, even if the plaintiff's own negligent actions contributed to the injury at issue. However, a plaintiff may only recover from a defendant if the jury believes that the plaintiff's own negligence does not exceed that of the defendant.

Pope v. Red River Groceries

Where the damages and liability phases have been bifurcated, the plaintiff is still required to establish "harm" in order to establish liability. At the same time, the burden in a liability phase is to establish only the existence and not the extent of the liability. Trial judges must be vigilant in applying Rule of Evidence 403 with respect to evidence that either does not or only marginally relates to questions of harm during the liability phase.

Winget v. Kaufman

The purpose of the complaint and answer is to frame the issues for trial and enable each party to develop its presentation accordingly. Utopia does not permit the plaintiff to call rebuttal witnesses; accordingly, it is inappropriate for a party that has alleged or denied an assertion in its pleading to seek to amend those pleadings during trial by arguing that it is no longer interested in alleging or contesting that assertion.

Medical Malpractice and Wrongful Death

Heath v. Milam Medical Center

In a medical malpractice action, the injured plaintiff-patient must prove the following four legal elements:

(1) The healthcare provider owed a duty to the patient to provide treatment consistent with the standard of care in the provider's field;
(2) The provider breached that duty by failing to act in accordance with the standard of care;
(3) The healthcare provider's failure was the direct and proximate cause of the plaintiff's harm; and
(4) The plaintiff was harmed or injured.

The standard of care and any breach thereof are objective elements, making a defendant's motive or intent irrelevant in determining these elements.

O'Neill v. Howie Medical Center
In medical malpractice cases, the trier of fact must consider only the information the defendant obtained or should have reasonably obtained in determining whether the defendant followed the accepted standard of care.

Sridhar v. Stebbins All-American Medicine
In a medical malpractice case, evidence of medical conditions unknown to a defendant-physician that defendant-physician could not reasonably be expected to know is inadmissible to show a standard of care or deviation therefrom. However, such evidence may be admissible for other purposes, such as to show negligent or intentional misconduct by the plaintiff or an alternate theory of causation of the plaintiff's harm.

Pyada v. Choi
In a medical malpractice case, a physician's failure to obtain information normally obtained during a patient examination may constitute a breach of the duty of care. Such information could include family history, drug allergies, previous drug or alcohol use, and mental illness. In this case, the defendant-physician did not ask the patient about known drug allergies, and the patient died after the defendant prescribed a drug to which the patient had previously suffered a severe reaction. The court ruled that the defendant's lack of knowledge due to a failure to attempt to obtain such information did not excuse the defendant from liability.

Josan's Coffee Shop v. Covington
When a parent sues on behalf of a deceased child, that parent is not a party for the purposes of establishing harm or injury as she/he is serving purely as a representative of the deceased. Thus, emotional distress suffered by the parent as the result of the child's injury or death is not relevant under Rule 401 of the Rules of Evidence.

Preliminary Concerns

Schmidly v. Yasinovsky
As various rules of evidence are applied, the ruling sometimes turns on who made a particular statement. If the proponent of a statement produces evidence that would permit a reasonable jury to find that a specific person made a statement, then the statement may be attributed to that person for admissibility purposes. Specifically, absent evidence to the contrary, statements in text messages or emails may be attributed to the owner of the phone or email account from which the communications were sent.

Romain v. Fox
Under Rule 104(b) of the Rules of Evidence, the court recognizes that some evidence may only be relevant if some other fact exists. In cases where a party seeks to introduce such evidence, the court may admit the evidence conditionally, and the party introducing the evidence may lay the foundation after the evidence is admitted. However, during trial, that party must introduce evidence that would allow a jury to find that the contingent fact is more likely than not true. If the party fails to do so, the court shall strike the conditionally admitted evidence from the record provided that the opposing party renews its objection.

Expert Testimony

Frankford's Shrimp Shack v. The Oceanic

Prior to testifying to an expert opinion, a witness must be formally tendered to the court as an expert in a specific field. Trial judges serve as the gatekeepers of expert testimony and are tasked with ensuring that such testimony is reliable. In making this determination, the judge may consider the expert's qualifications, data, and methods, but not the expert's actual conclusions. When a party seeks to tender an expert, they must prove, by a preponderance of the evidence, that the expert's testimony meets the requirements of Rule 702.

Hudson v. Ridgeway

When assessing an expert's methods under Rule 702(c) of the Rules of Evidence, judges may consider factors such as: (1) whether the theory or technique has been or can be tested; (2) whether it has been peer reviewed and published; (3) whether it has gained widespread acceptance within the field; and (4) whether it has a known, calculable error rate. However, there is no definitive checklist of what must or must not be present for admission; judges must apply the rule based on the totality of the circumstances.

Kleinschmidt v. Bunce

Rule 703 of the Rules of Evidence does not allow experts to act as conduits to hearsay who merely repeat what others tell them. Experts may only present otherwise inadmissible evidence once they relate such evidence to some specialized knowledge on the expert's part, as required under Rule 702, and the evidence otherwise comports with Rule 703.

Gaballah Rehabilitation Clinic v. Gomez

In a medical malpractice case, a witness shall not give expert testimony about the standard of care in a field unless the party attempting to tender the witness as an expert proves by a preponderance of the evidence that:

(1) The witness's proffered testimony satisfies each section of Rule 702 of the Rules of Evidence;
(2) The witness is a licensed healthcare provider;
(3) The witness specializes in the same or a substantially similar area of practice as the party against whom or on whose behalf the testimony is offered; and
(4) The expert must have spent the majority of the past year practicing, teaching, or researching in that field.

The witness's specialty need not be the entire scope of the treatment; the witness need only specialize in the procedures that are the basis for the action. In this case, an orthopedic surgeon was not permitted to provide expert testimony against a rehabilitation specialist, as the surgeon did not specialize in the same area of practice.

Hearsay

Belgium's Best Waffles v. Great American Cookie Company
While practices may differ in other jurisdictions, in the state of Utopia, the definition of "hearsay" may include any declarant's out-of-court statement, even if the declarant is on the stand or scheduled to testify in trial.

Allen v. Williams
Rule 801(d)(2) of the Rules of Evidence may be invoked in only one direction. Under this rule, when the plaintiff conducts an examination, they may offer statements by the defendant, regardless of which party called the witness being questioned. Likewise, when the defendant conducts an examination, they may offer statements by the plaintiff, regardless of which party called the witness being questioned. However, Rule 801(d)(2) permits neither the defense to offer the defendant's statements, nor the plaintiff to offer the plaintiff's statements, even if the opposing party has already elicited such statements in a preceding examination.

Gill v. Posey Nature Supply
In wrongful death cases, while living representatives are not parties for the purposes of showing harm, both the deceased and the living representative filing the suit are considered parties for all evidentiary purposes. Therefore, when the defendant offers statements of either the decedent or the living representative, such statements qualify under Rule 801(d)(2)(A) as statements by an "opposing party," and thus are not hearsay.

Brown v. Michaels Counseling Center
While practices may differ in other jurisdictions, in Utopia statements made by a patient to a treating therapist or psychologist in the course of treatment can qualify as statements made for the purpose of medical diagnosis or treatment under Rule 803(4) of the Rules of Evidence. However, any statements made by the treating therapist, psychologist, or physician to a patient or about the patient's condition do not qualify under Rule 803(4), although such statements may qualify as exceptions to hearsay under Rule 803(6) if proper foundation can be laid.

Burke's BBQ v. Phil's Dixie Queen Diner
The fact that a witness is not present in court does not, by itself, make the witness unavailable under Rule 804(a) of the Rules of Evidence. In addition, the mere fact of a declarant's unavailability pursuant to Rule 804(a) is not itself an exception to hearsay. Unless a statement meets an exception under Rule 804(b), it may be excluded as hearsay, even if its declarant is considered to be unavailable, pursuant to Rule 804(a).

SUPERIOR COURT FOR THE STATE OF UTOPIA
ST. THOMAS MORE COUNTY

RORY THOMAS, as Surviving Parent of SLOANE THOMAS, Deceased, **Plaintiff**, **v.** **ARYA DAVIS, M.D.**, **Defendant**.	**CIVIL ACTION** **DOCKET NO. 18-CIV-0803** Judge Lucy Ridgeway **ORDER ON MOTIONS IN LIMINE**

This Court, having read the briefs submitted by counsel and heard oral argument on the parties' motions *in limine,* rules as follows and establishes the following procedures for trial:

1. Defendant's Motion to Bifurcate

Defendant has moved *in limine* to bifurcate the trial such that the question of liability is separated from the question of damages. The motion is GRANTED. In the first phase, the plaintiff must demonstrate "harm" in order to establish liability and prove that the Defendant is liable for the damages suffered by Sloane Thomas. If Plaintiff prevails in the liability phase, the same jury will hear evidence on the question of the amount of damages to be assessed each party. Therefore, during the liability phase, evidence going solely to the extent of harm suffered by the Plaintiff will not be admitted.

The Court also notes that evidence related to damages may still be admissible during the liability phase if it is relevant to prove or disprove (1) other elements of the Plaintiff's claim; or (2) the affirmative defense asserted by Defendant.

IT IS SO ORDERED.
DATE: August 22, 2018

Lucy Ridgeway
Lucy Ridgeway
Superior Court Judge

SUPERIOR COURT FOR THE STATE OF UTOPIA
ST. THOMAS MORE COUNTY

RORY THOMAS, as Surviving Parent of SLOANE THOMAS, Deceased, **Plaintiff**, **v.** **ARYA DAVIS, M.D.**, **Defendant**.	**CIVIL ACTION** **DOCKET NO. 18-CIV-0803** Judge Lucy Ridgeway **VERIFIED COMPLAINT** **JURY TRIAL DEMANDED**

COMES NOW Plaintiff, RORY THOMAS, as Surviving Parent of SLOANE THOMAS, deceased, by and through counsel, and, for a complaint against Defendant ARYA DAVIS, M.D., states as follows:

PARTIES

1. Rory Thomas is the parent and duly authorized Personal Representative and Independent Administrator of the Estate of Sloane Thomas, deceased. Rory Thomas is qualified to bring this action on behalf of decedent Sloane Thomas (collectively, "the Thomases" or "Plaintiffs"). Both were and/or are residents of Utopia City in the State of Utopia.

2. Defendant Arya Davis, M.D. ("Defendant"), upon information and belief is a resident of the State of Utopia. Defendant was at all times relevant hereto licensed to practice medicine in the State of Utopia as a specialist in the fields of Orthopedic Surgery and Sports Medicine.

JURISDICTION AND VENUE

3. The Superior Court for the State of Utopia, St. Thomas More County (the "Court") has subject matter jurisdiction because this action is brought under the Utopia Civil Code.

4. The Court has personal jurisdiction over Defendant because the acts and omissions forming the basis for this Complaint took place in Utopia.

5. Venue is properly placed in this district because (i) the parties are inhabitants of or transact business in this district; and (ii) the events or omissions giving rise to Plaintiffs' claims occurred in this district.

6. In the aggregate, Plaintiffs' claims exceed $25,000 exclusive of interests and costs, and therefore this Court has original jurisdiction.

FACTUAL BACKGROUND

7. On February 6, 2013, Plaintiffs sought and received medical care for Sloane Thomas, a minor child, from Defendant after Sloane Thomas suffered a fractured right ankle during a high school basketball game. Defendant placed the ankle in a cast and prescribed a seven-day course (42 pills) of Vicodin HP, an opioid painkiller, to Sloane Thomas. After the cast was removed, Defendant prescribed physical therapy. Sloane Thomas fully recovered.

8. On March 16, 2017, Sloane Thomas, now a scholarship basketball player at Utopia University, sought medical care and treatment from Defendant after Thomas sustained a torn left shoulder rotator cuff in a neighborhood basketball game. Defendant scheduled surgical repair of the torn rotator cuff on March 21, 2017.

9. Post-surgery, Defendant prescribed a 30-day course (180 pills) of Vicodin HP, an opioid painkiller, for Sloane Thomas.

10. Defendant extended the prescription two additional times, providing Sloane Thomas with a total course of 90 days (540 pills) of Vicodin HP.

11. As a result of the Defendant's excessive prescription of the opioid Vicodin HP, Sloane Thomas became addicted to the medication.

12. Sloane Thomas attended and successfully completed a 60-day drug rehabilitation program in North Carolina from June 6, 2017 – August 5, 2017.

13. Defendant was informed about Sloane Thomas's enrollment in the drug rehabilitation program.

14. On November 30, 2017, Sloane Thomas reinjured his right ankle and left shoulder during a Utopia University basketball game.

15. On December 1, 2017, Sloane Thomas sought treatment from the Defendant for said injury. Defendant prescribed a 30-day course (180 pills) of Vicodin HP despite knowing about Sloane's previous addiction to Vicodin HP and stint in drug rehabilitation.

16. Sloane Thomas relapsed into opioid addiction after taking the prescribed Vicodin HP.

17. Sloane Thomas tried to schedule a follow-up visit with Defendant in mid-December, but Defendant claimed to be unable to meet with Sloane Thomas until January 2, 2018.

18. On December 31, 2017 – January 1, 2018, Sloane Thomas overdosed on Vicodin at a New Year's Eve party.

19. Sloane was nonresponsive when emergency personnel arrived, and efforts to revive him were unsuccessful.

20. Sloane's time of death was listed as 4:16 a.m. on January 1, 2018.

COUNT ONE
NEGLIGENCE OF ARYA DAVIS, M.D.

21. Paragraphs 1 through 20 are hereby incorporated by reference as if they were set forth fully herein.

22. On or about February 6, 2013, Defendant undertook for valuable consideration to provide treatment and care upon Sloane Thomas and continued to provide treatment and care upon Sloane until Sloane's death on January 1, 2018.

23. In prescribing medication for Sloane Thomas's injuries, Defendant had the duty to exercise the degree of care and skill of a reasonably competent Orthopedic Surgeon and Sports Medicine specialist practicing in the same or similar circumstances.

24. Defendant failed to exercise the requisite degree of care and skill in prescribing medication to treat Sloane Thomas's injuries in that:

a. Defendant failed to obtain and update a detailed medical history regarding Sloane's possible use of alcohol or recreational drugs or any family history of substance abuse;

b. Defendant prescribed an unreasonably and unjustifiably long course of the addictive opioid Vicodin HP for Sloane's injury occurring in March 2017;

c. Defendant failed to provide adequate instruction, monitoring, and follow-up care regarding said opioid prescription, thereby failing to recognize that Sloane had become addicted to the opioid Vicodin HP;

d. Defendant failed to make note in Sloane's chart that Sloane had undergone inpatient drug rehabilitation for opioid addiction when informed of the same; and

e. Defendant prescribed the addictive opioid Vicodin HP to Sloane in December 2017, knowing that Sloane had entered a drug rehabilitation program in summer of 2017.

25. The failure of Defendant to follow the standard of care in prescribing pain medication for Sloane Thomas was the direct and proximate cause of Sloane's initial opioid addiction and Sloane's subsequent relapse after a later opioid prescription.

COUNT TWO
WRONGFUL DEATH

26. Paragraphs 1 through 25 are hereby incorporated by reference as if they were set forth fully herein.

27. As a direct and proximate result of the negligence of Defendant Arya Davis, M.D., Plaintiff Sloane Thomas suffered and died of an opioid overdose on January 1, 2018.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests judgment for the following:

A. Judgment against the Defendant for compensatory damages in an amount to be determined by a jury;

B. Judgment against the Defendant for punitive damages in an amount to be determined by a jury, but not inconsistent with Utopia law regarding awards of punitive damages;

C. Such other and further relief as this Court deems just and proper.

DATED: May 17, 2018

RESPECTFULLY SUBMITTED,
FELDER, WILSON, & YASINOVSKY
Attorneys for Plaintiff

SUPERIOR COURT FOR THE STATE OF UTOPIA
ST. THOMAS MORE COUNTY

RORY THOMAS, as Surviving Parent of SLOANE THOMAS, Deceased, **Plaintiff**, **v.** **ARYA DAVIS, M.D.**, **Defendant**.	**CIVIL ACTION** **DOCKET NO. 18-CIV-0803** Judge Lucy Ridgeway **VERIFIED ANSWER** **JURY TRIAL DEMANDED**

COMES NOW the Defendant ARYA DAVIS, M.D., and answers as follows:

PARTIES

1. Admitted.

2. Admitted.

JURISDICTION AND VENUE

3. Admitted.

4. Admitted.

5. Admitted.

6. Admitted.

FACTUAL BACKGROUND

7. Admitted.

8. Admitted.

9. Admitted.

10. Admitted.

11. Defendant lacks sufficient knowledge to form a belief as to the truth of the allegations in paragraph 11, and thus it is denied.

12. Defendant lacks sufficient knowledge to form a belief as to the truth of the allegations in paragraph 12, and thus it is denied.

13. Denied.

14. Admitted.

15. Denied.

16. Defendant lacks sufficient knowledge to form a belief as to the truth of the allegations in paragraph 16, and thus it is denied.

17. Defendant lacks sufficient knowledge to form a belief as to the truth of the allegations in paragraph 17, and thus it is denied.

18. Admitted.

19. Defendant lacks sufficient knowledge to form a belief as to the truth of the allegations in paragraph 19, and thus it is denied.

20. Admitted.

COUNT ONE
NEGLIGENCE OF ARYA DAVIS, M.D.

21. Defendant's responses to paragraphs 1 - 20 are incorporated herein by reference.

22. Admitted.

23. Admitted.

24. Denied in its entirety (sections a – e).

25. Denied.

COUNT TWO
WRONGFUL DEATH

26. Defendant's responses to paragraphs 1 – 25 are incorporated herein by reference.

27. Denied.

AFFIRMATIVE DEFENSE: COMPARATIVE NEGLIGENCE

27. Defendant asserts the defense of comparative negligence. Plaintiff failed to exercise reasonable care for Plaintiff's own safety and thereby contributed to Plaintiff's own death in one or more of the following ways:

a. Consuming alcohol while taking Vicodin HP despite clear written and verbal warnings to abstain and failing to inform Defendant of said consumption;

b. Obtaining and consuming additional Vicodin HP not prescribed by Defendant and failing to inform Defendant of said consumption; and

c. In such further ways as may be shown by the evidence in this case.

WHEREFORE, Defendant prays the following from the Court:

A. That Plaintiff recover nothing from Defendant Arya Davis, M.D.; and

B. Such other and further relief as this Court deems just and proper.

DATED: June 7, 2018

RESPECTFULLY SUBMITTED,
KRISHNAMURTHY & DOLDER
Attorneys for Defendant

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.

[Please note: These instructions may NOT be read aloud or tendered to the mock trial jury or used as an exhibit during the competition; however, students may use these concepts in fashioning their case and making arguments to the jury.]

PRELIMINARY INSTRUCTIONS

I. Role of the Jury

Now that you have been sworn, and before the presentation of evidence, I have the following preliminary instructions for your guidance as jurors in this case.

You and only you will be the judges of the facts. You will decide what happened. You should not take anything I may say or do during the trial as indicating what I think of the evidence or what your verdict should be. My role is to be the judge of the law. I will make legal decisions during the trial, and I will explain to you the legal principles that must guide you in your decisions.

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.

II. Evidence

The evidence from which you are to find the facts consists of the following:

1. The testimony of the witnesses;
2. Documents and other items received as exhibits; and
3. Any facts that are stipulated—that is, formally agreed to by the parties.

