KATHERINE JACKSON V AEG LIVE September 3rd 2013 AM SESSION ONLY, WAITING ON PM

Dr. Paul Earley

Court. Good morning.

Court. Can you make your appearances?

Mr. Panish. Yes. Good morning, your honor. Brian Panish for the plaintiffs.

Mr. Boyle. Good morning, your honor. Kevin Boyle for the plaintiffs.

Ms. Cahan. Good morning. Kathryn Cahan for defendants.

Ms. Bina. Good morning. Jessica Stebbins Bina for the defendants.

Mr. Putnam. And Marvin Putnam for the defendants.

Court. Good morning. I see you have a proposed jury instruction you want me to read. This was jointly agreed upon, correct?

Mr. Putnam. Yes, your honor.

Court. Plaintiffs?

Mr. Boyle. Yes, your honor.

Court. All right. Then I will read that. The other issue I had is, I wanted to give the jury an estimate of the trial, so I wanted something realistic to tell them this morning. So if you could give me an estimate, then I can give that to them. And then I want to talk about some other things.

Mr. Putnam. We believe we will be done by the end of next week, your honor. We will see if we can finish earlier.

Court. You will finish when?

Mr. Putnam. End of next week, if not earlier.

Mr. Panish. So that will be the 13th?

Mr. Putnam. 11th or 12th.

Mr. Panish. So by the end of the week you'll be done?

Mr. Boyle. Well, yeah.

Mr. Panish. Hopefully.

Mr. Putnam. Yeah. But if I can, I will shorten it even further. So the longest, I'm saying, will be through the end of next week.

Court. Okay. Okay.

Mr. Panish. And then --

Court. And then that would be the defense case. And then the plaintiffs rebuttal?

Mr. Panish. And then the rebuttal, we were preparing to start on the 16th pursuant to Mr. Putnam telling us that's when he thought they would be done. And then there are -- there's court on the 16th, 17th, half day on the 18th. Maybe we could finish by then. Not sure. Actually, there's also court on the 19th and 20th. So there's four and a half days of court that day, so I see there's no reason we can't be done by that week.

Mr. Putnam. And, your honor, I also let them know they should be prepared to start next week. I told them the latest would be the 16th, so I want to make sure that was noted.

Mr. Panish. He told us they would give us a week's notice.

Mr. Putnam. Never said that.

Mr. Panish. Yes, he did, multiple times on the record. I have the citations.

Mr. Putnam. I disagree.

Court. Well, if they do rest earlier, you cannot be ready?

Mr. Panish. Well, some may, but other witnesses I prepared for the 16th, as he kept telling me to come on that day. I kept asking, and he said he would give us a week's notice.

Mr. Putnam. That's not correct.

Court. I understand that. But even if you had to, can you scramble and get some --

Mr. Panish. I can try, but I know several can't come until the week of the 16th.

Mr. Boyle. There's two days next week, they know what videos they have in the can. So, really, it sounds like the question is: are they going to call another live witness or not? That's the only issue.

Court. You mean one live witness?

Mr. Putnam. There's actually three, your honor.

Court. Oh. So, then, it's unlikely we'll be done by that time.

Mr. Putnam. Yes, but it may be unlikely that we even need to call them.

Mr. Panish. So they told us -- and I can get the citations.

Mr. Putnam. I'd love to see them.

Mr. Panish. You've heard him say the 16th.

Court. No, I understand. I understand the 16th is the day you had planned. But I guess what I'm trying to find out is, if you had to rearrange it, could you? Sounds like --

Mr. Panish. Some can't. But I will try for others, certainly.

Court. Okay. But there are some you cannot?

Mr. Panish. Some cannot.

Mr. Boyle. We'll try.

Mr. Panish. But they might be pretty short. That's the only thing. I don't know if they're going to take up very much time.

Court. The ones you can bring up are short ones?

Mr. Panish. Right.

Mr. Putnam. And, your honor, there's one thing that gives us concern that I've noted for the court, is my concern is, before they even rested they said they had four rebuttal witnesses --

Mr. Panish. No. More.