The following things are NOT evidence:

1. Statements, arguments, and questions of the lawyers for the parties in this case;
2. Objections by lawyers; and
3. Any testimony I tell you to disregard.

You must make your decision based only on the evidence presented in court. Do not let rumors, suspicions, or anything seen or heard outside of court influence your decision in any way.

You should use your common sense in weighing the evidence. Consider it in light of your everyday experience with people and events, and give it whatever weight you believe it deserves.

Certain rules control what can be received into evidence. When a lawyer asks a question or offers an exhibit into evidence, and a lawyer on the other side thinks that it is not permitted by the

rules of evidence, that lawyer may object. An objection simply means that the lawyer is requesting that I make a decision on a particular rule of evidence. Objections to questions are not evidence. You should not be influenced by the objection or by my ruling on it. If the objection is sustained, ignore the question. If it is overruled, treat the answer like any other.

A. Direct and Circumstantial Evidence

Evidence may either be direct or circumstantial. Direct evidence is direct proof of a fact, such as testimony by a witness about what that witness personally saw, heard, or did. Circumstantial evidence is proof of one or more facts from which you could find another fact. You should consider both kinds of evidence. The law makes no distinction between the weight to be given to either direct or circumstantial evidence. You may decide the case solely based on circumstantial evidence.

B. Credibility

In deciding the facts, you must determine what testimony you do and do not believe. You are the sole judges of the credibility, or believability, of the witnesses. You may believe all, some, or none of a witness's testimony. In deciding which testimony to believe, you should use the same tests of truthfulness as in your everyday lives, including the following factors:

1. The ability of the witness to see, hear, or know the things the witness testifies to;
2. The quality of the witness's understanding and memory;
3. The witness's manner and behavior while testifying;
4. The witness's interest in the outcome of the case or any motive, bias, or prejudice;
5. Whether the witness is contradicted by anything the witness said or wrote before trial or by other evidence; and
6. How reasonable the witness's testimony is when considered in the light of other evidence that you believe.

Inconsistencies or discrepancies within a witness's testimony or between the testimonies of different witnesses may or may not cause you to disbelieve a witness's testimony. Two or more persons witnessing an event may simply see or hear it differently. Mistaken recollection, like a person's 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.

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. More important is how believable the witnesses were, and how much weight you think their testimony deserves.

You will now hear opening statements by the parties and the presentation of evidence. At the conclusion of the evidence, I will instruct you on the law that you are to apply to the facts.

POST-TRIAL INSTRUCTIONS

I. Duty of Jury; Apply the Law

Members of the jury, you have seen and heard all the evidence and the arguments of the lawyers. It is your duty to find the facts and to render a verdict reflecting the truth. You should consider all the evidence, the arguments, contentions and positions urged by the attorney(s), and any other contention that arises from the evidence. All of you must agree to your verdict.

My role now is to explain to you the legal principles that must guide you in your decisions. 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.

II. Burden of Proof

This case is a civil case in which Plaintiff Rory Thomas, the parent and duly authorized Personal Representative and Independent Administrator of the Estate of Sloane Thomas, seeks damages. The Plaintiff has the burden of proving his or her case by the preponderance of the evidence. That means the Plaintiff must prove to you, in light of all the evidence, that what he or she claims happened is more likely true than not. If the Plaintiff fails to meet this burden, then the verdict must be for the Defendant ("not liable"). If you find after considering all the evidence that a claim or fact is more likely true than not, then the claim or fact has been proved by a preponderance of the evidence.

The Defendant in this case has asserted an affirmative defense of comparative negligence, claiming that the Plaintiff's harm was caused by the Plaintiff's own actions. The Defendant has the burden of proving the affirmative defense by a preponderance of the evidence.

In determining whether any fact has been proved by a preponderance of evidence, you may, unless otherwise instructed, consider the testimony of all witnesses regardless of who called them, and consider all exhibits received into evidence, regardless of who produced them.

This case is divided into two parts, and in this part of the trial, the amount of damages is not an issue that you will decide. As such, the Plaintiff need not prove the amount of the injuries or damages at this time, although the Plaintiff is required in this phase to prove the existence of some damages in order to meet the Plaintiff's burden of proof.

III. Issues in the Case

The Plaintiff claims that Sloane Thomas suffered injury and wrongful death when the Defendant, Arya Davis, M.D., did not follow the Standard of Care when prescribing pain medications to Plaintiff Sloane Thomas. The Plaintiff has the burden of proving his/her claims. The Defendant denies the Plaintiff's claims.

To the extent that you find that the Defendant did not follow the Standard of Care in the medical treatment of Plaintiff Sloane Thomas, the Defendant argues that Plaintiff's own actions were responsible for the Plaintiff's injury and death. The Defendant has the burden of proving this affirmative defense by a preponderance of the evidence.

To find the Defendant liable for negligence, medical malpractice, and wrongful death, you must determine by the preponderance of the evidence that the healthcare provided by the Defendant was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities under the same or similar circumstances at the time. Specifically, the Plaintiff must prove the following:

1. The Defendant had a duty to exercise reasonable care in treating the Plaintiff with drugs or medications;
2. The Defendant failed to exercise reasonable care;
3. The Plaintiff suffered an injury; and
4. The Defendant's failure to exercise reasonable care directly and proximately caused the Plaintiff's injury and death, meaning that (a) but for the Defendant's conduct, the death would not have occurred; and (b) the death was a reasonably foreseeable result of the Defendant's conduct.

To the extent you determine that the Defendant is liable for failing to follow the Standard of Care in the medical treatment provided to the Plaintiff, you must determine what percentage, if any, of the Plaintiff's harm was caused by the Plaintiff's own actions. Any monetary damages provided to the Plaintiff will be reduced by the percentage of harm caused by the Plaintiff's own actions. If the negligence of the Plaintiff exceeds that of the Defendant, the Plaintiff will recover nothing.

You may now retire to the jury room to deliberate.

AFFIDAVIT OF RORY THOMAS

My name is Rory Thomas. I'm a 46-year-old single parent living in Utopia City, Utopia. My spouse Rowan and I were high school sweethearts. Because Rowan's father was an alcoholic, Rowan never touched the stuff. My older sister suffered from severe depression and died of a drug overdose when I was a child, so I avoided alcohol and drugs, too. We didn't need any of that stuff to have fun! In fact, we had the perfect life: one child, a house with a white picket fence, the whole bit -- until Rowan died 16 years ago in a car crash.

In 2002, Rowan's father invited Rowan to come with him to the Super Bowl to celebrate his one-year anniversary of being sober. Their car ran off the road on the way home, hitting a tree at 75 mph, killing both of them instantly. I've always wondered if alcohol was involved. I'd stayed home with our son, Sloane, who had just turned five years old a month earlier. I was devastated by Rowan's death and walked around in a daze for weeks, but I finally pulled myself together for Sloane's sake. As soon as Sloane started kindergarten, I studied to get my Master's degree in Library Science. For more than a decade now, I've served as Curator for the Rare Books collection at Utopia University. The quiet, peaceful surroundings in the library are the only thing keeping me from falling apart, now that Sloane's gone, too.

Sloane was an outgoing, athletic child who loved life. I can remember Sloane leading all the neighborhood kids on "adventures" in the woods near our home, climbing trees, jumping off big rocks into streams, that sort of thing. Sloane worked hard at whatever he took an interest in, earning his Eagle Scout rank and demonstrating strong leadership skills. As a teen, Sloane talked about one day starting an "Ecology Adventure" camp for city kids who'd never had the chance to explore the outdoors like he had.

As soon as Sloane was old enough, I enrolled him in every sport I could, just to channel all that energy. Basketball, soccer, volleyball, lacrosse – if a ball was involved, Sloane was all about it. Sloane was tall, and incredibly fast and coordinated. Basketball soon became Sloane's passion. As a high school freshman, Sloane not only made the varsity basketball team at Utopia High School, he became the starting forward by mid-

season, despite the fact that we couldn't afford for him to play on travel teams. College scouts started attending the high school games, and it was clear Sloane would be offered scholarships to multiple schools. By the middle of his sophomore year, Sloane was focused on earning a full ride to college and playing pro ball as a career. Sloane figured fame and fortune would eventually make it possible to start those adventure camps.

I went to as many high school games as I could, and I even joined the athletic boosters club to help support the program. On February 5, 2013, I had a front-row seat as the team played their biggest rival, Bethlehem High, at home. The refs were letting the game get pretty physical, and early in the second half, Sloane was scrambling under the basket for a rebound when an opposing player stepped on Sloane's right foot and shoved Sloane to the floor. Sloane tried to get up but couldn't put weight on his ankle, crying out in pain. The team trainer wrapped the ankle, and first thing the next morning, I took Sloane to see the sports medicine doctor the trainer recommended: Dr. Arya Davis, an orthopedic surgeon at Utopia University Sports Medicine Clinic.

We filled out the required forms, got the ankle x-rayed, and then waited for Dr. Davis to see us. Dr. Davis didn't ask a lot of questions, spending maybe five minutes examining Sloane's ankle and reviewing the x-rays. I was a bit surprised Dr. Davis didn't review Sloane's medical history in more detail before moving on. Dr. Davis diagnosed a fractured ankle but concluded that no surgery was needed. Dr. Davis put a cast on the ankle and prescribed a week-long course of the painkiller Vicodin HP. I was present for Sloane's entire examination, and I don't remember Dr. Davis going over any cautions or warnings about Vicodin HP being addictive. We picked up the prescription at the clinic pharmacy and headed home so Sloane could rest. We didn't ask any questions of the pharmacist because we planned to read the drug information sheet when we got home. But I must admit I was so busy caring for Sloane that I only skimmed it briefly.

I went with Sloane to the weekly follow up visits for x-rays to make sure the bones were healing properly. At the first visit, Sloane was still in pain and asked for more Vicodin HP, but Dr. Davis told Sloane that Advil should do the trick and that too much Vicodin HP wasn't a good idea. After eight weeks the cast came off and Sloane

started twice-weekly physical therapy ("PT") sessions to strengthen his ankle. Sloane worked hard at the PT exercises and by mid-summer was playing just as well as before.

In fall of his senior year (2014-15), Sloane received basketball scholarship offers from many top schools, including UNC, Kentucky, Michigan, and Villanova. I was sure Sloane would attend college out of state, but instead, he accepted a full-ride scholarship from our hometown Utopia University. UU had a strong basketball team and a top-five program in Outdoor Adventure Leadership that would prepare Sloane for his long-term career goals. It seemed a perfect fit, and I was glad he decided to stay close to home.

Sloane's basketball scholarship required him to live in one of the campus houses set aside for scholarship athletes. They were similar to Greek houses, so I must admit I was a bit worried they might have a "party" atmosphere. But Sloane's coaches assured me that wasn't the case; they told us at the pre-season orientation that having athletes-only housing helped students deal with the extra pressures of classes and intense practice schedules. Sloane wasn't a starter as a freshman, but he did average 15 minutes or so a game. I was proud that Sloane earned a starting position as a sophomore, although I was a bit concerned that Sloane seemed more stressed when we spoke. Sloane finally admitted that his grades had slipped a bit, but he assured me that all was under control and the scholarship wasn't in danger. The team was doing great and advanced to the first round of the NCAA tournament before losing to UNC.

Sloane decided to stay in town for spring break (March 11-19, 2017) and on March 15, he came by the house to do laundry. Several of his friends stopped by, and they went outside to play a pick-up game. I had just gone to the door to ask if I should order pizza when Sloane went up for a dunk, was bumped, and fell, landing hard on his outstretched left arm. Sloane screamed in pain and I rushed over. He insisted that applying ice and resting would be sufficient, but when he couldn't sleep due to the pain or raise his arm the next day, we went to see Dr. Davis. An MRI revealed a serious tear to Sloane's rotator cuff, and Dr. Davis scheduled surgery for Tuesday, March 21, 2017.

I went with Sloane to the surgery appointment. The surgery went well, but Dr. Davis said Sloane would experience pain for quite a while afterward. Dr. Davis wrote a

30-day prescription (180 pills) for Vicodin HP, which I filled at the clinic pharmacy before we left. When going over post-operation instructions with both of us, Dr. Davis said little, if anything, about a risk of addiction to Vicodin HP. After Sloane spent one night at home, I took him back to campus. Of course I didn't attend his follow-up doctor visits, but Sloane was still on my medical insurance so I got invoices for all medical visits and prescriptions. I noticed that he refilled the Vicodin prescription two more times, on April 12 and May 17, but I didn't think much about it. I sure wish it had caught my attention, but I trusted that Dr. Davis was following Sloane's care closely.

After the semester ended in early May, Sloane came home for the summer. He had lined up a job as a YMCA camp counselor starting on June 19. In the meantime, Sloane was asleep when I left for work and gone when I came home, returning after I went to bed. I wondered what he was up to, so on June 6, I came home for lunch, hoping he'd be there. I heard music blaring, so I knocked on his door and went in.

I saw Sloane and a friend playing video games. I didn't really notice who the friend was because I saw Sloane's Vicodin HP bottle on the dresser, empty, even though it should have had pills for ten more days since it was refilled on May 17. Walking closer, I saw another prescription bottle beside it. That bottle had someone else's name on it – I don't remember who – and ten to twelve Vicodin pills in it. Several empty beer bottles lay on the floor as well. I didn't know the age of Sloane's friend, but Sloane was only 20 years old. Alarmed, I dragged Sloane into the kitchen and confronted him (the friend left at some point; I don't know when). We were both pretty upset. After we calmed down, Sloane denied drinking but reluctantly admitted that he had taken extra pills to deal with his pain and had finished up all his Vicodin already. He said Dr. Davis wouldn't prescribe more without seeing him in person later in June, so he got a few extra pills from a friend at college. He claimed, "It's no big deal, really it isn't."

Well, it was a big deal to me. I suspected Sloane might be drinking, but either way, he was definitely taking others' prescription opioids. I was terrified he'd inherited his grandfather's susceptibility to addiction. I'd never told Sloane about the family history of substance abuse, and I didn't do so now either. Maybe if I'd been honest about

it, he would have been more careful and none of this would have happened. In any case, I knew it was important to get help for Sloane right away, whether he wanted it or not.

So I ordered Sloane to pack a bag, telling him that he had to enter rehab or I'd call the cops. Sloane knew I meant it. Our neighbor's child had gone to Four Seasons Recovery Center in North Carolina that spring and come home clean. Four Seasons had a highly-regarded inpatient Adventure Therapy program that would be perfect for Sloane, so I called them and begged them to give Sloane a spot. The Director finally agreed. While Sloane packed, I flushed the other Vicodin pills down the toilet and threw away the bottle. I drove Sloane to Four Seasons that very day. When I got home, I called Dr. Davis's clinic to cancel Sloane's next appointment and inform them he was in rehab for 60 days. My call went straight to voicemail, so I tried to leave a message. But the system didn't work right; the recording said the mailbox was full. I'm sure I would have called back and left a message the next day, although no one from Dr. Davis's office ever followed up with me. I never told anyone at UU about Sloane's rehab because I figured Sloane should decide who to share the information with, and I didn't want to do anything that might cause him to lose his basketball scholarship.

When Sloane came home with me in early August, he was a changed person – happy, motivated, back on track. I was so thankful! He didn't talk much about his experiences at Four Seasons – I figured he'd confide in his friends – but I was confident he would be okay. He returned to the university a week later and called me weekly to check in. When preseason basketball training began, Sloane retained his starting position, and it was clear that Sloane was fully recovered physically as well as mentally.

When the season started, I went to every home game. Sloane was doing great, and I saw some NBA scouts in the stands. But on November 30, 2017, Sloane dove for a ball going out-of-bounds and landed awkwardly, twisting his right ankle and falling on his left shoulder. He was clearly in a lot of pain when he was subbed out of the game. I called to check on him the next day and he told me nothing was broken; that he just needed to take it easy for a few weeks. Sloane didn't mention that he'd been prescribed any pain medications, much less Vicodin HP. I figured he was just taking Advil.

On New Year's Eve, Sloane told me that friends had invited him to a party to celebrate the New Year and Sloane's upcoming 21st birthday. I reminded Sloane not to drink: "Your rehab counselor said no alcohol, right?!" I was tempted to reveal our family history of alcoholism and substance abuse, but I trusted Sloane and didn't want to imply otherwise. I'll regret that decision for the rest of my life.

In the middle of that night – I think it was around 4:00 a.m. on January 1 but I'm not positive – I got a call from Utopia University Medical Center telling me to come right away, that Sloane was in trouble. I threw on clothes and got there as fast as I could. When I arrived, an ER doctor took me aside and told me how sorry he was, but that Sloane had passed away. He said something about an overdose and "unresponsive when emergency personnel arrived" and "we did all we could." I screamed and my knees buckled as the doctor caught me before I hit the floor. The rest of the night is just a blur.

The very next day, my insurance invoices for Sloane's December medical expenses arrived in the mail. That's when I learned he'd seen Dr. Davis, who had prescribed Vicodin HP again. I was stunned. Sloane didn't share a lot with me when he got back from Four Seasons, but he did say that he should never take opioid pain meds again; the risk of a relapse was just too high. When I saw that Dr. Davis had prescribed Vicodin HP again right before Sloane died, I decided I had to bring this lawsuit.

I can't bring Sloane back, but I can try to make sure Dr. Davis never puts any other person in harm's way. Dr. Davis needs to be held accountable for Sloane's death. I plan to donate every penny I receive to the Four Seasons Recovery Center.

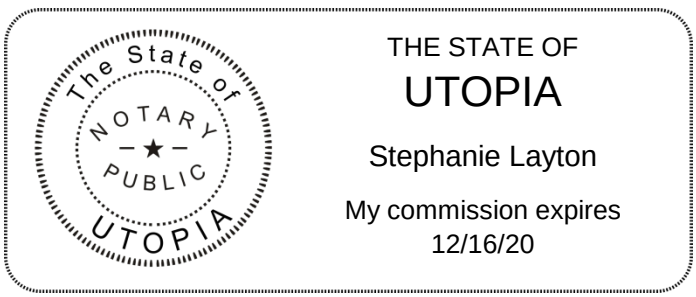
Of the available exhibits, I am familiar with the following and only the following: Exhibit 1, the photos of Vicodin HP pills and bottle; Exhibit 2B, the Vicodin HP Medication Guide; and Exhibits 5A-C, Dr. Davis's notes from Sloane's medical chart at the UUSMC.

Rory Thomas

SIGNATURE

Stephanie Layton

Stephanie Layton
Notary Public



Date: July 20, 2018

AFFIDAVIT OF DALLAS SANCHEZ

My name is Dallas Sanchez. I'm from California, but in August of 2015, when I was 18 years old, I moved to Utopia City to attend Utopia University on a track scholarship. UU requires all scholarship athletes to stay in athletes-only housing. Thirty of us lived in the house I was in (guys and girls on separate floors), including Sloane Thomas. Even though we played different sports, Sloane and I became great friends. After he overdosed, I was so upset I dropped out of UU a month into the semester and transferred to UCLA in the fall. I still can't believe Sloane's gone. I never thought anything like this could happen.

Sloane's death hit me hard because I encouraged him to attend the New Year's Eve party where he overdosed. Sloane had been saying over and over how he needed more pain meds until he could see his doctor again, and I'd heard that meds would be available at the party. I was just trying to help Sloane out so he could keep playing and impress the NBA scouts. Even though I know it's not my fault he overdosed, I can't help feeling a bit responsible. But the person who's really at fault is the doctor who got Sloane hooked on pain meds in the first place. If Dr. Davis had been paying attention, Dr. Davis would've recognized Sloane's addiction and would have prescribed something else, and then Sloane would still be here. Sloane wasn't a druggie – he only got addicted because of Dr. Davis.

Sloane was such a great guy. Like I said, everyone in our UU house was on a sports team. Sloane and I started chatting at the ice cream social during Orientation week, and we found that we had a lot of the same interests. For instance, we both liked playing Madden. We didn't have any classes together – I was majoring in Athletic Training while he was doing Outdoor Leadership – but we started hanging out a lot. He'd even come watch my track meets sometimes, and of course I went to all the men's basketball games.

Freshman year, Sloane played 5-10 minutes every game, which is a big deal because UU doesn't have a bunch of "one and done" players like Kentucky. Soon Sloane became a fan favorite and started getting invited to a lot of parties. I was a little jealous that he was so popular, but he took me along most of the time, so we were still close. It didn't hurt that Sloane was also super fun at these parties. He was always cracking jokes and making people laugh. I wished I could be so comfortable and at-ease around crowds of people; he

was just incredibly friendly and not at all conceited. Unlike many students, he didn't need to get drunk to have a good time. I'd usually have a beer or two, but he mostly stuck to soda – said he didn't want to take a chance on doing something stupid and getting hurt. I only saw him snag a beer once or twice all year. By our sophomore year, Sloane was a starter and star player on the team and was already drawing attention from NBA scouts.

I don't know for sure when Sloane first started taking Vicodin. The first time I learned about it was April 29, 2017, when we went to watch a lacrosse game. I saw Sloane take some Vicodin HP from a prescription bottle during a break in the action. I knew some guys at UU who took Vicodin they got illegally because they said it made them feel happy and relaxed. But from what I observed, the guys who took it regularly were unfocused and moody. Sloane didn't seem like the kind of person who would be into drugs like that. He was very straight and narrow, and he always talked about his basketball career. So, I asked him about the Vicodin.

Sloane said he got the Vicodin from his surgeon, Dr. Davis, to deal with the pain after his shoulder surgery in March. I knew Sloane had hurt himself playing basketball over spring break. He had told me he got undercut going up for a dunk shot in a pick-up game and tore his rotator cuff. I was surprised he was still taking Vicodin more than a month after surgery, but he said the meds made him feel a lot better. Maybe they did. But I'd already noticed that he hadn't seemed like himself for several weeks; he'd been anxious and gotten upset easily, and he'd thrown up several times for no apparent reason. I had assumed he was stressed about missing practice because of the injury, but now I wondered if it was more than that. My sister had taken Vicodin for a short period after an ACL surgery, and she'd experienced similar side effects. In fact, she quit taking it and threw out the rest of her pills. From what I saw with my sister, Vicodin is pretty powerful stuff.

I know Sloane was still using Vicodin HP on June 2, 2017, because I saw him taking them when I went to his house to play Madden (he was living with Rory for the summer). I noticed the bottle only had a couple of pills left. When he saw me looking, Sloane asked me if I knew any way he could get more. He said it was a few weeks before he'd see Dr. Davis again, but he was still in pain and over-the-counter meds like Advil didn't cut it. He

was shaking and seemed anxious and obsessive about it – almost panicky, even. When I said no, he balled up his fist and looked really upset; it startled me, to be honest. I was worried about him. I asked if he knew these kinds of pills could be dangerous, and I told him about my sister's negative experience. After what she'd gone through, I'd read blogs online that said people can overdose on opioids, and I didn't want Sloane to get hurt.

Sloane looked at me like I was crazy for questioning him. He said he had talked to Dr. Davis, who'd told him he'd be fine as long as he didn't overdo it. Sloane added, "In fact, Dr. Davis told me to call if I ever needed more. I'm going to do that right now!" He picked up his phone and dialed, but it went straight to voicemail with a bunch of selections. Sloane hit buttons trying to get a live person on the line, but no luck. He finally left a message in the general mailbox, asking Dr. Davis to call him. I remember what he said in the voicemail because he was so upset: "I'm almost out of Vicodin and I'm still in lots of pain. Dr. Davis told me to call if I need more meds. Well, I need more now!! Where is this doc?!" Sloane looked incredibly frustrated after he hung up. He said, "All I ever get is voicemail. I can't take this. I've got to get more Vicodin somehow." I didn't know what to say, so I didn't say anything.

Next time I saw Sloane was June 6, 2017. We were chilling in his room at his house playing Madden. I thought maybe Sloane had gone to see Dr. Davis on the weekend, because at one point he grabbed his left shoulder like it hurt and then took a Vicodin pill from a bottle on his dresser. The bottle had a dozen or so pills in it, certainly more pills than what I'd seen three days earlier. Just then, Sloane's parent Rory walked in. Rory looked at the label on the bottle, grabbed Sloane's right arm, and dragged him out of the room, leaving the bottle on the dresser. I don't know what happened exactly, but I heard Rory shouting, and I heard Sloane yell, "Those are prescription, come on." I looked at the bottle and it was a prescription, but it didn't have Sloane's name on it. I wasn't sure what was going on, but Rory and Sloane were still yelling, so I snuck out the back door. I tried texting Sloane afterward, several times in fact, but he never responded. I didn't see him anymore that summer. I figured he was ticked off at me because I was there when he got in trouble with Rory – it made no sense but I couldn't think what else could be going on.

When I saw Sloane at school in August, he avoided me at first. I tried asking about his summer, but he changed the subject. It was kind of awkward for a bit. And Sloane seemed different somehow: quieter, more careful, and even a little bit slower on the court. He also avoided the party scene. That changed in mid-November, though; Sloane was really stressed about exams, so I invited him to come out with some friends. I figured a burger and maybe a beer or two (I had a fake ID) would help him to chill out. He really didn't want to go, but I kept pressuring him. Finally he told me Rory had sent him to drug rehab in the summer, and the rehab docs said he should stay away from alcohol and everything like that. I was pretty shocked he'd been to rehab, but I kept my cool. I said he could just have soda, that he should get out and have some fun. Eventually Sloane agreed. We went out, Sloane stuck to burgers and soda, and he seemed like his old cheerful self again. After that he started going to parties and even had a beer or two occasionally. I never saw him taking any pain pills and he certainly never got plastered at any parties we both attended, so I figured it was all good.

On November 30, 2017, I was at the UU basketball game. We were playing our biggest rivals, the Eden University Salmon, in the season's first conference game. Sloane was absolutely dominating for the whole first quarter when, fighting for a loose ball, his right foot buckled under him and he landed hard on his left shoulder. Instantly he was surrounded by medical staff. When he tried to stand, he couldn't put any weight on his right ankle, and he held his left shoulder and grimaced like he was in a lot of pain. They took him to the locker room and he didn't come back out that night.

The next time I saw Sloane, he had another bottle of Vicodin HP, and he was popping pills like candy. I was surprised that he'd be taking opioids again after going to rehab. I started to ask about it, but he waved me off and said not to worry about it. Sloane said he told Dr. Davis about his stint in rehab when he saw the doctor for this new injury, and he even told Dr. Davis that his rehab therapist warned him not to take opioids again. But he said Dr. Davis told him that Vicodin HP was the only medication that would allow him to keep playing, which Sloane really wanted to do because so many NBA scouts were coming to watch him. According to Sloane, Dr. Davis said he'd be okay taking Vicodin HP

as long as he was careful. I was surprised to hear that, but I figured Dr. Davis would know best what was safe and what wasn't.

I didn't see Sloane again until almost three weeks later, when we got together for pizza at Pepper's. He wasn't acting like himself; he was moody and volatile, like he'd been acting back in June right before everything blew up with Rory. I asked if he was okay, and he said, "I'm almost out of my Vicodin. I really, really need more. I've been trying to get in touch with my doc, but when I called to make an appointment, I was told that Dr. Davis couldn't see me until after the holidays. I don't know what to do. I can't sleep, I'm in so much pain, and I can't keep any food down." I asked if he'd tried going to another doctor, but he said, "Nah, no one will see me over the holidays. It's a terrible time to try to get help. I need to find another way. Do you know anyone at school who sells these things?"

He looked so desperate, I was afraid he might do something crazy. I tried to think, and I remembered that I'd heard someone might be selling stuff at a New Year's Eve party at a frat house on campus. I didn't want to tell him, but I think he could see in my eyes that I knew something. He grabbed my arm and said, "If you know someone, you have to tell me. I'm dying here." So I told him about what I'd heard – that I didn't know who the person was, just that they'd be at the party dressed as someone from Game of Thrones (it was a costume party). Sloane looked relieved and said, "Thanks, I owe you big time. I'll be there, then; I gotta have it." I'm sure I looked uneasy, so Sloane added, "This'll help me celebrate my 21st birthday a little early! I really appreciate it." Sloane looked happier than I'd seen him in weeks, so I felt a little better.

New Year's Eve finally arrived. I went to the party dressed as Snoopy, and Sloane was uncreatively dressed as a basketball player. As usual, Sloane was the center of attention most of the night, while I mainly hung out in a different room with some other friends. He had a couple of beers in his hands when I saw him around 10:00 pm. There were several people dressed up like Game of Thrones characters at the party, so I don't know exactly when Sloane met up with the one who had the pain meds. But around 11:30 pm, Sloane found me and flashed a bag filled with pills that looked like Vicodin. I never saw Sloane take any, but given what happened that night, I believe he did.

I didn't see Sloane for several hours until I heard people shouting from the room where he had been hanging out. I ran in to see someone dressed as a strawberry shaking Sloane and trying to wake him up. Apparently Sloane had been unconscious for some time, but nobody noticed or tried to do anything about it. People were freaking out, acting all panicked, so I dialed 911 and told them what was happening. They said EMTs were on the way. It seemed to take forever for the ambulance to arrive, and nearly everyone else fled the scene, afraid of getting charged with underage drinking or worse. I had stayed with Sloane and was trying to help. I didn't know what to do, but I looked up CPR and rescue breathing on my phone and tried to save him. I did my best, but it wasn't working. I don't think he was breathing when they finally put him on the stretcher. I was terrified when the police started grilling me about it all.

Even though I don't think Sloane's death is my fault, I can't forgive myself for telling him about the party. I try to remember that I didn't give the pills to Sloane at the party and I didn't know he was going to take any that night. And anyway, Sloane got addicted from the Vicodin HP that Dr. Davis kept prescribing to him. Doctors are supposed to watch out for their patients, not get them addicted and leave them hanging. Sloane would still be here if Dr. Davis had been paying attention to how Sloane was acting. The jury should make Dr. Davis pay.

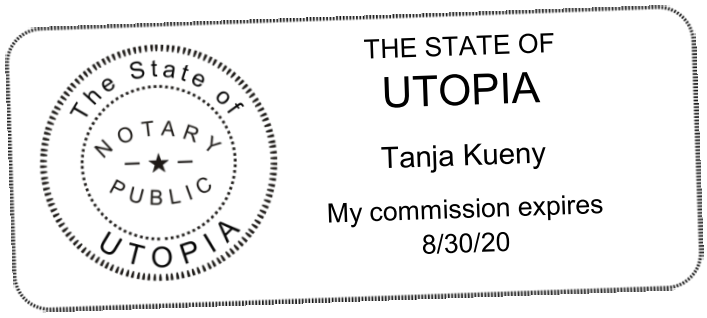
Of the available exhibits, I am familiar with the following and only the following: Exhibit 1, the photo of Vicodin pills and bottle; and Exhibit 3, the texts between me and Sloane in December of 2017.

Dallas Sanchez

SIGNATURE

Tanja Kueny

Tanja Kueny
Notary Public



Date: July 27, 2018

BLAKE SPALLER, M.D.
THOMAS v. DAVIS, EXPERT REPORT
AUGUST 15, 2018

INTRODUCTION

I have been retained by Plaintiff's counsel to evaluate the medical care provided to Sloane Thomas by Dr. Arya Davis. Specifically, I was asked to determine whether or not Dr. Davis's prescription of opioid painkillers was conducted in accordance with the standards of ordinary care used in the fields of orthopedic surgery and sports medicine.

PROFESSIONAL BACKGROUND

I am the Chief of Sports Medicine and a Distinguished Professor of Orthopedic Surgery at Emory University School of Medicine in Atlanta, Georgia. Prior to accepting a position at Emory, I worked as an orthopedic surgeon for six years at the Utopia University Sports Medicine Center. I am Board certified in both Sports Medicine and Orthopedics and have published numerous research articles and penned many textbook chapters. I also serve as the head Team Physician and orthopedist for the Georgia Institute of Technology and the NBA Atlanta Hawks. Please refer to my C.V. (Exhibit 4, attached) for more details.

I have testified as an expert in medical malpractice cases ten times, half of them for the defense. I should note that my nephew became addicted to prescription opioids, which culminated in a heroin addiction and his death in 2014 from an overdose. Since then, I have made it my mission to educate physicians and the general public on factors contributing to the current opioid epidemic. I have received grant funding from the Centers for Disease Control ("CDC") to conduct research on the effects of opioid-based pain management on athletes. In the future, I hope to work with the CDC in a more formal capacity and desire one day to lead that organization. My involvement in this case will bring my research and expertise relating to opioid prescription into the public eye and may act as a stepping-stone to that career change. I am not being compensated, and will not be compensated on any contingency basis, for my investigation or testimony in court.

MATERIALS REVIEWED

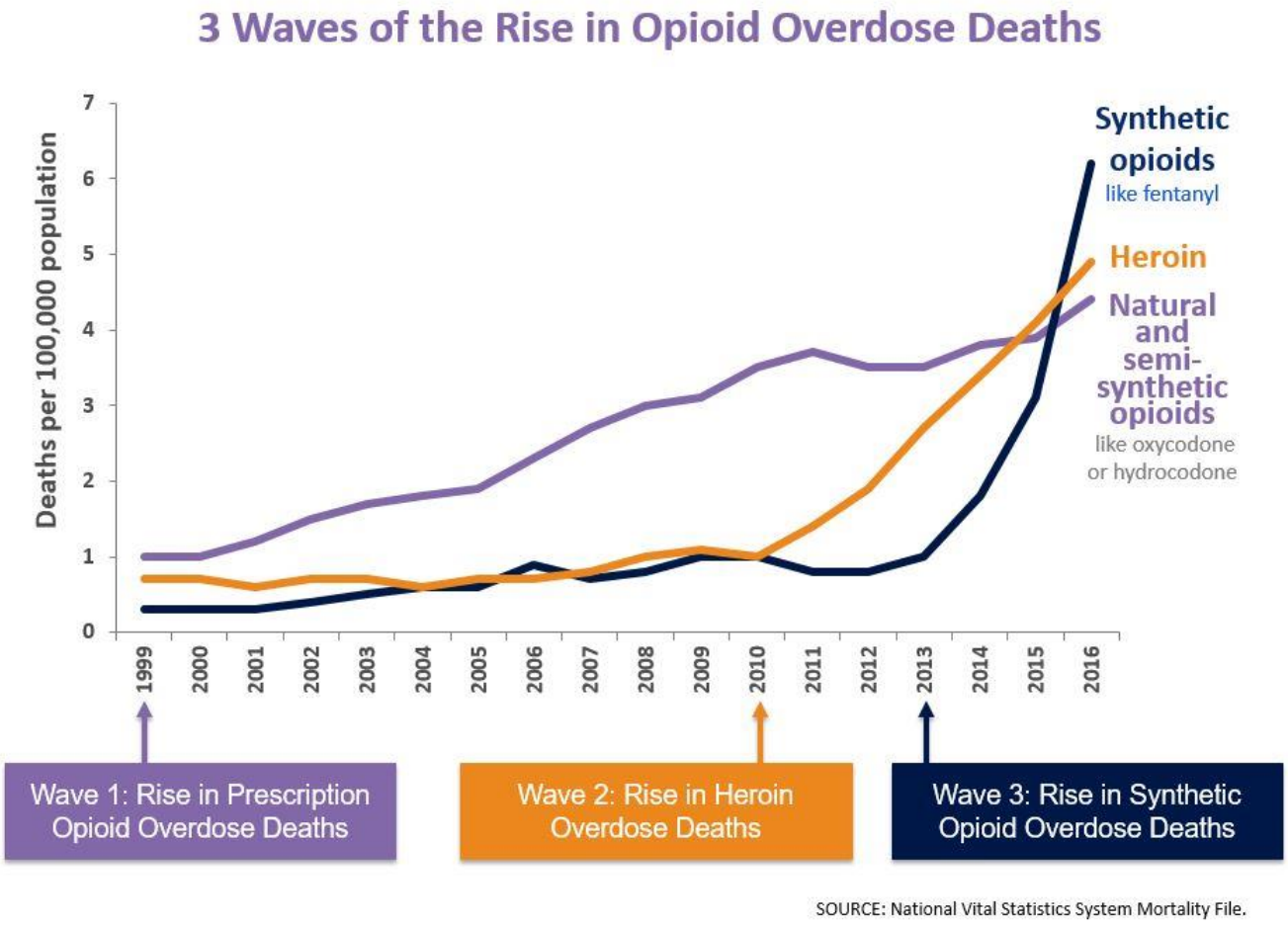
I reviewed documents relating to Sloane Thomas's medical care, including Sloane's medical records from Dr. Davis's office and the autopsy report created after Sloane's death. In addition, I reviewed the statements of Rory Thomas and Dr. Arya Davis. I also consulted Exhibit 2A, the 2017 Physicians' Desk Reference ("PDR") Fact Sheet for Vicodin HP. I attempted to interview Dr. Davis, but my request was declined, based on advice of Dr. Davis's counsel. I did not request interviews with any other witnesses related to this case. While an interview with Dr. Davis would have aided in my analysis, the documents I

reviewed gave me all of the information I needed to reach my conclusions.

From my own Orthopedics and Sports Medicine practice in both Utopia and Georgia, I have extensive experience regarding the prescription, use, and misuse of opioid pain relievers. I was able to use my experience in the field, my knowledge of the appropriate standard of care, and the documents I reviewed to perform an independent audit of Dr. Davis's actions. This type of analysis is standard in my field, and the methods I used for assessing Dr. Davis's actions have been published in numerous medical journals.

BRIEF BACKGROUND INFORMATION ON THE OPIOID EPIDEMIC

A brief recounting of the current opioid epidemic is warranted. The CDC recently reported that in 2016, approximately 115 Americans died each day from opioid overdose (both prescription and illicit opioids). Opioid deaths have been on the rise ever since patients' self-reported levels of pain became the "fifth vital sign" in 1989. At that time, physicians were encouraged to manage pain by using opioids when necessary and were assured by manufacturers that if used properly, opioids presented a very low risk of addiction or harm to patients. In truth, recent research reveals that up to one quarter of patients receiving prescription opioids long-term (more than a year) in a primary care setting struggle with



addiction. Susceptibility to addiction can vary, but it is known that those with a history of personal or familial substance abuse (including alcohol and drugs) or untreated mental health issues are at greater risk of addiction. As prescription opioids such as Vicodin rose in price, addicted individuals turned first to heroin (which was less expensive), and then to synthetic opioids such as fentanyl, to satisfy their cravings and to avoid suffering withdrawal syndrome. **The figure above** shows the impact of these substances on the number of deaths due to opioid overdose from 1999 - 2016.