Mr. Putnam. They said it on the record. And as you know, it's not proper rebuttal. If you can call them in your case-in-chief, then you should do so. So one thing I should note for the record, as I did previously, I'm looking forward to hearing who they are. Since they know who they are, I'd love to know who they are, because there may be grounds to challenge them in terms of proper rebuttal.

Mr. Panish. We'll see. We'll follow the same rules they've been following. And there's more than four.

Court. Well, I guess you'll know when you know. I don't think they have an obligation to disclose them to you now.

Mr. Putnam. No, they do not, your honor.

Ms. Bina. Well --

Mr. Putnam. I could be done as soon as Friday, is what I'm trying to do.

Court. Well, the only thing, Mr. Putnam, is that there's a big difference between only having one live witness left and then having three.

Mr. Putnam. They're very short, if I call them. And the three of them have somewhat overlapping but not quite the same testimony. So the determination I'm trying to make, in terms of the record, is to make sure I have in the record what I need, is whether or not I need to call each of them. And if I don't need to call each of them, what combination, if any. So we've been looking at it over the last several days. Still looking at the court record, your honor, to check the places where evidence came in that wasn't necessarily planned with that witness to see if that covered this, because I, like the court, is very concerned with how long we've been here in terms of the jury. And particularly, as I noted all along, with the defense, that we often have only two days a week to put on our defense. So we've decided it's probably prudent for us, instead of going two a week, two a week, two a week, to see if we're covered and try to end this sooner, is what I'm trying to say.

Mr. Panish. Your honor, if he has three short witnesses, and he calls them all, it would seem like he would finish on the 11th. Then the problem is, if he doesn't make that determination until Saturday, or whatever, there's no court on the 9th and 10th. And let's say he decides he's not calling any witnesses, and we could show up, and there's no witnesses at all on the 11th.

Mr. Putnam. I will certainly know by Friday. My intention has been, why we were looking and worked over the holiday weekend, is to know by Friday. So there should be by the end -- by Friday I could do that thing called resting where you tell the jury you're resting. And then they will have five days, which is more than we had, to know that they're starting their case. And we certainly didn't have five days to know when they were ending theirs and starting ours. I think that's adequate time.

Mr. Panish. Actually, we gave them more than a week. And we told you when we were going to rest, and we did. It doesn't matter. I just need to know --

Mr. Putnam. I would plan for next week.

Mr. Panish. -- whether we should try to schedule for witnesses on the 11th and 12th.

Mr. Putnam. And I am trying to --

Court. When will you know on Friday?

Mr. Putnam. Certainly know when we get here. Video that day.

Mr. Panish. No court on Thursday.

Mr. Putnam. Yes. We have argument on Thursday.

Mr. Panish. Well, no jury.

Court. Okay. So video all day Friday?

Mr. Panish. Yeah. All right. So let's just assume hypothetically -- I mean, there's going to have to be some time with instructions, word form, arguments, timing of arguments. I wanted to talk about that. I don't know if this is the right time or not.

Court. Well, I don't know.

Mr. Panish. I mean, I don't want the arguments to go on for days and days.

Court. No, it shouldn't. I mean, there are some standard instructions in the area, right, in the cases?

Mr. Panish. Right.

Court. So in that case, there shouldn't be too much tinkering with the jury instructions.

Mr. Panish. We have to go over the verdict forms.

Ms. Bina. There are special instructions as well and tweaking some of the ones we submitted before because of the evidence, your honor. We plan to submit new versions.

Mr. Putnam. That's what we were working on this weekend, to look back through the entire record, see what actually occurred, and compare that with the original, what we provided, throughout the weekend and realizing that the end is now.

Court. No. That happens.

Mr. Panish. So can I just -- is the court thinking about putting -- I would like to have a limitation on the time of arguments. Same amount for both sides.

Court. Argument on the jury instructions or argument in closing?

Mr. Panish. No. Final arguments.

Court. All right. What are you suggesting?

Mr. Panish. I think like three hours. I don't know.

Mr. Putnam. I was thinking more like a day, and a day, but I would be happy to --

Court. Thinking about?

Mr. Putnam. A day and a day.

Court. I was thinking of four hours.

Mr. Putnam. Four is what we were thinking. Three is what we were thinking, a day and a day, because we're usually here four to four and a half hours.

Mr. Panish. Well, but you have rebuttal.