OLDER STANDARDS OF CARE

In 2012-13, CDC guidelines focused on safety precautions for “high risk patients,” which included patients already struggling with addiction, those with a family history of substance abuse, and individuals with mental illness. If a patient did not fall into one of those categories, medical providers were informed they could confidently prescribe opioids at low to moderate doses without putting patients at risk for negative outcomes.

RECENT DEVELOPMENTS

As opioid-related addiction, misuse, abuse, and deaths have skyrocketed, it has become clear that opioids are not as safe as was previously believed to be the case. To deal with the escalating crisis, the standard of care has evolved. In 2018 prescribing high doses of opioids for management of acute pain is substantially less acceptable than it was five to ten years ago. CDC guidelines for management of chronic, long-term pain (lasting six months or more) have also become more stringent, albeit to a lesser degree than for acute pain management. Nonetheless, in all cases, physicians are expected to be much more cautious than before when evaluating the proper use of opioids to alleviate pain.

1. ASSESSING PATIENT RISK FACTORS

Physicians should assess patients for known risk factors prior to prescribing opioids. Patients at increased risk include those with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (such as major depression). If absolutely necessary, such patients may be prescribed opioids with great care, but only with intensive counseling about the risks and proper use of opioids and intensive monitoring for signs of addiction, abuse, and misuse. Patients who have previously suffered from opioid addiction should not be prescribed opioids again, except in extreme cases such as pain management for end-stage cancer or life-ending illnesses.

Obtaining an accurate personal and family medical history is extremely important when evaluating patients. While approaches may differ, general agreement exists that a physician must, at minimum, ask the patient to complete a questionnaire requesting the individual’s and their family’s history regarding any alcohol or drug use, past addiction, or related medical problems. Some physicians repeat key questions orally during the

examination to ensure accuracy of answers, while others find that such redundancy annoys patients and results in little, if any, new information. That being said, orthopedists generally agree that best practices require oral confirmation of crucial information. While a doctor may delegate that role to a nurse or other aide, the doctor ultimately assumes the responsibility of ensuring the medical history is complete.

It is important to note that patients can and sometimes do provide inaccurate information to physicians. To combat this problem, physicians should ensure that their questions are phrased clearly and concisely, reducing the likelihood of inaccurate reporting. Nonetheless, patients wishing to conceal or omit pertinent medical information cannot be prevented from doing so. Those administering questionnaires should be alert to patient behaviors that indicate possible false information, but ultimately, when a medical professional asks a clear question and a patient gives a false answer, the blame lies with the patient.

2. ASSESSING PATIENT INJURY

Physicians should reserve opioids for situations where non-opioid painkillers, such as Non-Steroidal Anti-Inflammatory Drugs ("NSAIDs"), are insufficient. This criterion is, admittedly, one that requires judgment on the part of the doctor. With some injuries, it is perfectly acceptable to prescribe an opioid after the first visit, while with others, it is much more appropriate to manage pain solely with NSAIDs.

3. DETERMINING PROPER DOSAGE

When opioids are appropriate, a clinician should begin by prescribing the lowest effective dosage, consulting the PDR and following the guidelines listed. For instance, if a painkiller can be taken every four to six hours, a clinician should start by giving the patient only enough to take it every six hours; if a painkiller can be safely taken in multiples of one or two per dose, the clinician should start by giving the patient enough to take only one. If the patient's pain persists, a physician can consider increasing the dosage but must use extreme caution when considering dosages greater than or equal 50 morphine milligram equivalents ("MME") per day. Under no circumstances should a physician prescribe more than 90 MME per day without extraordinary justification.

4. DETERMINING LENGTH OF PRESCRIPTION

Patients who take opioids for a longer period of time face a higher risk of tolerance, physical dependence, or addiction. Tolerance is the need for increasing doses of opioids to maintain a desired effect. Physical dependence results in withdrawal symptoms after abrupt discontinuation or a significant reduction in dosage. Thus, physicians should limit the length of any initial prescription, particularly for pain from acute injury. In the early 2010s, it may have been acceptable to give a low-risk patient a prescription lasting several

weeks, but that standard has changed. Since 2015, orthopedists have generally agreed that an initial prescription for more than 10 to 14 days is unacceptable for injuries requiring only outpatient surgery. Many choose to limit initial prescriptions to five to seven days. That being said, if necessary, physicians may authorize additional medication after the initial prescription ends or begin with longer prescriptions, as long as they conduct frequent follow-up with the patient (online, over the phone, or in person) and have a clearly documented rationale for the departure from the standard.

5. ENSURING PATIENT COMPLIANCE

Because some patients are susceptible to addiction even at recommended dosages, orthopedists have a duty to ensure that patients are adequately warned about the risks of opioid use. While the pharmacy provides written information to accompany the prescription, the prescribing doctor should make some effort to articulate warnings orally. At a minimum, a physician should advise the patient to take the medication only as directed and only as long as the severe pain persists. Doctors should warn patients that these drugs are addictive. This warning should be accompanied by an instruction to abstain from consuming alcohol for the duration of the prescription and to avoid driving or operating heavy machinery while under the influence of the narcotic.

Prescribers should monitor patient compliance. Follow-up appointments every three months should include blood tests to determine levels of opioids, alcohol, and other drugs. Physicians should also engage in a detailed discussion of the patient's behavior with regard to the prescription, including dosage and frequency of ingestion. No prescription should be extended if the patient is taking more than the maximum safe dosage.

ANALYSIS OF DR. ARYA DAVIS'S TREATMENT OF SLOANE THOMAS

1. 2013 INJURY AND RECOVERY

Dr. Davis first saw Sloane Thomas for an ankle injury in February of 2013. Based on Dr. Davis's notes, it is my professional opinion that Dr. Davis conducted an appropriate physical examination and asked questions on the written intake form to obtain the proper medical history. While I, personally, would have asked more follow-up questions during the patient encounter and given more verbal warnings about opioid risks, Dr. Davis did meet the minimum standard to obtain proper medical history. Dr. Davis's diagnosis seems valid and the course of treatment met the standard practice of care followed by other sports medicine physicians at the time. The decision to prescribe a one-week course of Vicodin HP was appropriate. While one could question Dr. Davis's decision to prescribe the maximum recommended safe dosage (six pills per day), the history Sloane provided on the patient intake form gave Dr. Davis no information to suggest that that Sloane was a high-risk patient. Based on this, I must conclude that Dr. Davis's 2013 actions met the standard of care Dr. Davis owed to Sloane.

2. SPRING 2017 INJURY AND SURGERY

Dr. Davis treated Sloane again when Sloane presented with a torn rotator cuff in March 2017. Post-surgery, Dr. Davis prescribed a 30-day course (180 pills) of Vicodin HP for pain management. The use of an opioid painkiller was acceptable in this situation, but the length and dosage of this initial prescription were unacceptable. Although physicians had not yet reached consensus on the proper prescription length for an injury of this type, the debate only encompassed prescription lengths of 7 to 14 days – nowhere near the month-long period of Dr. Davis's initial prescription. Furthermore, instead of prescribing the minimum effective dosage (one pill every six hours, or 40 MME per day), Dr. Davis prescribed the maximum dosage of six pills (60 MME) per day. Dr. Davis's medical notes offer no explanation to justify such a prescription. As a result, I must conclude that Dr. Davis deviated from the accepted standard with respect to the length and dosage of this initial prescription.

Additionally, Dr. Davis's minimal efforts to update Sloane's medical history leave much to be desired. Particularly with college athletes, who are frequently pressured to use alcohol and other drugs by peers, sports medicine practitioners are expected to clarify alcohol and drug use orally. That being said, knowing that Sloane exhibited no signs of abuse and that Sloane's parent kept him in the dark about their family history of substance abuse, it is possible that follow-up questions by Dr. Davis may not have yielded any new information that would have led Dr. Davis to re-think whether to prescribe Vicodin HP.

Dr. Davis's failure to properly follow up with Sloane is a much clearer breach of accepted practice. Dr. Davis conducted no weekly in-person follow-up sessions to monitor Sloane's adherence to the opioid directives, despite extending the prescription two times for a total length of 90 days and 540 pills. Even more alarmingly, Dr. Davis extended the prescription in spite of clear evidence that Sloane had abused the first course of medication. Sloane finished a 30-day prescription in 21 days, indicating that he either took more than the maximum recommended dosage or gave the pills to someone else. Assuming that Sloane took all the pills himself, he was averaging over 8.57 pills per day, or 85.7 MME. While this dosage does not exceed the 90 MME danger threshold, it is perilously close. In any event, the fact that Sloane claimed to have finished the prescription a week early should have been a red flag. Given Sloane's report of continued, severe pain, Dr. Davis should have insisted on an in-person meeting prior to renewing the prescription in order to assess Sloane's behavior, measure the amount of narcotic in Sloane's blood, and ensure that the pain, if legitimate, did not indicate a complication in the healing process.

Instead, Dr. Davis extended the prescription prior to the April appointment, and both the April and May appointments were not sufficiently comprehensive. I could find no record of blood tests to assess the presence of opioids, alcohol, or other drugs, or to check for

adrenal insufficiency. Such an omission is serious, especially given that Sloane demonstrated signs of Vicodin abuse, such as anxiety, mood swings, and a strong preoccupation with obtaining more Vicodin. Admittedly, these indicators can also reflect severe pain such as Sloane reported. However, the presence of these symptoms should prompt any competent provider to test, at minimum, the levels of opioids in the patient's blood. While Dr. Davis reportedly warned Sloane about opioid abuse in April and appropriately refused to extend the prescription again after May, Dr. Davis's decision to extend the prescription *at all* after Sloane admitted to deviating from the prescribed dosage was inappropriate. As a result, I must conclude that Dr. Davis failed to follow the standard of care, not only in Dr. Davis's initial prescription of an excessive amount of Vicodin HP, but also in Dr. Davis's failure to limit Sloane's access to Vicodin HP after Sloane's actions pointed to potential abuse.

3. DECEMBER 2017 INJURY

Dr. Davis saw Sloane again on December 1, 2017, after yet another sports injury. Sloane had no broken bones and did not require any surgery, yet Dr. Davis again prescribed a 30-day course of Vicodin HP. While other sports medicine practitioners might prescribe an opioid for a similar injury, widespread agreement exists that a five- to ten-day prescription is the appropriate amount for initial pain management in this type of situation. Furthermore, even if Dr. Davis was unaware of Sloane's stint in drug rehab as Dr. Davis claims, Sloane had exhibited questionable behavior with respect to opioid use previously. Dr. Davis should have insisted that Sloane initially manage his pain with rest, rehabilitation, and NSAIDs. Instead, Dr. Davis again overprescribed narcotics at Sloane's request. While Dr. Davis did adequately warn Sloane about the risk of addiction at this juncture, Sloane's high risk for addiction should have prompted Dr. Davis not to prescribe opioids at all.

4. SLOANE THOMAS'S DISCLOSURES

Based on my review of the documents in this case, it is clear that Sloane Thomas repeatedly failed to disclose all relevant information to Dr. Davis regarding Sloane's personal and family medical history. Reportedly Sloane's narrative was consistent and convincing enough that Dr. Davis had no reason to suspect that the information Sloane provided was incomplete or untrue. While Rory Thomas claims to have attempted to disclose Sloane's admission to Four Seasons Recovery Center to Dr. Davis, I could find no evidence that Rory's communications ever reached Dr. Davis or Dr. Davis's office. Had Dr. Davis been provided with accurate information detailing the family history of substance abuse and Sloane's history of addiction, Dr. Davis would have been able to change the course of Sloane's treatment accordingly. In that case, it is possible that Dr. Davis would not have prescribed opioids in December 2017 and Sloane would not have experienced the relapse that led to his death. That being said, Dr. Davis's decision to repeatedly prescribe lengthy courses of Vicodin HP was irresponsible even with the amount of information Dr.

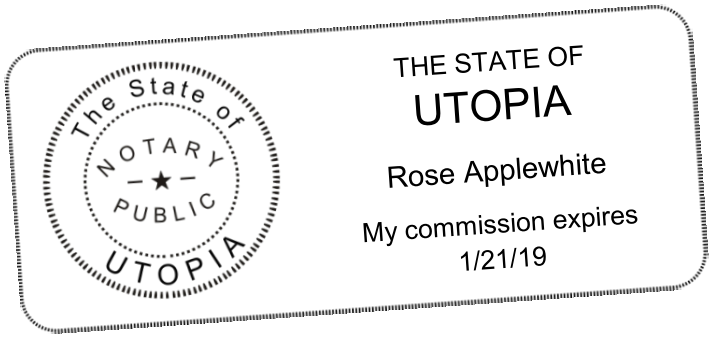
Davis had, so I must still conclude that Dr. Davis failed to abide by the standards of care expected in the fields of sports medicine and orthopedics.

DISCLAIMER

All of my expert conclusions related to this case are detailed in this report. Every conclusion presented has been rendered to a reasonable degree of scientific certainty. I know I have the obligation to update this report if new information comes to light that would alter my conclusions in any way.

Blake Spaller, M.D.
SIGNATURE

Rose Applewhite
Rose Applewhite
Notary Public



AFFIDAVIT OF ARYA DAVIS, M.D.

My name is Arya Davis, M.D. I live in Riverdale, Utopia. I earned my BSPH in Health Policy and Management at UNC-Chapel Hill in 1997 and my MD/MPH with a focus on Health Administration at East Carolina University Brody School of Medicine in 2002. I then completed my five-year residency in Orthopedic Surgery at Duke University. For the past ten years, I have worked as an orthopedic surgeon at Utopia University Sports Medicine Center ("UUSMC"). Like all physicians at UUSMC, I also hold a faculty appointment at Utopia University Medical School. While I spend most of my time working with patients, the faculty position enables me to work with students and conduct research. I've collaborated on three studies published in peer-reviewed journals. Because of my background in Health Administration, I was asked to serve on our UUSMC Human Resources committee in 2009.

Since my appointment to the HR committee, I've done everything possible to make UUSMC into the best sports medicine center in the country. I persuaded the committee to implement a continuing education program to make sure our surgeons are following best practices and instituted a weekly speaker series on sports medicine treatments and practices. I'm most proud of my role in strengthening UUSMC's focus on patients. As doctors, our primary job is to help patients regain and maintain their health, so high-quality patient care is our number one priority. Whenever patients call our office with questions or to report a problem, we make sure that they are able to speak with a live person and that the call is noted in the patient's chart. In 2010, UUSMC implemented a full-transparency system, where patients rate every single person involved in their care at UUSMC on a scale from one to five stars (with "five" being best). My personal goal is to make UUSMC a center with nothing but five-star ratings.

Pain management is a huge part of our role in ensuring patient satisfaction. At UUSMC, it's a priority to ensure our physicians are educated about recent advances in medical research and evolving standards of care. Opioids and pain management have been much in the news the past few years, leading some to think opioid-based painkillers

should only be used for end-stage cancer or patients with chronic, debilitating pain. Such concerns are valid for powerful, extended-release opioids, such as Oxycontin, but not for medications such as Vicodin. While every opioid-based pain reliever presents some risk of addiction, as long as patients take the recommended dosage of Vicodin, it is very unlikely they will become dependent. It is true that those with a personal or family history of substance abuse are at increased risk. Patients need to know that hydrocodone – one component of Vicodin – can lead to life-threatening respiratory depression at high doses or when combined with alcohol. That's why we ask patients about their family history, current medications, and use of alcohol or other drugs on our medical intake form. We need that information to prescribe any medication safely. In addition, every prescription dispensed at our clinic comes with the Physicians' Desk Reference ("PDR") Medication Guide that describes appropriate dosage, warnings, and other information.

In 2008 Finn Morrissey, an M.D. employed as a medical liaison for Empower Pharma, approached me to set up a meeting. Empower Pharma's main product line focuses on prescription pain relievers ("analgesics") such as Vicodin, which are frequently needed by our patients at UUSMC. I wanted to learn more about Empower's products, so I agreed to get together. I grilled Finn about Empower's research, testing methods, product effectiveness, side effects, and comparisons to other companies' products. Finn was very informative and answered all of my questions. Finn reinforced what I'd always believed about opioids – that when prescribed correctly, opioids significantly improve patients' lives by managing or even eliminating their pain. I was impressed by Finn's depth of knowledge and passion for promoting patient health. Finn also told me that physicians can earn bonuses for speaking about Empower's products at medical conferences, but I didn't really care about that. My concern was for my patients. I began prescribing Empower products, and I saw the difference they made in my patients' lives. So I encouraged other physicians at UUSMC to switch, too.

While some UUSMC physicians were reluctant to prescribe more opioid pain-relievers, citing concerns about side-effects or the potential for addiction, those fears proved unfounded. Our patients clearly appreciated the emphasis on effective pain

management and proactively asked for appointments with those physicians who were forward-thinking in that regard. The difference was unmistakable: the doctors who prescribed Empower analgesics had more five-star ratings than those who hesitated to do so. My own average rating rose from 4.1 stars to 4.9 stars as I prescribed more Empower products, and our overall patient ratings at UUSMC were higher than they'd ever been. When Finn offered me the opportunity to spread the word about our results by speaking at conferences, I jumped at the chance. I enjoy networking and educating others about effective pain management for their patients. And the free travel and bonus checks from Empower didn't hurt. Life was good. But that was about to change.

In October of 2016, my father was diagnosed with an aggressive pancreatic cancer. He started chemotherapy and radiation and was soon in so much pain that he could barely move or speak. In his younger days, dad had been a singer and guitarist for the band Driveshaft; he had always connected with the world through music, so it was devastating when he couldn't even strum a guitar without feeling pain. As an only child, I was responsible for taking care of dad and mom. I cut my work hours down to half of my usual load and stopped attending conferences; even so, I often felt like I was barely keeping my head above water. As dad's condition continued to worsen, my mom begged me to help him, so I finally asked his oncologist to prescribe Empower's Vicodin HP to manage dad's pain.

The change was dramatic. My dad's pain largely went away at first, although as the cancer progressed, the Vicodin HP wasn't enough. Soon it was clear that dad didn't have much time left. His pain kept increasing, so he was eventually put on a morphine drip. Thankfully that worked, and he was even able to strum his guitar and serenade my mom just like old times. One month later dad passed away, on January 5, 2017. Mom died one week later, of a massive stroke. I was in shock when I got the news.

I returned to work at UUSMC on January 14, 2017, still reeling at how quickly my world had turned upside down. Even now grief hits me hard at times. But as difficult as it was initially to focus on work, it felt cathartic to start seeing patients again. It gave me a chance to solve problems and help people get their lives back.

Sloane Thomas was one of my patients. I first met Sloane when he came to UUSMC on February 6, 2013, after he suffered an ankle injury during a high school basketball game the night before. I remember our first meeting very well because of how scared Sloane and his parent, Rory, were. As I reviewed Sloane's medical history form upon entering the examination room, Rory kept asking me if Sloane "would ever be able to play again," while Sloane gnawed nervously on his fingernails.

I examined Sloane's ankle for a few minutes and then I had him do some flexibility exercises. Sloane visibly grimaced as I rotated his ankle; it was clear he was in serious pain. Afterward Sloane exclaimed, "My ankle really, really hurts!" and Rory said, "Sloane has been in a lot of pain since the injury happened." I ordered a panel of x-rays, which showed that Sloane had a serious ankle fracture.

I put a cast on the ankle and prescribed a seven-day course (42 pills) of Vicodin HP for the pain. Each pill contained 10 mg of hydrocodone (twice the amount in regular Vicodin) and 300 mg of acetaminophen. I instructed Sloane to take one pill every four to six hours, with a maximum of six pills per day (the standard dosage, per the PDR). On his medical history form, Sloane indicated no family history pertaining to substance abuse or addiction and denied consuming alcohol, so I felt comfortable prescribing Vicodin HP. I told Sloane and Rory to read the Medication Guide included with the medication and sent them on their way, reminding Sloane to rest and keep the ankle elevated. As per UUSMC's regular business protocols, I made notations in Sloane's chart after every visit, detailing my findings and his care plan.

I never asked Sloane or Rory orally about any family history of addiction or use of other drugs or alcohol. We ask patients to disclose such information on the medical history form, and I trusted that they were honest. We can only provide our patients with the best care if they disclose such information. If they don't, they're hurting themselves, and patients know that. In my experience, any patient who would be less-than-honest on our form would be unlikely to tell the truth if asked again orally.

Starting on February 13, 2013, I began seeing Sloane for weekly checkups, our routine protocol for such injuries. During these visits the x-rays showed Sloane's ankle

was healing properly. At every visit I asked Sloane about his level of pain. At the first visit, Sloane told me, "This injury is the most painful thing I've experienced since 'Cowboys and Aliens.'" I wasn't sure what that meant, but then Sloane asked me for more Vicodin. At that time, the American Medical Association recommended against prescribing opioids unless pain could not be controlled without them, so I told Sloane to stick to Advil and tell me if pain management was a problem. For the next eight weeks, Sloane told me the pain was under control. At the end of those eight weeks, I removed Sloane's cast and prescribed physical therapy to help him fully recover.

I didn't see Sloane in a professional capacity again until March 2017, but I'd seen him on the court quite a few times. I hold season tickets for UU men's basketball, and Sloane had developed into one of the team's best players. Thus, I was taken aback when I saw Sloane and Rory come into my office on March 17, 2017. Sloane reported that he had been playing a game of pick-up basketball with friends when he fell and landed on his left arm. Rory said that Sloane couldn't sleep because of the pain in his shoulder. Sloane's eyes were red and puffy, and his left shoulder was visibly bruised and swollen. After a brief physical examination, I sent Sloane for an MRI. My suspicions were confirmed: Sloane had a torn rotator cuff. I scheduled surgery for March 21.

The surgery went well. I told Sloane and Rory that with proper rehab, the shoulder should be back at full strength in about three months. As I was reviewing Sloane's care plan, Sloane didn't make eye contact with me. I asked him if everything was ok, and he said, "I'm sorry Doc, I know I'm not paying full attention but my shoulder just hurts too much. I just can't focus on what you're saying." While NSAIDs ("Non-Steroidal Anti-Inflammatory Drugs") are recommended for pain management whenever possible, Sloane clearly was going to need more than Advil. I wrote Sloane a 30-day prescription (180 pills) for Vicodin HP. Knowing he was in too much pain to listen to detailed instructions, I said, "I'm sure you already know this, since you've taken this medication before, but re-read the warnings on the bottle and review the Medication Guide from the pharmacy. Take one pill every four to six hours, up to six per day." Sloane nodded.

When reviewing the medical history form, I saw that Sloane again only noted a

family history of high blood pressure and high cholesterol; Sloane also denied any use of alcohol or illicit drugs. I trusted that Sloane's medical history form was accurate, so I didn't bother orally confirming the information on the form. Patients get frustrated when you ask them the same questions they already answered on the written form. Frustrated patients give low ratings, so I avoid re-asking about medical histories unless I suspect their written answers are untruthful. But nothing in Sloane's demeanor made me suspect that he was hiding anything.

About three weeks later, on April 12, Sloane left a message on my office line, asking me to call back right away. When I did, Sloane was very blunt, declaring, "I need more pills, now, because this pain is too much!" I told Sloane that the Vicodin should last another week, but Sloane snapped, "I used that stuff up two days ago! I need more now!" I was somewhat concerned by Sloane's vehemence, but I knew that he was trying to get back to 100% as quickly as possible for basketball, so I renewed his prescription for 30 more days. I was very clear with Sloane that these pills had consequences: "You have a bright future. These pills can mess that up if you're not careful. Just take the prescribed amount from now on." I also prescribed physical therapy starting on May 2 to prevent formation of scar tissue and help Sloane regain range of motion.

Sloane had follow-up appointments scheduled for May 17 and June 19, 2017. In the May meeting, Sloane appeared moody and anxious, reporting that he was still in quite a bit of pain. I extended the prescription one final time for another 30 days, strongly cautioning him that I would be highly unlikely to extend it again. Sloane said that he understood, so I figured all was well. Sloane missed his June appointment, but I didn't think much of it. Since he had never been shy about seeking pain medication or other medical attention before, I figured all was fine or he'd let me know.

The last time I saw Sloane was on December 1, 2017. He showed up in my office with serious bruising on the left shoulder and a swollen right ankle, the result of another basketball injury. I felt terrible for Sloane. I knew that all of these injuries would hurt his chances of achieving his dream of getting drafted into the NBA. When I conducted a physical examination and MRI of Sloane's shoulder and ankle, I found

serious muscular strains and some bruising, but nothing was torn or functionally damaged. I instructed Sloane to take Advil, rest for the next two or three weeks, and then repeat some of the earlier rehab exercises. I hoped that a hiatus over the holidays would enable him to recover so he could impress those NBA scouts.

Sloane didn't want to rest. In fact, he said, "I can't miss these early conference games – I need to keep myself in front of pro scouts this year. If I get some Vicodin for the pain, will I be able to play on these injuries?" I told Sloane that it was possible, but that Vicodin HP can cause drowsiness and affect a person's reaction time, impairing the person's ability to perform complex physical tasks and significantly increasing the risk of re-injury. Sloane said, "I can't be in college anymore. I'm gonna go pro this year, so I'm willing to risk it." Sloane was adamant, so I wrote a 30-day prescription for Vicodin HP and gave him a strict warning. "Under no circumstances should you take more than the prescribed dose. If the pain is too much, don't just take more pills -- come to me, and we will figure something out. I'm here to help you, ok?" I glanced at Sloane's medical history form and saw that he had initialed the form indicating that nothing had changed from his spring visit. During our conversation, he never mentioned any changes to his medical history or status, so I assumed everything was the same as before.

When I heard on the evening news on January 2, 2018 that Sloane had died of an overdose at a New Year's Eve party, I was stunned. Because of the circumstances of Sloane's death, an autopsy was performed by the Utopia City Medical Examiner's office. Autopsy reports are public records, and I am familiar with Sloane's autopsy report. It revealed significant concentrations of hydrocodone, acetaminophen, and alcohol in Sloane's blood. The ME determined that respiratory arrest from Vicodin overdose was the cause of death. The level of hydrocodone was higher than would be expected if Sloane were taking Vicodin HP as prescribed.

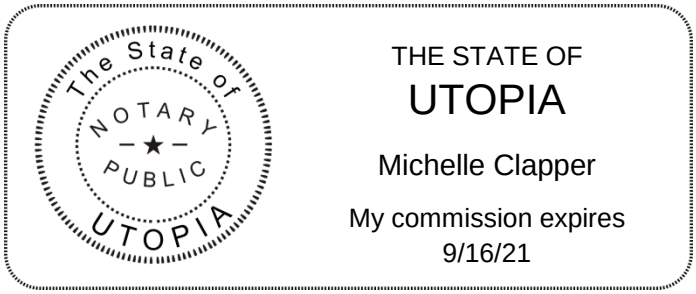
Rory filed a lawsuit against me soon after Sloane's passing. I am deeply sorry for the pain Rory is feeling – I know what it's like to lose a loved one – but Sloane's death is not my fault. I became a doctor to help people in need. When one so young and with so much potential is taken out of this world, it breaks my heart. Still, I stand by every

medical decision I made during my interactions with and care for Sloane Thomas. Rather than simply meeting the standard of care, I am confident I exceeded the standard and provided Sloane with the best possible care, seeking to mitigate his pain so he could recover from his recurring injuries and achieve his dream of playing in the NBA. I am truly saddened by the tragedy of his untimely death.

Of the available exhibits, I am familiar with the following and only the following: Exhibit 1, the photos of the Vicodin pills and prescription bottle; Exhibits 2A and 2B, the 2017 Physicians' Desk Reference Fact Sheet and Medication Guide for Vicodin HP; Exhibits 5A, 5B, and 5C, the medical notes and forms in Sloane's chart at the UUSMC; Exhibit 6, the autopsy of Sloane's body; and Exhibit 7, the Empower Pharma handout given to me by Finn Morrissey.

Arya Davis, M.D.
SIGNATURE

Michelle Clapper
Michelle Clapper
Notary Public



Date: July 12, 2018

AFFIDAVIT OF FINN MORRISSEY, M.D.

My name is Finn Morrissey. I live in Utopia City, Utopia with my two daughters. I have hospital privileges at Utopia General Hospital and am currently the Team Physician for the Utopia Guardians, the largest (and only) professional basketball team in the state. As Team Physician, I specialize in the treatment of sports injuries and the various orthopedic procedures typically required when athletes injure themselves during play. I used to pick up additional work as a Medical Liaison for Empower Pharma's Utopia marketing team. I consulted with Empower from May 2007 until March 2017, when I decided to part ways with the company.

I double majored at the University of Pennsylvania, earning a BS in Biology and a BA in Economics in 1996, with a focus in Health Care Management and Policy. After that, I attended medical school at the University of North Carolina, completed my residency in Orthopedic Surgery at Duke, and returned to UNC for a one-year fellowship in Sports Medicine. In 2006, I moved back to Utopia to work as Team Physician for the Utopia University Unicorns before joining the Utopia Guardians in 2010.

In 2007, I was approached by Empower Pharma about working part-time as a Medical Liaison. I was already familiar with the company and impressed by its products, so I agreed. Empower Pharma specializes in pain medications, especially opioids; while I worked with Empower, more than 85% of its profit came from opioid-based analgesics. When pain became the "fifth vital sign" in the late 1980s, doctors assumed the obligation and expectation to manage their patients' pain more intentionally than had previously been the case. Because Empower's drugs significantly reduced patients' chronic and post-operative pain, Empower's products were well-received by patients and physicians alike. As a result, Empower was extremely profitable, and its margins rose every year.

Empower's main "cash cow" was Vicodin, a combination of hydrocodone and acetaminophen that was produced in three different formulations: regular Vicodin (5 mg hydrocodone), Vicodin ES (7.5 mg hydrocodone), and Vicodin HP (10 mg hydrocodone). Early formulations contained up to 660 mg of acetaminophen, but in April 2012 the level

of acetaminophen was lowered to 300 mg to reduce the risk of liver damage.

My job as a Medical Liaison was simple. I traveled to various conferences, hospitals, and doctors' offices to consult with physicians and educate them about the benefits of Empower's products. I would also educate marketing consultants and drug representatives about correct medical terminology so they could speak effectively with different types of doctors. While even general practitioners had patients who benefited from Empower's products, Empower drug reps were most successful when they focused on oncologists, orthopedic surgeons, and other specialists who expressed a need for effective, long-term pain management.

Empower's higher-ups always said that a patient's Empower experience starts with the doctor who prescribes the medication, so they worked hard to make physicians feel appreciated. Empower provided free lunches to medical office staff, treated physicians to dinner meetings in fancy restaurants, and hosted continuing education seminars in exotic locations, paying the full cost for physician-spokespersons and their spouses to attend. That's not to say that these perks were necessary to convince doctors to prescribe Empower's products; because of their overall effectiveness, Empower's products essentially sold themselves. Empower's products had passed rigorous FDA testing with flying colors, and Empower's research demonstrated that its products reduced patients' pain with minimal side effects. Empower's opioid analgesics soon became the premiere pain-management medication in the US – doctors everywhere espoused the benefits of Empower. While the medical community has scrutinized the risks associated with opioid use much more closely in the past few years, Empower's opioids were commonly prescribed for even relatively minor pain as recently as mid-2017.

As one who was involved with promoting Empower's products (including Vicodin) to my Sports Medicine colleagues, I was aware of the extensive use of Empower's painkillers by Sports Medicine practitioners. One of the main selling points was the widespread acceptance of Empower's painkillers – Medical Liaisons had a little canned speech about how "if you're not 'Empowering' your clients, you're not practicing medicine in the 21st century." Empower had data to back that up. The handout I took with me to

every client meeting contained charts explaining how frequently sports physicians prescribed Vicodin. The information reassured physicians who were unfamiliar with Empower's products. State-specific surveys, produced by the Centers for Disease Control and Prevention ("CDC"), showed that most doctors prescribe Vicodin or an equivalent painkiller after surgery and for reported severe pain. For every 100 people in Utopia, 70 to 85 opioid prescriptions were issued annually, depending on the year. The number of prescriptions per capita varied by age group, but the statistics for males aged 18-25 in Utopia were not substantially different from the overall average.

The CDC also gathered data on the average amount prescribed: in 1999 physicians prescribed on average only 180 MME (morphine milligram equivalents) per prescription, while in 2010 the average patient received 782 MME per prescription. As time went on, the prescribed amount declined somewhat, but even as recently as 2015, an average prescription contained 640 MME. While the CDC eventually started using this data to allege that doctors were prescribing more opioids than they should, until recently, Empower and other companies used this data to communicate that prescribing opioids was normal, standard practice for pain management, and that the vast majority of doctors believed that opioids were safe. That was what I believed, and what I told my clients, including Dr. Arya Davis.

I met Dr. Davis in early 2008. Dr. Davis was an up-and-comer at the Utopia University Sports Medicine Clinic ("UUSMC") and was on the faculty at Utopia's best medical school. Dr. Davis was also on the UUSMC Human Resources committee and was instrumental in making sure their surgeons were up-to-date on all the latest medications. Empower's marketing department was certain that Dr. Davis could be a valuable client, giving us an inside track to a large group of physicians who would see the value of Empower's products. Potential clients were usually contacted by drug representatives who were not MDs, but Dr. Davis was known for being studious and skeptical of new methods. Empower decided a liaison with a medical degree would be more likely to receive a positive response. Because Dr. Davis and I share the same specialty – Sports Medicine and Orthopedics – Empower decided I would be the one to meet with Dr. Davis.

I met Dr. Davis at a formal business dinner at Spud, which despite the name, was the best steak restaurant in Utopia City. Dr. Davis seemed very interested in the idea of better pain management for Dr. Davis's patients but also asked a lot of questions about efficacy and side-effects. I answered everything I could, pulling out studies and test results when I had them. Dr. Davis responded positively to everything I said, especially when I mentioned that Empower always pays for our spokespersons and their spouses to attend conferences in glamorous locations. Dr. Davis exclaimed, "We love to travel, so that's really terrific! I'm definitely interested, then." We left Spud that night as business colleagues, and we have become great friends since then.

During my time with the company, I frequently met Dr. Davis at Empower's medical conferences. It was clear that Dr. Davis relished being a spokesperson and educating colleagues about Empower's products. More than once I heard Dr. Davis tell other physicians, "Opioids are the future of pain medication in America. The best way to help your patients is to put Empower's products in their hands." In the evenings, Dr. Davis and I would get together for a drink and discuss our respective medical practices, talk about the latest innovations, and watch UNC basketball games (we were both Tarheel fans). Not many physicians are as dedicated to sports medicine as Dr. Davis is, and I've enjoyed having such a close friendship with someone in my field.

In October of 2016, Dr. Davis suddenly started turning down the chance to speak at Empower's medical conferences. I reached out to Dr. Davis's office to see what was going on, but I didn't hear back for months. In February of 2017, Dr. Davis finally contacted me. It was then that I heard that Dr. Davis's father had recently died from a particularly aggressive pancreatic cancer. Equally shocking, Dr. Davis's mom passed away only days later. I felt for Dr. Davis, but there was little I could do to help except listen.

Right around that time, researchers began making the connection between prescription opioids and addiction, but it was still early in the process. The marketing directors at Empower assured me that Empower's products were safe and not addictive, so that's what I told our clients. It's true, by early 2017 several politicians had given speeches asking for increased regulation of all prescription opioids, but I thought they

were just looking for a hot issue to get them elected. Dr. Davis agreed; I remember Dr. Davis saying, "These politicians are getting in the way of our only hope of dealing with our patients' pain!" and "I hope your lobbyists are doing their jobs right!" In late spring of 2017, Dr. Davis mentioned more than once how Empower's Vicodin HP had made Davis's dad's final days more bearable.

Early in 2018, I decided to leave Empower to focus on my family and my sports medicine practice. As the CDC and other organizations published more and more information about issues associated with opioid use, I began having doubts about my work with Empower. Not only were legislative caps on prescriptions likely to make the job less lucrative, but the data convinced me that prescribing opioids, especially at the high levels Empower sometimes advocated, might increase patients' risk of addiction. And while Dr. Davis's practices regarding opioid prescriptions were relatively standard at the time, it became clear that the field was changing.

When I heard about Sloane Thomas's death early in 2018, I was sure Dr. Davis felt horrible, as any caring physician would. Rory Thomas's lawsuit was filed soon thereafter. I've spoken to Dr. Davis numerous times since, assuring Dr. Davis that in the case of Sloane Thomas, if a patient conceals his addiction, a doctor can't help him. Dr. Davis did what every other doctor – including myself – would have done in that situation: relied on the medical history information provided by the patient and prescribed the appropriate medications to fit the situation. I am happy to testify in Dr. Davis's defense if asked. Dr. Davis has faced so many struggles and worked so hard to get where Dr. Davis is – it would be terrible for a vindictive family member to take that all away over a death that Dr. Davis could not have foreseen or prevented.

It is true, at times Dr. Davis may have prescribed more Vicodin HP than Sloane Thomas really needed. Particularly in December 2017, when no surgery was required, it might have been advisable to try using NSAIDs for pain management prior to prescribing opioids. But had I been in Dr. Davis's position, I wouldn't necessarily have done anything much differently. Even with all the information circulating these past couple of years about the risk of addiction from opioids, the medical profession is slow

to change, and Dr. Davis was only doing what physicians had been doing for decades. Granted, the 2017 PDR Vicodin HP Fact Sheet contained warnings about the dangers of opioid addiction, so I probably would have followed up with Sloane a bit more than Dr. Davis did or prescribed a shorter course of Vicodin, but I honestly can't be sure.

The laws about opioid prescriptions have changed quite a bit recently, but the regulations doctors must abide by in 2018 wouldn't have applied at the time that Dr. Davis was seeing Sloane. Back then, prescription lengths were decided by doctors, not legislators, and doctors made their decisions on a case-by-case basis. As a result, I can't say that Dr. Davis did anything wrong.