Court. That's an addition. In other words, you have four hours for your opening and closing and four hours.

Mr. Panish. I don't know that I would go four hours in my first argument.

Court. Okay.

Mr. Panish. But I don't know yet. Is that what they -- Mr. Putnam wants, four hours?

Mr. Putnam. I was just --

Court. I don't know. I thought perhaps it would be four, but if that's three, that's fine.

Mr. Putnam. I would prefer four to three, certainly.

Mr. Panish. How about three and a half?

Mr. Putnam. I think four would be good. We have been here since April 2nd.

Court. A lot of that was jury selection.

Mr. Putnam. April 29th.

Mr. Panish. Well, it was time qualifying.

Court. Yeah.

Mr. Panish. Opening statements were April 29th.

Court. So three and a half to four is what I'm hearing for argument. Have plaintiffs -- sounds like defendants have gone back to look at their jury instructions and do some revisions and restorations. Plaintiffs, have you had a chance to think about that?

Mr. Boyle. Yeah. We didn't have very many. I don't recall if we had any specials. But we might -- in looking at what they have, we might propose a couple counter-specials. But our plan is to try to stick with caci as much as possible.

Ms. Bina. I think you had three or four specials.

Mr. Boyle. Yeah. We had --

Court. Well, hopefully it doesn't sound like it will take too much argument.

Mr. Panish. We have the verdict form.

Mr. Boyle. I think they're going to --

Court. You think that's where the argument's going --

Mr. Boyle. I mean, I --

Mr. Panish. Based on what they've submitted, we have a lot.

Court. Okay. Have you considered revising the verdict form?

Mr. Putnam. We are.

Ms. Bina. Yes, your honor. We're going to be proposing a revised verdict form with the tweaked instructions. I don't think it will be dramatically different, but there will be revisions.

Mr. Boyle. Your honor, if you recall, their verdict form was about 17 pages long. And I think your honor already indicated that the court didn't believe they were going to go with all those questions.

Mr. Panish. That's going to be their argument.

Mr. Boyle. That will be argument.

Ms. Bina. If you recall, your honor, actually, both parties had the same number of questions, and I think your honor wanted something slightly shorter. There's also another issue with the verdict form. If you recall, plaintiffs needed to get a waiver from their minor clients regarding the fact that they wanted the damages to be -- from all their clients, the damages apportioned individually for each client, as opposed to a lump sum, and they were going to go get that waiver. I don't know if that's happened yet, otherwise the verdict form will have the damages payment in a lump sum.

Court. I kind of remember something about that.

Mr. Panish. *Psa vs. Canavin* -- it's *Canavin vs. Psa* is the case that we're proceeding under. We'll get the appropriate agreement.

Court. All right. Make sure you give that to me because --

Mr. Boyle. I think there's an agreement between the parties.

Mr. Putnam. There was.

Mr. Boyle. They want a waiver from our clients.

Mr. Putnam. It was agreed to, the way --

Mr. Panish. And the case is *Canavin*, c-a-n-a-v-I-n, *vs. Psa*, and it's actually in the use note in the wrongful-death instruction.

Court. Oh, thank you. I can look that up, then.

Ms. Bina. The idea being, your honor, if you're splitting the damages from a lump sum, there's arguably conflict amongst each of the plaintiffs, and they can certainly waive that conflict, but they need to do so.

Mr. Panish. Actually, it's the other way --

Court. So you don't ask on the verdict form for them to apportion the damages among the plaintiffs or --

Mr. Panish. You do.

Ms. Bina. Historically, your honor, it's done as a lump sum. They want apportionment. That issue came up before. And the case law says you can have apportionment, but you need a waiver.

Mr. Panish. First of all, it's not historically done in lump sum, it's historically done in apportionment so the conflict doesn't occur. But we will get the waiver. That's for us to do.

Mr. Boyle. Yeah, that's for ours. Presumably, both sides representing the individuals in the company might have their own conflicts.

Court. Right. That's your concern. Depends on how your clients want to do it.

Mr. Boyle. Right.

Mr. Panish. We don't want to have a subsequent, assuming that happens, issue regarding that.

Court. Okay. I'll read the use note. Do you remember which jury instruction?