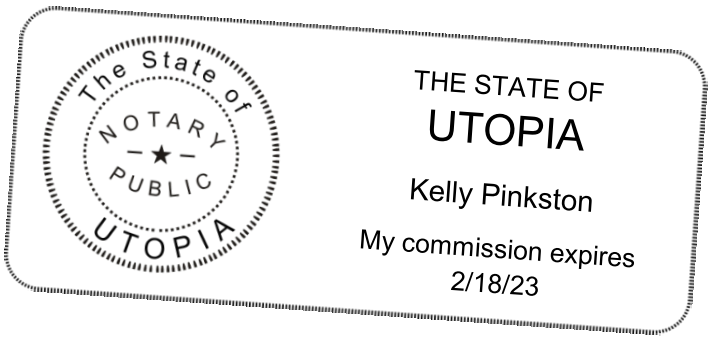
Before writing this affidavit, I reviewed Dr. Arya Davis's sworn statement. Of the available exhibits, I am familiar with the following and only the following: Exhibit 1, the photo of the Vicodin HP pills and bottle; Exhibits 2A and 2B, the 2017 PDR Fact Sheet and Medication Guide for Vicodin HP; and Exhibit 7, the Empower Pharma handout.

Finn Morrissey

SIGNATURE

Kelly Pinkston

Kelly Pinkston
Notary Public



Date: August 7, 2018

AFFIDAVIT OF DORIAN WILSON

My name is Dorian Wilson. I am a Licensed Professional Counselor ("LPC") and Director of Rehabilitation Therapy at the Four Seasons Recovery Center in Asheville, NC. Sloane Thomas was one of our clients, attending a 60-day session beginning on June 6, 2017 to deal with an addiction to the prescription opioid Vicodin HP. Sloane made great progress while at Four Seasons, and I was very hopeful that he would successfully transition back home and avoid a relapse. All of us at Four Seasons were deeply saddened and shocked when we learned of Sloane's death due to an overdose.

Just like me, Sloane was a native of the state of Utopia. I grew up in Eden, a beautiful town surrounded by tree-covered mountains and crystal-clear lakes. As a teen, I spent every free moment rock climbing and snowboarding, and I dreamed of winning gold medals at the X-Games. But after several broken bones and concussions, I wised up. I enrolled at Eden University and earned my Bachelor's degree in Psychology, with a minor in Biology. I loved it at Eden U; I was excelling in my classes and had an incredible group of friends.

But the stress of college life was too much for some students, and I had classmates who became very depressed or dependent on alcohol or drugs. Seeing them inspired me to earn my Masters in Clinical Mental Health Counseling at Eden University. As part of that program, I interned for six months at the Silver Lake Rehabilitation Center in Eden and gladly accepted a position there as a Rehabilitation Therapist after graduation.

After eight years at Silver Lake, I moved to Asheville, NC, to serve as Director of Rehabilitation Therapy at the Four Seasons Recovery Center. Four Seasons is a licensed addiction treatment program accredited by the Commission on Accreditation of Rehabilitation Facilities. Ten to fifteen percent of our patients at Four Seasons arrive addicted to prescription pain relievers, so even though I am not a physician, I am very familiar with the specifics of common opioids abused by our patients, such as Vicodin and Oxycontin. I keep up-to-date on information published in the PDR and by the CDC and am well aware of the recommended dosages, risks, and common withdrawal symptoms of these drugs.

Since Four Seasons wants to give our clients the best chance of avoiding a relapse, we require them to stay for a minimum of 42 days rather than the 30 days required at most

facilities. Our clients meet with their therapist in intensive one-on-one sessions, daily for the first six days and weekly thereafter. In addition, all clients are assigned to small support groups where they work through our modified 12-Step curriculum that incorporates aspects of the SMART Recovery (Self-Management And Recovery Training) program. As the clients get to know and trust their counselors and fellow group members, they learn to take responsibility for their choices and to persevere when things are difficult. When clients graduate from the program, we stay in touch. We help them identify accountability partners, introduce them to local 12-Step groups, and provide ongoing support for 12-24 months.

Our fully-integrated Adventure Therapy component is what makes us truly unique. After their first week, our clients take part in offsite wilderness expeditions led by a clinical treatment staff member. Facing physical challenges brings out deep-seated emotions and behaviors in our clients, giving our therapists a chance to help them address issues in more constructive ways. Our program is so effective that only 25% of our clients suffer a relapse within a year of graduating our program, and 65% of our clients successfully transition to college or jobs upon release. Of course, individual results can differ.

Tragically, Sloane Thomas was not one of our success stories. Sloane was admitted to our program on June 6, 2017, after his parent, Rory Thomas, called and begged us to take him. Rory told me that a friend had highly recommended Four Seasons, saying that the program had helped the friend's daughter turn her life around. Rory said that Sloane loved the outdoors and would respond best to an adventure-based program. Ordinarily we cannot admit clients on such short notice, but a client had just canceled that afternoon, unexpectedly opening up a spot in our 60-day session. I offered the spot to Sloane, and Rory said they'd get on the road right away and should arrive by 9:00 p.m.

I met with Sloane right after breakfast on June 7, 2017, his first full day at Four Seasons. I explained the program and asked if he had any questions. Sloane wouldn't look at me at first; then he burst out, "I'm not an addict! I just took like four extra pills I got from a friend at college. My shoulder was killing me after surgery, and my Doc wouldn't give me more pain meds. Isn't that what Docs are for? I just need to get past the pain." Sloane's apparent aversion to being at Four Seasons wasn't really unusual. Even when clients have "hit bottom"

and are desperate to get clean, they can be scared of the hard work to come. I acknowledged Sloane's feelings and sought to engage him in further discussion, but he didn't want to talk. Yet he didn't ask to be discharged, so I was confident that with time, Sloane would respond.

For the first three days, Sloane continued to be unresponsive in both the individual and group sessions but did not ask to leave. He appeared to be experiencing withdrawal symptoms, complaining of pain in his muscles and bones, difficulty sleeping, feeling cold, and intermittent nausea and vomiting. I observed that he was restless and also had uncontrollable leg movements during our sessions. Until the symptoms abated, it was not safe for Sloane to take part in any of the group wilderness adventures.

On the fourth day, Sloane finally opened up in our private session. He talked about his dream of playing in the NBA and how scared he was that his recurring injuries might prevent that. Sloane shared that he was first introduced to Vicodin HP by Dr. Arya Davis in 2013 when he was given a seven-day prescription for pain after an ankle injury. Reportedly Sloane did not become addicted at that time. In March 2017, Sloane was prescribed a 30-day course, six pills per day, of Vicodin HP by Dr. Davis after surgical repair of a left rotator cuff injury. The prescription was extended twice. This long-term prescription of what I know to be the maximum safe dosage of Vicodin HP appeared to be the cause of Sloane's addiction. I was not surprised; medical practice groups that use pain management ratings like those used by physicians at UUSMC typically prescribe higher amounts of addictive pain medication than do other providers. Four Seasons frequently admits patients from such offices, although I don't believe we have ever had a patient from Dr. Davis's office prior to Sloane's admission.

Sloane admitted that he took more medicine than was prescribed, finishing up his prescription ahead of time. When he ran out of pills, he asked a college friend to get him more. Sloane agreed that he should have talked with Dr. Davis about his pain rather than exceeding the prescribed dose or securing illicit narcotics. It was important that Sloane take responsibility for his choices and admit that he needed help in order to begin the recovery process. I emphasized that Sloane must acknowledge his own culpability; any client must accept responsibility and agency over their actions before they can begin to heal, even if

other forces precipitated their addiction. Sloane was a textbook example of this truth: even though Dr. Davis's lengthy prescription was what initially exposed Sloane to addictive levels of opioids, Sloane's choice to use that medication, exceed the prescribed dose, and seek out illicit medication when he used up his prescription prematurely were all decisions for which he should take responsibility.

With this breakthrough and the lessening of his withdrawal symptoms, Sloane began to participate in the biweekly adventure sessions. Sloane took part in canoeing, whitewater rafting, mountain biking, rock climbing, and hiking, as well as other therapeutic activities, including martial arts, life skills training, and solution-focused therapy. As part of our protocols at Four Seasons, I receive detailed reports on each client from our clinical treatment staff. They reported that, for the most part, Sloane was open, responsive, and willing to take correction. After six weeks had passed, staff agreed that Sloane was considered a leader among his peers, and the majority of our staff was confident that Sloane would transition successfully back to college and the "real world."

Prior to discharge, all of our clients take part in a one-week transitional program, working with staff to develop a detailed relapse prevention plan and create a support system to sustain the progress they have made. Our staff emphasize that recovery is a lifelong process and clients must remain vigilant to prevent relapse. We also offer a 14-day Sober Living Transition Extension Program to males aged 18 to 30, to help cement the gains they have made. Unfortunately, despite my urging, Sloane insisted he was unable to avail himself of this program because of his college basketball preseason training camp.

I meet with each client for a final exit interview before they are discharged, and Sloane was no exception. In that meeting, we discussed what Sloane had learned during his time with us. I reviewed Sloane's discharge plan and discussed the support system we had developed, which included avoiding people and situations that would put him at risk for relapse. I emphasized that Sloane should avoid future use of opioid-based pain relievers and inform any future medical providers that he was recovering from addiction to prescription opioids. I reminded Sloane that we couldn't share any information with his physicians unless he signed a release form, which I strongly encouraged. But Sloane was very worried about

confidentiality given his interest in an NBA career. Instead, he assured me that he would self-disclose his struggles to his physicians, trainers, and others who should know about his history. Sloane was very emphatic: "I never want to take Vicodin or any other opioid again! I'll be sure to say that to any doctor who wants to prescribe them. I can't imagine pain severe enough to be worth the risk of going through this again."

Sloane and I also discussed that he should consider avoiding doctors known for prescribing high levels of narcotic pain medications, such as Dr. Davis. While such medications might be fine for most people, they are not safe for recovering addicts. I provided Sloane with the names of several physicians he could choose instead, although admittedly, none of them specialized in Sports Medicine.

I reminded Sloane that for up to six months after his last dose of Vicodin HP, he might experience recurrent insomnia, a loss of energy, and low blood pressure. He would be highly susceptible to environmental triggers that could lead to relapse, so it was vital that he follow his discharge plan and seek out local support groups. Without such support, his chances of success were greatly reduced. I reiterated that Sloane should avoid using alcohol, as difficult as that might be on a college campus. Research shows that those who have become addicted to one substance, such as opioids, are more likely to become addicted to other substances, such as alcohol. While some rehabilitation centers assert that moderation is possible and clients need not avoid all alcohol or opioid-based pain relievers in the future, in my experience, the only way to ensure success is through abstinence. Sloane asked very few questions, but he appeared to understand the seriousness of what I was saying and assured me he would follow the plan.

For the first few months after discharge, Sloane kept every phone appointment and seemed to be staying on track. Once basketball season began, Sloane missed several calls, claiming his schedule was too busy. I continued to reach out, but by early December he quit responding to calls and emails. When I saw in the news that Sloane had died of an overdose on New Year's Day, I was devastated. The article said that Vicodin was the cause of death, and that alcohol also played a part. Such a tragedy. Sloane was a remarkable young man with a bright future ahead of him. While other clients have relapsed, it's always

heartbreaking when they do. Sloane had seemed so determined; I was really hopeful he would make the right choices and stay clean.

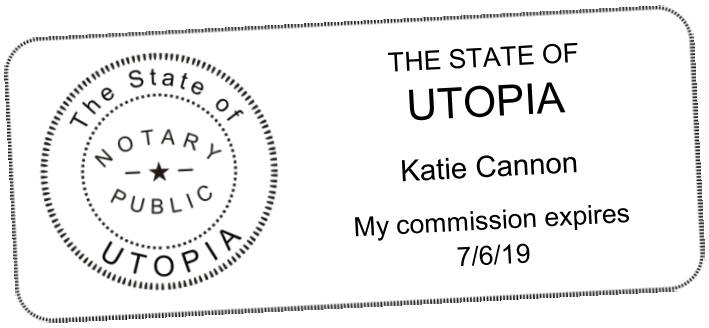
Of the available exhibits, I am familiar with the following and only the following: Exhibit 1, the photo of Vicodin HP pills and bottle; Exhibit 2B, the 2017 PDR Medication Guide for Vicodin HP; and Exhibit 8, chart notes from Sloane Thomas's stay at Four Seasons Recovery Center.

Dorian Wilson

SIGNATURE

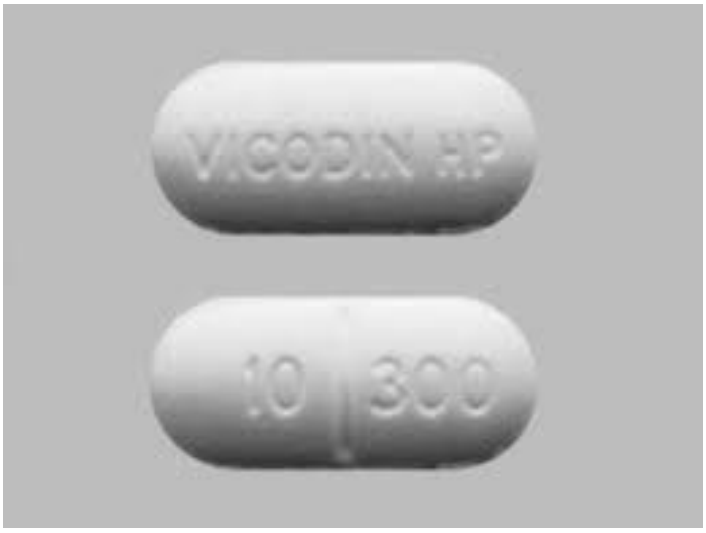
Katie Cannon

Katie Cannon
Notary Public



Date: August 1, 2018

EXHIBIT 1



Vicodin HP (enlarged)

Vicodin Bottle Showing Warnings on Label

PDR.net

VICODIN HP
(HYDROCODONE BITARTRATE AND ACETAMINOPHEN) TABLETS, USP. Rx only. CS-II

WARNING: ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION

Addiction, Abuse, and Misuse

Hydrocodone bitartrate and acetaminophen tablets expose patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk prior to prescribing hydrocodone bitartrate and acetaminophen tablets, and monitor all patients regularly for the development of these behaviors and conditions.

Life-Threatening Respiratory Depression

Serious, life-threatening, or fatal respiratory depression may occur with use of hydrocodone bitartrate and acetaminophen tablets. Monitor for respiratory depression especially during initiation of hydrocodone bitartrate and acetaminophen tablets or following a dose increase.

DESCRIPTION

Each VICODIN HP® (Hydrocodone Bitartate and Acetaminophen Tablets, USP 10 mg/300 mg) contains:
Hydrocodone Bitartrate…… 10 mg Acetaminophen…….. 300 mg

CLINICAL PHARMACOLOGY

The principal therapeutic action of hydrocodone is analgesia (pain relief). Hydrocodone produces respiratory depression by direct action on brain stem respiratory centers.

INDICATIONS AND USAGE

Hydrocodone bitartrate and acetaminophen tablets are indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse, with opioids, even at recommended doses, reserve hydrocodone bitartrate and acetaminophen tablets for use in patients for whom alternative treatment options (non-opioid analgesics) have not provided, or are not expected to provide, adequate analgesia.

WARNINGS

Addiction, Abuse, and Misuse

Hydrocodone bitartrate and acetaminophen tablets contain hydrocodone, a Schedule II controlled substance. As an opioid, hydrocodone bitartrate and acetaminophen tablets expose users to the risks of addiction, abuse, and misuse. Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed such tablets. Addiction can occur at recommended dosages and if the drug is misused or abused.

Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing hydrocodone bitartrate and acetaminophen tablets, and monitor all patients receiving hydrocodone bitartrate and acetaminophen tablets for the development of these behaviors and conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent the proper management of pain in any given patient. Patients at increased risk may be prescribed opioids such as hydrocodone bitartrate and acetaminophen tablets, but use in such patients necessitates intensive counseling about the risks and proper use of hydrocodone bitartrate and acetaminophen tablets along with intensive monitoring for signs of addiction, abuse, and misuse.

Life-Threatening Respiratory Depression

Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids, even when used as recommended. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death.

Adrenal Insufficiency

Cases of adrenal insufficiency have been reported with opioid use, often following greater than one month of use. Presentation may include non-specific symptoms and signs including nausea, vomiting, anorexia, fatigue, weakness, dizziness, and low blood pressure. If adrenal insufficiency is suspected, confirm the diagnosis with diagnostic testing as soon as possible.

PRECAUTIONS

Risks of Driving and Operating Machinery

Hydrocodone bitartrate and acetaminophen tablets may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of hydrocodone bitartrate and acetaminophen tablets and know how they will react to the medication.

Information for Patients/Caregivers

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

Addiction, Abuse, and Misuse

Inform patients that the use of hydrocodone bitartrate and acetaminophen tablets, even when taken as recommended, can result in addiction, abuse, and misuse, which can lead to overdose and death. Instruct patients not to share hydrocodone bitartrate and acetaminophen tablets with others and to take steps to protect hydrocodone bitartrate and acetaminophen tablets from theft or misuse**.**

Life-Threatening Respiratory Depression

Inform patients of the risk of life-threatening respiratory depression, which can occur at recommended dosages. Advise patients how to recognize respiratory depression and to seek medical attention if needed.

DRUG ABUSE AND DEPENDENCE

Controlled Substance

Hydrocodone bitartrate and acetaminophen tablets contain hydrocodone, a Schedule II controlled substance.

Abuse

Hydrocodone bitartrate and acetaminophen tablets contain hydrocodone, a substance with a high potential for abuse similar to other opioids, can be abused and are subject to misuse, addiction, and criminal diversion.

All patients treated with opioids require careful monitoring for signs of abuse and addiction, because use of opioid analgesic products carries the risk of addiction even under appropriate medical use.

Prescription drug abuse is the intentional non-therapeutic use of a prescription drug, even once, for its rewarding psychological or physiological effects.

Drug addiction is a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and includes a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal.

“Drug-seeking” behavior is very common in persons with substance use disorders. Drug-seeking tactics include emergency calls or visits near the end of office hours, refusal to undergo appropriate examination, testing, or referral, repeated “loss” of prescriptions, tampering with prescriptions, and reluctance to provide prior medical records or contact information for other treating healthcare provider(s).

Preoccupation with achieving adequate pain relief can be appropriate in a patient with poor pain control.

Abuse and addiction are distinct from physical dependence and tolerance. Health care providers should be aware that addiction may not be accompanied by concurrent tolerance and symptoms of physical dependence in all addicts. In addition, abuse of opioids can occur in the absence of true addiction.

Proper assessment of the patient, proper prescribing practices, periodic re-evaluation of therapy, and proper dispensing and storage are appropriate measures that help to limit abuse of opioid drugs.

Risks Specific to Abuse of Hydrocodone Bitartrate and Acetaminophen Tablets

Hydrocodone bitartrate and acetaminophen tablets pose a risk of overdose and death. The risk is increased with concurrent use with alcohol and other central nervous system depressants.

Dependence

Both tolerance and physical dependence can develop during chronic opioid therapy. Tolerance is the need for increasing doses of opioids to maintain a defined effect such as analgesia (in the absence of disease progression or other external factors). Tolerance may occur to both the desired and undesired effects of drugs, and may develop at different rates for different effects.

Physical dependence results in withdrawal symptoms after abrupt discontinuation or a significant dosage reduction of a drug. Physical dependence may not occur to a clinically significant degree until after several days to weeks of continued opioid usage.

Hydrocodone bitartrate and acetaminophen tablets should not be abruptly discontinued in a physically dependent patient, or a withdrawal syndrome may occur. Some or all of the following can characterize this syndrome: restlessness, perspiration, chills, and myalgia (muscle pain). Other signs and symptoms also may develop, including: irritability, anxiety, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhea, or increased blood pressure, respiratory rate, or heart rate.