Mr. Panish. I can find it for you.

Ms. Bina. Probably 39 -- whatever the one on wrongful death is. 3931 or 3941.

Court. On the wrongful death.

Ms. Bina. The wrongful-death instruction. Its own instruction.

Court. Okay.

Mr. Panish. So --

Court. That would be helpful for me to read that. Okay.

Mr. Panish. Now, I assume I don't know when we argue, but the 26th, 27th and the 30th of September, there's no trial.

Court. Well --

Mr. Panish. We haven't gone past that yet.

The clerk. The 26th, 27th, juror no. 7 --

Mr. Panish. And no. 30 and alternate 5, which, if we're in deliberations at that time, that wouldn't be an issue.

Court. Have we asked them to consider the September -- we did already?

The clerk. Yes.

Mr. Putnam. But, your honor, if we're able to end in the time period we're talking about, this may not be an issue at all.

Mr. Panish. No. But deliberations.

Mr. Putnam. Still may not be an issue.

Court. I don't think it's as big a deal. Then it's on them, as far as how long they take.

Mr. Panish. Depends on when we argue. I mean, I don't want to be arguing up to the day, and then they'll be gone for three days.

Mr. Putnam. Seems to me we could be giving our closing the week of the 16th.

Mr. Panish. I don't think so, but we'll see.

Mr. Putnam. In which case this is not an issue.

Court. Well, without telling me how many issues you have in rebuttal, how many days do you think rebuttal will take?

Mr. Panish. Maybe three days.

Court. Three?

Mr. Panish. Maybe four.

Mr. Putnam. So, again, your honor, if they have the ability to go next week, we could therefore be able to get -- we have -- it's conceivable to give closing at the end of that week. Also, your honor, it's possible, in light of the court days next week, that we could have some of these arguments, or some of the discussions next week with the court, since we only have two days with the jury, in terms of jury instructions, in terms of the verdict form, et cetera.

Mr. Panish. Well --

Court. So basically you're saying use some of that down time?

Mr. Putnam. Yeah.

Mr. Panish. 13th, I can't be here. 9th and 10th would probably be OK.

Ms. Bina. We could reserve the early part of next week to deal with verdict form and jury instructions?

Mr. Putnam. Yes.

Ms. Bina. Hopefully resolve those issues?

Mr. Putnam. Monday and Tuesday, your honor?

Court. Would be for -- are those half days or full days?

Mr. Putnam. We would be with you full days, nothing with the jury.

Court. Full days. Non-jury full days?

Ms. Bina. Right.

Mr. Putnam. And do jury instructions and verdict form.

Ms. Bina. And those issues would be done, everybody will know, for closing, the jury instructions and the verdict form.

Mr. Putnam. And that would give us the week to do so.

Court. Okay. So in terms of -- the one thing -- are you finished, or you have more you want to tell me in terms of timing?

Mr. Panish. Timing? Just the soonest he can tell us, the better. That's all.

Court. Oh, Mr. Putnam?

Mr. Panish. Yes. I don't want to schedule someone on the 11th, and then I have to tell them they can't come. That's all. I know he's going to try to do that, so I'll accept that and we'll go forward.

Mr. Putnam. And we know what that's like, having done that for days starting and not starting for months later. And so that's why I've indicated as soon as I know, I'm going to let you know. And you'll certainly have, at a minimum, five days to do so.

Mr. Panish. Five days? Okay.

Court. All right.

Mr. Panish. All right. So that's Thursday.

Mr. Putnam. Friday morning. That would be Wednesday starting. And I will stick to that, Mr. Panish. I know I will have that.

Court. Okay. The issue that I have that I wanted to raise with you is I've spoken to sergeant Wheatcroft, who is now retired from the sheriff's department and now does court security. And he has suggested to me -- actually suggested it a while ago, I just haven't raised it with you -- is partial sequester during the deliberations. And that has a whole procedure associated with it. And before I tell the jury that that's what we're going to do, I wanted -- I still call him sergeant Wheatcroft, even though he's retired -- but to just meet with you and to describe just to you what that procedure entails so that you can tell me if you have any concerns or if you have any suggestions or criticisms or anything else. Some of you may have experience with that, and maybe you find some things work better than others. He described it to me, but I think he should present it to you, and then you can express your concerns to him, and if you have concerns, I guess express them to me. But I want to stay out of that. It's really a security issue. But I want you to have information about how it works, and if you have an objection to it. I don't know if you have an objection to it now, if you do.