DOSAGE AND ADMINISTRATION

Use the lowest effective dosage for the shortest duration consistent with individual patient treatment goals.

Initiate the dosing regimen for each patient individually, taking into account the patient's severity of pain, patient response, prior analgesic treatment experience, and risk factors for addiction, abuse, and misuse.

Follow patients closely for respiratory depression, especially within the first 24-72 hours of initiating therapy.

Initiating Treatment with Hydrocodone Bitartrate and Acetaminophen Tablet:

The usual adult dosage is one tablet every four to six hours as needed for pain. The total daily dosage should not exceed 6 tablets.

Titration and Maintenance of Therapy

Individually titrate hydrocodone bitartrate and acetaminophen tablets to a dose that provides adequate analgesia and minimizes adverse reactions. Continually reevaluate patients receiving hydrocodone bitartrate and acetaminophen tablets to assess the maintenance of pain control and the relative incidence of adverse reactions, as well as monitoring for the development of addiction, abuse, or misuse. Frequent communication is important among the prescriber, members of the healthcare team, the patient, and the caregiver/family.

If the level of pain increases after dosage stabilization, attempt to identify the source of increased pain before increasing the hydrocodone bitartrate and acetaminophen tablets dosage. If unacceptable opioid-related adverse reactions are observed, consider reducing the dosage. Adjust the dosage to obtain an appropriate balance between management of pain and opioid- related adverse reactions.

PDR.net

MEDICATION GUIDE

VICODIN HP
Hydrocodone Bitartrate (10 mg) / Acetaminophen (300 mg) Tablets, USP, Rx only. CS-II.
Maximum dose: 6 pills/24 hours.

Vicodin is:

- A strong prescription pain medicine that contains an opioid (narcotic) that is used to manage pain severe enough to require an opioid pain medicine, when other pain treatments such as non-opioid pain medicines do not treat your pain well enough or you cannot tolerate them.
- An opioid pain medicine that can put you at risk for overdose and death. Even if you take your dose correctly as prescribed you are at risk for opioid addiction, abuse, and misuse that can lead to death.

Important information about Vicodin:

- Get emergency help right away if you take too much Vicodin (overdose). When you first start taking Vicodin, when your dose is changed, or if you take too much (overdose), serious or life-threatening breathing problems that can lead to death may occur.
- Taking Vicodin with other opioid medicines, benzodiazepines, alcohol, or other central nervous system depressants (including street drugs) can cause severe drowsiness, decreased awareness, breathing problems, coma, and death.
- Never give anyone else your Vicodin. They could die from taking it. Store Vicodin in a safe place to prevent stealing or abuse. Selling or giving away Vicodin is against the law.

Before taking Vicodin, tell your healthcare provider if you have a history of:

- Abuse of street or prescription drugs, alcohol addiction, or mental health problems

When taking Vicodin:

- Do not change your dose. Take Vicodin exactly as prescribed by your healthcare provider. Use the lowest dose possible for the shortest time needed.
- Take your prescribed dose every four to six hours as needed for pain.
- Do not take more than your prescribed dose. If you miss one, take the next at the usual time.
- Call your healthcare provider if the dose you are taking does not control your pain.
- If you have been taking Vicodin regularly, do not stop without talking to your healthcare provider.
- After you stop taking Vicodin, dispose of the unused tablets by flushing down the toilet.

While taking Vicodin DO NOT:

- Drive or operate heavy machinery, until you know how Vicodin affects you. Vicodin can make you sleepy, dizzy, or lightheaded.
- Drink alcohol or use prescription or over-the-counter medicines that contain alcohol. Using products containing alcohol during treatment with Vicodin may cause you to overdose and die.

The possible side effects of Vicodin:

- Constipation, nausea, sleepiness, vomiting, tiredness, headache, dizziness, abdominal pain. Call your healthcare provider if you have any of these symptoms and they are severe.

Get emergency medical help if you have:

- Trouble breathing, shortness of breath, fast heartbeat, chest pain, extreme drowsiness, feeling faint, agitation, high body temperature, trouble walking, or mental changes such as confusion.

EXHIBIT 3


●●●○○ Verizon
10:41 AM
73%
Messages
Sloane Thom
Dallas
Dec. 28, 2017 9:55 AM
Hey, wanna hang out? 😄
Sure! Madden?
Nah, I wanna get outta here. Pizza at Peppers?
Yah, that'd be cool. Noon?
Sounds good. See ya there 😎

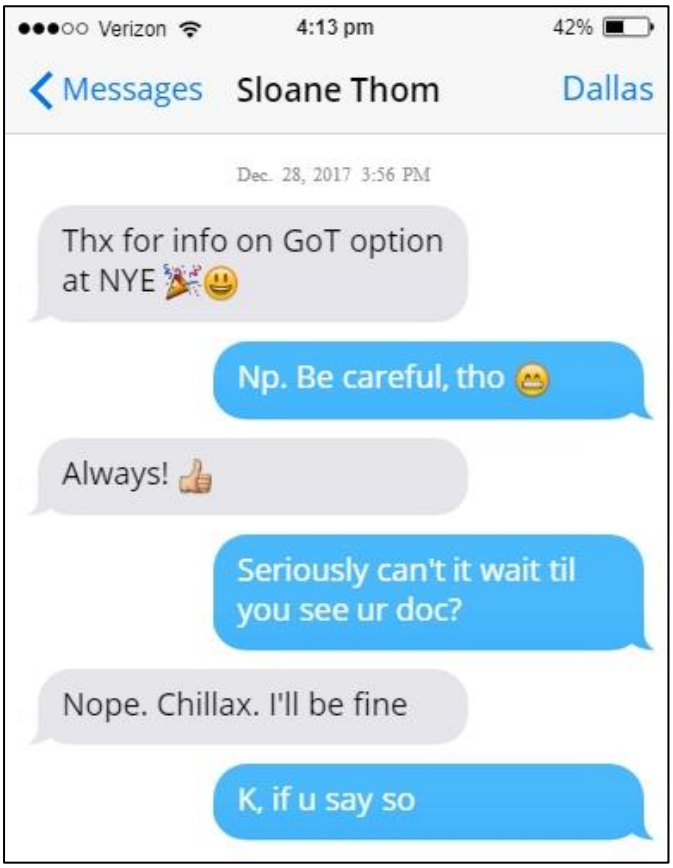

●●●○○ Verizon
4:13 pm
42%
Messages
Sloane Thom
Dallas
Dec. 28, 2017 3:56 PM
Thx for info on GoT option at NYE 🎉😃
Np. Be careful, tho 😄
Always! 👍
Seriously can't it wait til you see ur doc?
Nope. Chillax. I'll be fine
K, if u say so

EXHIBIT 4

BLAKE SPALLER, M.D.

1224 Peachtree Pavilion | Atlanta, GA | SpallerB@emoryhealth.org

EDUCATION

Mayo Clinic, Orthopedic Surgery Residency, 1999 (Chief Resident 1998-1999)

Johns Hopkins University, M.D. with Highest Honors, 1994

Yale University, B.S. in Biology with High Honors, 1990

EXPERIENCE

Emory University School of Medicine
Chief of Sports Medicine, 2012 – present
Orthopedic Surgeon, 2005 – 2012

Gregory J. House Distinguished Professor of Orthopedic Surgery, Emory University
Tenured Professor, Emory University School of Medicine, 2008 – present

Utopia University Sports Medicine Center
Orthopedic Surgeon, 1999 – 2005

AWARDS AND PROFESSIONAL MEMBERSHIPS

Inducted into the American Orthopedic Society for Sports Medicine Hall of Fame, 2012
Heinz Eulau Award for best article in the *New England Journal of Medicine*, with Whiteley Cantu and Caroline Kinnier, 2008
Alpha Omega Alpha
American Academy of Orthopedic Surgeons
American Orthopedic Society for Sport Medicine

REPRESENTATIVE PUBLICATIONS

Spaller, B. and D'Ippolito, M. "Comfortably Numb: Medicalizing and Mitigating Patient Suffering Due to Pain." *New England Journal of Medicine,* 24 Aug. 2017, pp. 700-704.

Spaller, B. and Kaufman, A. "Rotator Cuff Repair Using 3D MRI Reconstruction." *JAMA Surgery*, 16 July 2015, pp. 511-550.

Yasinovsky, C. and **Spaller, B.** "Optimal Outpatient Post-Operative Recovery Strategies: Meditate, Don't Medicate." *Journal of Orthopedic Surgery & Research,* Jan. 2009, pp. 65-77.

FUNDING AND EXTERNAL GRANTS

2017 – Center for Disease Control ($375,444): Determining Best Practices for Opioid Use in Pain Management of Acute Injuries

2014 – National Institute of General Medical Sciences ($595,436): Early Osteoarthritis (OA) Prevention

2011 – National Institutes of Health ($297,252): Collaborative Research, Investigating Radiographic Markers of Atypical Ankle Fractures

EXHIBIT 5A

Utopia University Sports Medicine Center
9727 North Morava Blvd., Utopia City, Utopia 18432
Phone: (342) 876-1267

PATIENT INFORMATION

Name: Shane Thomas Birth date: 1/2/1997

(Parent Name if not patient): Rory Thomas

Address: 111 Drake St. City: Utopia City State: Utopia Zip: 18432

Phone: Home (342) 742 - 1354 Work (___)_____ Cell (___)_____

SS#: 172 -- 59 -- 3892 Occupation: Student Gender: (M) F

Employer and Employer's address: Utopia High School

Primary Physician: Caleb Yasinovsky Phone: (342) 888 - 1234

Address: 8111 Gill Street Utopia City, Utopia 18432

Referring Physician: ↑ Phone: (___)_____

Emergency Contact: Rory Thomas Phone: (342) 742- 1354

Current Pharmacy Name and Phone #: Pope Pharmacy 342-812 - 9999

Is the reason for your visit today related to your employment or a car accident? (No) Yes

---

MEDICAL HISTORY

What is your current complain? Sudden Ankle After Basketball injury

How did your current problem begin? (ex. Injury/car accident etc.) Basketball injury

How long have you had symptoms? 2 days

Do you experience any of the following (please circle all that apply)

(Numbness/Tingling) Clicking/Locking (Weakness) (Pain)

Pain with pinching/Grasping (Swelling) (Stiffness)

On a scale of 1-10 how would you rate the pain (1 being the least, 10 being the most)? 10

EXHIBIT 5A

What makes your pain worse?

(Activity)

Overhead/Reaching

(Nighttime)

(Lifting)

What makes your pain better?

(Rest)

Brace (type/how long used?)_____

Medications _____

Therapy (How long?) _____

Is there any radiation of the pain? No (Yes) (If so, where?) Toes

Please circle any of the following tests you have had in regards to this particular problems:

X-Rays MRI Scan EMG/Nerve Condition Test Other:_____

Review of Systems: Do you currently or have you ever had any of the following (please circle):

Eye/Vision Problems	Hearing Difficulties	Throat/Swallowing Difficulties
Gastritis/Ulcers	Bowel Problems	Cardiac Disease
Lung/Breathing Diff.	High Blood Pressure	High Cholesterol
Diabetes	Thyroid Disease	Stroke
Osteoarthritis	Rheumatoid Arthritis	Osteoporosis
Neurologic Disease	Blood Transfusions	Cancer (type and when)_____

Other conditions (please list): Anxiety

CURRENT MEDICATIONS: please list any current medications and dosages.

None other than tylenol

Do you have any allergies to medications? (NO) YES(please list): _____

Are you allergic to latex? (NO) YES(please list reaction): _____

Please list any prior surgeries and/or hospitalizations and year they occurred:

None

EXHIBIT 5A

Family History:

Please list any medical problems of members in your family:

Grandparents: High Blood pressure

Father: High Cholesterol Mother: _____

Brothers: _____ Sisters: _____

Social History:

Are you currently employed? YES (NO)

Current occupation : Student

If NO are you (please circle): Retired SS/Disability Workman's Comp Unemployed

Do you currently smoke? (NO) YES (if yes, how many packs per day and how many yrs?):

_____

Have you ever smoked in the past and quit? (NO) YES (if yes, how many packs per day and how long ago did you quit?) _____

How often do you drink alcohol? (Never) 1-2 times per month Daily

Do you use any illicit drugs? no

Any history of alcohol/drug/pain pill abuse? (NO) YES (if yes, when?) _____

Highest level of education reached:

(High School/GED) Associate's Degree Bachelor's Degree Graduate degree

Other: _____

Reviewing Doctor/P.A. Signature : _____ Date: 2/6/13

EXHIBIT 5A

Utopia University Sports Medicine Center

9727 North Morava Blvd., Utopia City, Utopia
Phone: (342) 876-1267

Thomas, Sloane, DOB: 01/02/1997
Encounter Note 02/06/2013 | Davis, Arya, M.D.

This note has been signed by Davis, Arya on 02/06/2013 04:07:46 PM

Chief Complaint

Sloane Thomas is a 16 year old male. He presents with pain in his right ankle, reportedly as the result of an injury during a high school basketball game. He is here for initial evaluation.

History of Present Illness

Lateral Malleolus Fracture:

Sloane presents for an initial evaluation of ankle pain, which began after an injury during a high school basketball game on 2/5/13. Ankle pain is acute in nature. By report, swelling has increased over the last 20 hours; pain does not improve with NSAIDs and is a “10” on a 10-point scale.

Review of Systems

MUSCULOSKELETAL: Positive for leg pain and ankle pain.
NEUROLOGIC: Positive for numbness in extremities.

Physical Exam

Musculoskeletal

Ankle: Reduced range of motion. Severe swelling. Severe muscle tenderness in the ankle. Reduced ankle flexion strength.

Neurologic

Consciousness, orientation, cooperation: Alert, fully oriented. Cooperative with exam.

X-ray of Right Ankle

X-rays of right ankle show right lateral malleolus fracture.

Assessment

1. **Right Lateral Malleolus Fracture due to sports injury**

Plan

Lateral Malleolus Fracture:

Treatment of a stable lateral malleolus fracture should consist of efforts to reduce swelling followed by a gradual progression in weight-bearing. Ice application is helpful at reducing pain and minimizing swelling. Elevation is important to keep swelling limited. Be sure your ankle is above your heart. Nonsteroidal anti-inflammatory medications (“NSAIDs”), including ibuprofen and naproxen, are helpful at controlling both swelling and pain.

Rest/Immobilization: While stable ankle fracture can support your weight, it helps to limit weight-bearing to help control pain and swelling. Use of crutches for 2 weeks is suggested.

Cast installation for immobilization at today’s visit. Weekly follow up visits with x-rays monitored by radiology staff to ensure proper healing. Reevaluation in 8 weeks to monitor progress and determine whether cast removal and transition to physical therapy is appropriate.

A 1-week course of Vicodin HP is being prescribed for pain management, at which time patient should transition to NSAIDs for relief of ongoing pain. Patient was advised to read Vicodin HP Medication guide and call with any questions.

EXHIBIT 5A

Utopia University Sports Medicine Center

9727 North Morava Blvd., Utopia City, Utopia
Phone: (342) 876-1267

Thomas, Sloane, DOB: 01/02/1997
Encounter Note 04/05/2013 | Davis, Arya, M.D.

This note has been signed by Davis, Arya on 04/05/2013 02:21:24 PM

Chief Complaint

Sloane Thomas is a 16 year old male, returning for his 8-week follow up evaluation of injury to his right ankle on 2/6/13.

History of Present Illness

Lateral Malleolus Fracture:

Sloane presents for a follow up visit. Ankle pain has been present for 8 weeks, is acute in nature, and is reportedly better, rating a scale of 2 out of 10. Patient states pain is manageable with NSAIDs.

Review of Systems

MUSCULOSKELETAL: Positive for ankle pain, although much reduced from initial injury.
NEUROLOGIC: No abnormalities noted.

Physical Exam

Musculoskeletal

Ankle: Reduced range of motion. Mild swelling. Mild muscle tenderness in the ankle. Reduced ankle flexion strength.

Neurologic

Consciousness, orientation, cooperation: Alert, fully oriented. Cooperative with exam.
Reflexes: No abnormalities noted.

Assessment

1. **Right Lateral Malleolus Fracture due to sports injury**

Plan

Care Plan (Recommendations)

Cast was removed in today's visit and patient has been referred for physical therapy to improve ankle strength and range of motion. I advised patient to continue taking over-the-counter pain medications such as NSAIDs as needed for pain.

EXHIBIT 5B

Utopia University Sports Medicine Center
9727 North Morava Blvd., Utopia City, Utopia 18432
Phone: (342) 876-1267

PATIENT INFORMATION

Name: Sloane Thomas Birth date: 1/2/97

(Parent Name if not patient): Rory Thomas

Address: 111 Drake St. City: Utopia City State: Utopia Zip: 18432

Phone: Home (342) 742-1384 Work (___) Cell (___)

SS#: 172 -- 59 -- 3852 Occupation: Student Gender: (M) F

Employer and Employer's address: Utopia University

Primary Physician: Caleb Yasinovsky Phone: (312) 888-1234

Address: 8111 Gill St. Utopia City, Utopia 18432

Referring Physician: ↑ Phone: (___)

Emergency Contact: Rory Thomas Phone: (312) 742-1384

Current Pharmacy Name and Phone #:

Is the reason for your visit today related to your employment or a car accident? (No) Yes

MEDICAL HISTORY

What is your current complain? Pain in shoulder after basketball injury

How did your current problem begin? (ex. Injury/car accident etc.) Basketball injury

How long have you had symptoms? 1 day

Do you experience any of the following (please circle all that apply)

(Numbness/Tingling) Clicking/Locking (Weakness) (Pain)

Pain with pinching/Grasping (Swelling) (Stiffness)

On a scale of 1-10 how would you rate the pain (1 being the least, 10 being the most)? 10+

What makes your pain worse?

- Activity
- Overhead/Reaching
- Nighttime
- Lifting

What makes your pain better?

- Rest
- Brace (type/how long used?)_____
- Medications _____
- Therapy (How long?) _____

Is there any radiation of the pain? No Yes (If so, where?) Into fingers

Please circle any of the following tests you have had in regards to this particular problems:

X-Rays MRI Scan EMG/Nerve Condition Test Other:_____

Review of Systems: Do you currently or have you ever had any of the following (please circle):

Eye/Vision Problems	Hearing Difficulties	Throat/Swallowing Difficulties
Gastritis/Ulcers	Bowel Problems	Cardiac Disease
Lung/Breathing Diff.	High Blood Pressure	High Cholesterol
Diabetes	Thyroid Disease	Stroke
Osteoarthritis	Rheumatoid Arthritis	Osteoporosis
Neurologic Disease	Blood Transfusions	Cancer (type and when)_____

Other conditions (please list): _____

CURRENT MEDICATIONS: please list any current medications and dosages.

none

Do you have any allergies to medications? NO YES(please list): _____

Are you allergic to latex? NO YES(please list reaction): _____

Please list any prior surgeries and/or hospitalizations and year they occurred:

none

EXHIBIT 5B

Family History:

Please list any medical problems of members in your family:

Grandparents: High Blood Pressure

Father: High Cholesterol Mother: _____

Brothers: _____ Sisters: _____

Social History:

Are you currently employed? YES (NO)

Current occupation : Student

If NO are you (please circle): Retired SS/Disability Workman's Comp Unemployed

Do you currently smoke? (NO) YES (if yes, how many packs per day and how many yrs?):

_____

Have you ever smoked in the past and quit? (NO) YES (if yes, how many packs per day and how long ago did you quit?) _____

How often do you drink alcohol? (Never) 1-2 times per month Daily

Do you use any illicit drugs? none

Any history of alcohol/drug/pain pill abuse? (NO) YES (if yes, when?) _____

Highest level of education reached:

(High School/GED) Associate's Degree Bachelor's Degree Graduate degree

Other: _____

Reviewing Doctor/P.A. Signature : _____ Date: 3/16/17

I Certify no changes to my medical history Since 3/16/17

Signed : ST 12/1/17

EXHIBIT 5B

Utopia University Sports Medicine Center

9727 North Morava Blvd., Utopia City, Utopia
Phone: (342) 876-1267

Thomas, Sloane, DOB: 01/02/1997
Encounter Note 03/16/2017 | Davis, Arya, M.D.