Mr. Panish. Well, I think -- when you say "Sergeant," is that the gentleman that's in charge of the court security?

Court. Right.

Mr. Panish. Okay. Well --

Court. Have you seen him? Tall, thin guy?

Mr. Panish. Yeah, I know who he is.

Court. Wheatcroft.

Mr. Panish. I know who he is, retired from L.A.S.O., and he is in charge of court security. We've -- he's been around. I've seen him around.

Court. He provides -- he was head of judicial security.

Mr. Panish. And now he's in charge of everything?

Court. The whole thing.

Mr. Panish. And he's been around during the trial. I've spoken with him. I don't know how you were planning on -- was it that the lawyers would meet with him separate from the court, or would he come and meet with the court? How would you propose it?

Court. Yeah. Because it's security related and sensitive, it's something that isn't going to be made public. So it's something the public isn't going to know about. That's the point of sequestering. It's a partial sequester, not a full sequester. I think you need to be aware of what that entails. Maybe not the exact details of it all, but the general procedure. And if you have any concerns about it, you can express your concerns or suggestions to sergeant Wheatcroft.

Mr. Panish. So is it the plan that we would meet with the sergeant with the court, or basically what is the plan?

Court. I was just going to have him do a presentation to you in the jury room and express to you what he's allowed to express to you. And you can tell him your concerns. I wasn't going to be involved in it, because, frankly, I really -- security is mostly their thing. I mean, they decide the security. We have very little input. We have some, but not a lot in terms of how it's done.

Mr. Putnam. I think probably Thursday afternoon, your honor, because Thursday morning is the argument. So if you want to explain Thursday afternoon.

Mr. Panish. I got to go to -- I have to take my son to a -- I was going to ask if I could go to take him to a medical appointment. So I would be happy to do any other time. Or defense could meet with him, and then we could meet with him and question him. I mean, I have some idea what he's probably going to say, but I would like to talk to him about it.

Court. Okay. So -- but I'd really rather do it all kind of together --

Mr. Panish. Okay.

Court. -- so you're aware what they're saying and their concerns.

Mr. Panish. Okay. So the 9th? We should be fine to do it then.

Mr. Putnam. You mean at the same time we're doing the jury instructions, verdict form on the 9th, 10th? That's fine.

Mr. Panish. I mean, everybody should be there together. Then we could take out an hour of time and meet with them.

Mr. Putnam. That's fine.

Court. Okay. So the 9th or 10th?

Mr. Putnam. Uh-huh.

Court. Okay. It shouldn't take long, but, you know, I think you should be aware of what it entails.

Mr. Putnam. Certainly, particularly the fact it's a partial sequester. That comes in very different forms, so I'd like to hear what he has to say.

Court. Yeah, and what they want to do. And they've been aware of the issues that have come up throughout the trial. So I think he has -- at least from my discussions with him, he has a very specific idea of how he thinks it will work. And he's done it before, so he's aware of how it works and what works. And if any of you have any suggestions or concerns, you can also raise them. So, anyway, OK. So the 9th or 10th, then, I'll have him explain -- meet with him in the jury room, and you can talk with him about it.

Mr. Panish. Sure.

Court. I don't know how detailed he's going to get with you, but I think he'll give you a general outline of how it will work. And then he'll have to have a discussion with the jurors at some point, too.

Mr. Panish. Right. Because --

Court. But I want to run it by you first, to get that done, and then I can explain to the jury what's going to work. Or he can explain to the jury. I won't explain. I'll have sergeant Wheatcroft explain it to them.

Mr. Panish. That's done privately, right?

Court. It will be reported, but a sealed transcript. It will have to be sealed, definitely, because that's something -- we obviously can't have people know. Defeats the purpose of the sequester, so --

Mr. Panish. And would the lawyers be there when that was done?

Court. I don't think so. I can ask if that's something that the lawyers should be -- I don't know. That's a good question.

Mr. Panish. Well, I guess --

Court. I don't know.