This note has been signed by Davis, Arya on 03/16/2017 06:15:21 PM

Chief Complaint

Sloane Thomas is a 20 year old male. He complains of severe pain in his left shoulder.

History of Present Illness

Full-Thickness Rotator Cuff Tear:

Sloane presents for an initial evaluation of shoulder pain. Shoulder pain has been present for one day and is acute in nature. The pain began after a fall sustained during a pick-up basketball game. He states that the swelling and pain has gotten worse since the time of the incident. The pain is "unbearable"; Sloane describes it as a "10+" on a 10-point scale.

Review of Systems

MUSCULOSKELETAL: Negative for cervicalgia and low back pain. Positive for rotator cuff pain.
NEUROLOGIC: Negative for headache. Positive for numbness in extremities. Tingling in the fingers of the injured left arm.

Physical Exam

Musculoskeletal

Head and neck: No visible or palpable abnormalities. Cervical range of motion: normal.
Spine, ribs, and pelvis: Normal.
Rotator Cuff: Reduced range of motion. Severe swelling. Severe muscle tenderness in the left shoulder region. Reduced left shoulder flexion.

Neurologic

Consciousness, orientation, cooperation: Alert, fully oriented. Cooperative with exam.

MRI of Left Shoulder Region

MRI shows full tear of the left rotator cuff tendons. The tear appears new, consistent with the acute nature of the injury.

Assessment

1. **Full-Thickness Left Rotator Cuff Tear due to sports injury**

Plan

Care Plan (Recommendations)

Treatment of a full-thickness rotator cuff tear requires surgery, scheduled for March 21, 2017.

Addendum (03/21/2017): Outpatient surgery was successful. Patient was accompanied to surgical visit by parent Rory Thomas.

Post-surgical care: Patient is advised to rest and immobilize shoulder to the best of his ability for two weeks, at which time patient should schedule twice-weekly physical therapy sessions.

Given the severity of the injury, NSAIDs are unlikely to be sufficient for pain management. 30-day course of Vicodin HP is prescribed. Recommended dose: 1 pill every 4-6 hours as needed for pain

relief, maximum of 6 pills/day. No automatic refills, but will refill prescription up to 2X upon request if seems advisable. Patient must return for further extensive evaluation if pain management is still an issue after 90 days. Patient was reminded to read Vicodin HP Medication Guide drug insert.

Addendum (04/12/2017): Patient requested Vicodin HP refill; granted.

Addendum (05/17/2017): Patient requested Vicodin HP refill; granted; reminded must have full work-up prior to any additional refills.

Addendum (06/6/2017): Patient called office to request a Vicodin HP prescription refill, claiming that shoulder pain was still severe. Current prescription should last until June 19, so patient was advised to make an appointment at that time.

Addendum (06/19/2017): Patient was no-show for 10am appt.

EXHIBIT 5C

Utopia University Sports Medicine Center

9727 North Morava Blvd., Utopia City, Utopia
Phone: (342) 876-1267

Thomas, Sloane, DOB: 01/02/1997
Encounter Note 12/01/2017 | Davis, Arya, M.D.

This note has been signed by Davis, Arya on 12/01/2017 08:13:46 AM

Chief Complaint

Sloane Thomas is a 20 year old male. He complains of severe pain in his right ankle and left shoulder.

History of Present Illness

Rotator Cuff Injury:

Sloane presents for an initial evaluation of left shoulder pain. Shoulder pain has been present for one day and is acute in nature. The pain began after a fall sustained during a basketball game. Sloane has a history of a torn left rotator cuff injury which was repaired with surgery in March of this year. Sloane says that NSAIDs and over-the-counter medications do not help the pain, which he describes as a “9” on a 10-point scale.

Sprained Ankle:

Sloane presents for an initial evaluation of right ankle pain. Ankle pain has been present for one day and is acute in nature. The pain began after a fall sustained in a basketball game. Sloane claims that NSAIDs and over-the-counter medications do not help the pain, which he describes as an “8 or 9” on a 10-point scale.

Review of Systems

MUSCULOSKELETAL: Positive for rotator cuff pain and ankle pain.
NEUROLOGIC: Positive for numbness in extremities. Tingling in the fingers of the injured left arm.

Physical Exam

Musculoskeletal

Head and neck: No visible or palpable abnormalities. Cervical range of motion: normal.
Spine, ribs, and pelvis: Normal.
Rotator Cuff: Reduced range of motion. Severe swelling. Severe muscle tenderness in the left shoulder region. Reduced left shoulder flexion.
Ankle: Reduced range of motion. Severe swelling. Reduced ankle flexion.

Neurologic

Consciousness, orientation, cooperation: Alert, fully oriented. Cooperative with exam.

Assessment

1. **Left Rotator Cuff Injury**
2. **Right Ankle Sprain**

Plan

Care Plan (Recommendations)

Patient was advised to rest rotator cuff and ankle for natural healing. Patient was prescribed 30-day prescription for Vicodin HP because patient insisted that NSAIDs were not helpful. Patient was advised to come for a follow-up visit on January 2, 2018.

Addendum (01/02/2018): Patient was no-show for 9am appt.

EXHIBIT 5C

UTOPIA CITY MEDICAL EXAMINER'S OFFICE

14341 Rhinestone St NW, Utopia City, Utopia 18428

RELEASE OF PUBLIC DATA UTOPIA STATUTE 13.83

Deceased: Sloane Rogers Thomas DOB: 01/02/1997 DOD: 1/1/2018

Address: 111 Drake Street Age: 20 Marital Status: NA

City: Utopia City State: Utopia Zip: 18432

Occupation: Student Citizenship: USA Veteran: No

Decedent's place of birth: Utopia City, Utopia Parent's name: Rory Lee Thomas

Place of Death: Mu Tau Sigma Fraternity House, Utopia University

Date of injury: 01/01/2018

How injury occurred: EMT chart notes made at the scene note that the decedent self-administered a tablet obtained from an unidentified person attending the same party

Identifying Marks: NA

Description of decedent's clothing: Black Utopia University Basketball Team Athletic Jacket, Gold Utopia University Men's Basketball Jersey and Black Team Shorts, Black Tennis Shoes

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Autopsy Performed: Yes **Manner of death:** Accident Cause: Vicodin Overdose

Blood Test Results: Alcohol (BAC 0.07). Hydrocodone Bitartrate (24.2 ng/mL) Acetaminophen also present

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Synopsis:

THE DECEDENT IS A 20 YEAR OLD UTOPIA UNIVERSITY STUDENT ATHLETE WHO SUFFERED RESPIRATORY ARREST WHILE AT A FRATERNITY PARTY AFTER CONSUMING A COMBINATION OF HYDROCODONE BITARTRATE, ACETAMINOPHEN, AND ALCOHOL.

BLOOD LEVELS INDICATE SUBSTANCES WERE CONSUMED WITHIN 2 - 4 HOURS OF THE DECEDENT'S PASSING. EMERGENCY MEDICAL PERSONNEL ATTEMPTED TO REVIVE DECEDENT AT THE SCENE BUT WERE UNSUCCESSFUL.

Coroner of Utopia City Medical Examiner's Office: Riya Larsen

EXHIBIT 7

EMPOWER® Your Patients!

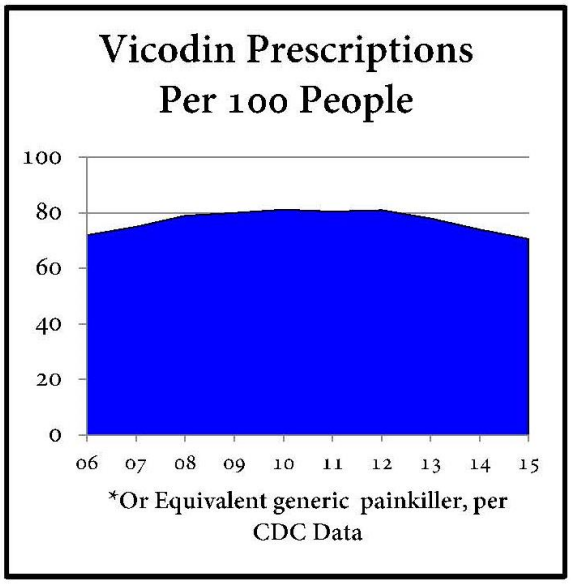
with Effective Pain Management

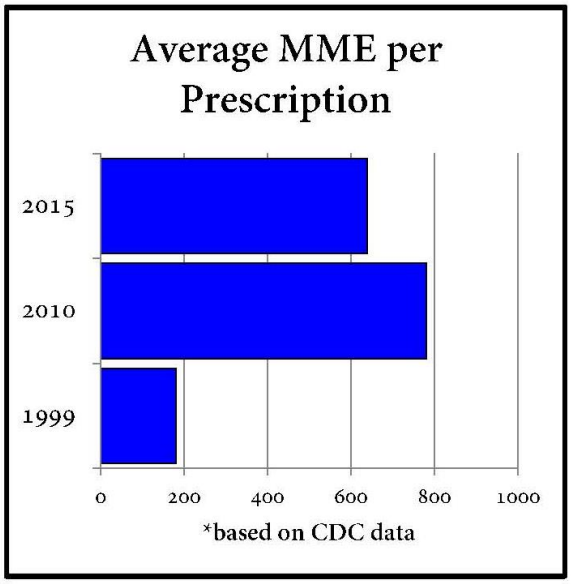
EMPOWER® products are:

✓ **Safe:**
Vicodin and other pain killers produced by EMPOWER® have been tested and approved based on rigorous FDA Guidelines

✓ **Respected:**
Since the mid-2000s the CDC has noted over 70 prescriptions of EMPOWER® or equivalent products for every 100 people

✓ **Effective:**
Since the 1990s, EMPOWER® patients have experienced more effective pain management, as EMPOWER® products have gained widespread use





Become an EMPOWER® provider and start EMPOWERING your patients today!

EXHIBIT 8

FOUR SEASONS RECOVERY CENTER
ASHEVILLE, NC

CLIENT: Sloane Thomas
DATE OF ADMISSION: June 6, 2017
PROGRAM: 60-day session
THERAPIST: Dorian Wilson, MA, LPC

PRESENTING PROBLEM: Addiction to opioid pain reliever (Vicodin HP) prescribed by orthopedic surgeon following surgical repair of left rotator cuff tear.

BACKGROUND INFORMATION:
Sloane Thomas, male, age 20 years 5 months, was referred by Sloane's parent, Rory Thomas. Sloane was prescribed a 30-day course of Vicodin HP by Dr. Arya Davis, MD, following surgical repair of Sloane's left rotator cuff on March 21, 2017. When Sloane reported ongoing severe pain, Dr. Davis extended the 30-day prescription twice, for a total of 90 days. This prescription appears to be the precipitating factor in Sloane's addiction. During my pre-admission phone conversation with Rory Thomas, Rory reported discovering that Sloane was taking Vicodin HP obtained illicitly (without prescription) after Sloane completed his prescribed 90-day course prematurely. Sloane was admitted to our 60-day inpatient recovery program.

COUNSELING SESSION SUMMARIES:

June 7, 2017
I met with Sloane one-on-one immediately after breakfast. Sloane was uncommunicative at first, avoiding eye contact and refusing to speak. After several minutes, he proclaimed that he was "not an addict." Sloane displayed signs and symptoms consistent with opioid withdrawal, including lack of focus, moodiness, lack of appetite, nausea, and mild tremors. Sloane is free to leave at any time but did not request discharge.

June 8, 2017
Little change from yesterday; Sloane continues to be non-responsive and resistant to communicating. He continues to display signs of opioid withdrawal, including several instances of emesis (vomiting).

June 9, 2017
Sloane's withdrawal symptoms continue as before. He remains unwilling to discuss his use and misuse of Vicodin yet still expresses no desire to be discharged.

June 10, 2017
Sloane experienced a breakthrough today. He started off the session by blaming his Sports Medicine physician, Dr. Arya Davis, for his addiction. When pressed, Sloane admitted to exceeding the prescribed dosage, thereby finishing his medications early, and choosing to obtain illicit Vicodin (off-prescription) from someone at school rather than speaking with Dr. Davis about his pain. As discussion continued, Sloane admitted that even though his surgical pain had diminished after 2-3 weeks, he had indicated otherwise to Dr. Davis in order to obtain more Vicodin. Sloane's description of his actions confirms that he became addicted to the Vicodin HP prescribed by Dr. Davis. He has been experiencing withdrawal symptoms and signs since his admission here. Those symptoms, while still present, are less severe than before.

June 11, 2017
Sloane continues to communicate openly and evidences a desire to change. Today we discussed the circumstances that influenced his poor choices, including his fears regarding his recurring injuries and their potential negative impact on his career goals. Despite Sloane's report of being popular at college, he indicates that he has few, if any, close friends in whom he can confide.

EXHIBIT 8

June 12, 2017
Today we discussed the challenges and benefits of our adventure therapy expeditions. Sloane expressed enthusiasm about "getting outside instead of being in buildings all the time." He listed his choice of activities in order as 1) rock climbing; 2) white water rafting; 3) strenuous hiking; and 4) kayaking. At the end of the session, I reminded Sloane that the two of us would only meet once/week going forward.

June 19, 2017
I have reviewed daily reports submitted by Sloane's small group leader and adventure activity leader per Four Season's patient protocols. By report, Sloane has transitioned moderately well to his small group and has formed a positive relationship with his group counselor. Sloane engages in discussion when prompted to do so but does not initiate sharing information in great detail yet. Sloane's group will take part in a white water rafting expedition tomorrow. If all goes well, he will go on a 4-mile hike with his group on June 24.

June 26, 2017
Today's session went very well. Sloane reports that he had a "fantastic time" on last week's expeditions and that he likes the others in his small group. Sloane appears to be making progress and has opened up about the pressure he feels from his parent, Rory, regarding the college basketball team: "Rory always emphasizes that I need to excel so I don't lose my scholarship, particularly when NBA scouts are watching. Sometimes I think I want to forget about basketball, but I can't; it's what everyone expects from me."

July 5, 2017
Sloane said he enjoyed our Fourth of July cookout and was surprised "how much fun I had without drinking." We discussed his alcohol intake, and at first, Sloane insisted that he rarely drank. His group counselor reported that Sloane has told a different story in small group sessions and that he seems very knowledgeable about many different beers and bourbons. When I probed further, Sloane recanted a bit, saying that he did have "a beer or two once in a while, that's all. Mainly I just act like I drink more because college students are expected to drink." We will continue to probe more into this area, since even if Sloane avoids a relapse into opioid addiction, he will be more susceptible to abusing substances such as alcohol.

July 11, 2017
Sloane is in his fifth week at Four Seasons, and the change in his attitude from the beginning is striking. His small group leader reports that Sloane displays leadership skills both in the group discussions and during the adventure expeditions. In our sessions, Sloane is open and engaged, willing to discuss any topic. He appears to understand the need to avoid alcohol, opioids, and illicit drugs after discharge and expresses a strong desire to maintain sobriety when he returns home. Based on what we observe, I and our other staff feel that Sloane's chances of success upon discharge appear high if he complies with his discharge plan.

July 18, 2017
Sloane continues to show remarkable progress. He openly admits his shortcomings and seeks to learn and grow from his mistakes. Sloane demonstrates maturity and patience during group discussions. On several occasions, his support has encouraged less-confident group members to exceed their own expectations.

July 25, 2017
Sloane is scheduled to be discharged on August 5. I encouraged him to extend his stay to participate in our 14-day Sober Living Transition Extension program. He indicated that he is unable to do so due to preseason basketball training camp at his university, so we moved on to talk about his discharge plan. Sloane seemed very thoughtful during our discussion; he was quieter than usual but still very engaged in the process.

August 2, 2017
Sloane and I met for a 3-hour period to review his discharge plan, which includes the following:

- Sloane will schedule weekly follow-up phone calls with me for six months, changing to twice/month for the next twelve months, to report on his progress, concerns, difficulties, and successes.
- Sloane will identify and confirm a minimum of three (3) accountability partners with whom he can share his struggles and to whom he can turn for support at a moment's notice. Ideally these should be individuals who live close to Sloane, but that is not strictly necessary.
- Sloane will inform all current and future medical providers of his successful completion of the 60-day program at Four Seasons and ask them to note in his chart that he should not be prescribed opioids unless no other medical options exist, and that in such instances, close monitoring is crucial.
    - Sloane was reminded of our recommendation to sign the disclosure form and provide contact information for any physicians whom he would like to receive his records.
- Sloane will consider avoiding providers known for prescribing high doses of opioids, such as Dr. Davis.
    - Sloane was given a list of several primary care physicians in his area who work with recovering addicts and who do not prescribe high levels of addictive pain medications.
- Sloane will commit to avoiding alcohol and all recreational drugs and will report to his accountability partners and to Four Seasons if he violates this commitment.

Both Sloane and I initialed the formal written plan. I reiterated how important it was for Sloane not to deviate from the plan. Sloane indicated that he understood and thanked me and the other staff for "saving my life – truly. I won't be back, at least not as a client. You'll see; I'll make you proud."

August 5, 2017
Rory arrived to bring Sloane home prior to his return to college. Rory was clearly relieved to see that Sloane looked healthy and happy and appeared deeply touched by the staff's obvious affection for Sloane.

MONTHLY POST-DISCHARGE UPDATES:

September 5, 2017
Sloane scheduled and kept all of his phone interviews with me this month. He reported no problems or issues, although he was still trying to confirm three accountability partners. He sounded happy and healthy, so I have few concerns at this time.

October 10, 2017
Sloane kept three of his four scheduled phone appointments. He indicated that he has three accountability partners but did not provide names. He reported that he was avoiding college parties. Our conversations were briefer than I would have preferred, but I have no indication that Sloane is in danger of relapsing.

November 14, 2017
Sloane missed two of our four calls this month, blaming it on his lack of time due to basketball. Sloane sounded stressed, but when I inquired further, he insisted he was okay and cut the conversation short. I reminded Sloane that he can call us at any time and that he should also reach out to his accountability partners. I am concerned that he may be facing more pressure than he can handle in this early phase of recovery and will redouble my efforts to keep in contact with Sloane over the next four weeks.

December 19, 2017
Despite my attempts, I have only spoken with Sloane one time, on November 21, and that call was very brief. All other calls have gone to voicemail, and Sloane has not returned them. I am quite concerned and will keep reaching out.

January 3, 2018
I have just learned, via a news report, that Sloane died of an overdose on January 1. Words cannot express the shock and grief that I and the other staff are feeling. What a tragic outcome.