Mr. Panish. We can take that up with him when we talk with him.

Court. Yeah. Neli's just raised with me, and you're right, we had a discussion with sergeant Wheatcroft. There would be details that would be disclosed to the jurors that wouldn't be disclosed to counsel.

Mr. Putnam. Right.

Court. So she's right. You would not be present for that. I could be present. I'm not sure I need to be, but I don't think counsel will be, so that answers your question.

Mr. Panish. Well, there will be a record of it, though?

Court. There will be a record. We can seal it. And I guess if you had to look at it, you could, after the trial.

Mr. Panish. Well, I'm uncomfortable with some third party, even though I know he's head of security, talking to the jurors without having -- who knows.

Court. I could --

Mr. Panish. We could talk to him about it.

Court. I could be present, perhaps, if that would make you more comfortable, while he's explaining to the jurors so you would be more comfortable.

Mr. Panish. Well, we'll talk about that after we talk to him.

Court. Okay. Let me talk to sergeant Wheatcroft to make sure September 9th or 10th works for him. I think that was all.

Mr. Panish. Now I have some issues on the trial.

Court. Oh, OK. There are more?

Mr. Boyle. Two things, your honor. One is the defense filed a motion in limine to limit cross-examination of Dr. Earley, who is their witness for today.

Court. I haven't seen it.

Mr. Boyle. We filed opposition this morning.

Ms. Cahan. We filed it August 19th. That was the one we were talking about last week, asking when they were going to get opposition in. You gave them until today. They filed something this morning. So it affects the scope of both the direct examination and the cross-examination, so we'd like to resolve that before he takes the stand.

Court. Why don't you tell me what it says?

Mr. Boyle. Well --

Ms. Cahan. It's our motion, so I'm happy to explain it.

Court. Okay. First of all, Dr. Earley is a defense witness?

Ms. Cahan. Yes. He is a physician who is an addiction expert. He's also been designated as a life-expectancy expert for us. Although he's not an actuary, he doesn't put a number on it, he talks about the effects of drug addiction on life-expectancy, and he's an expert on propofol. And Dr. Earley was initially retained in February of 2011 as a consulting expert to help educate the defendants about propofol, because nobody knew anything about it, and almost no literature. And he's one of the people who does study this, because his addiction treatment program focuses on addicted physicians and other health care providers. So he's seen more propofol addiction than almost anybody. And so in his consulting capacity -- and this is something he testified to in his deposition -- he essentially gathered the existing literature, answered questions for us about what is propofol, how does it work, things like that. That's something we allowed him to talk about at his deposition, to the extent that it all affects the opinions that he's offering or the things that he's discussing as a testifying expert. And there was a second phase where Dr. Earley had informed us that he was in the process of working on a retrospective article, looking at 22 people who had health care providers who had come into treatment

for propofol addiction, looking back at their case files, crunching the data on those, and it was something he wanted to put together and publish, and he hadn't been able to do that yet because he hadn't had the resources available. So AEG Live agreed to provide the funding necessary to complete the study. That was disclosed. It was disclosed when he submitted the study, consistent with the *Journal Of Addiction Medicine* rules for publication. The actual published article has a little blurb at the end that says "Thanks to AEG Live for the unrestricted funding." so that was sort of phase II. And all the three phrases are temporally distinct as well. He sort of finished the consulting work, he did the study, which we funded but was not part of consulting for us. That was something he began working on in 2008 and finished and submitted for publication in, I believe, late 2012. And then in January 2013, we retained him as a testifying expert to talk about life expectancy and addiction generally and also to talk specifically about propofol addiction. His study doesn't really relate to the issues that he's testifying about, but we allowed full exploration of it in his deposition to the extent if he read anything during the consulting period, or looked at anything during the time he was working on his study that added to his knowledge based on propofol, and he said there was nothing specific that comes to mind, but we sort of opened the doors on that, let them explore it. There's no -- this is not one of these cases where somebody does, you know, modeling of an accident until they get a really good model, and then they said all the old stuff is consulting, and only this one good model for us is testifying. We're not shielding anything with that. At the same time, the case law is clear that someone's work as a consulting expert, to the extent that it is not co-extensive with their testifying work, does not lose work-product protection when they're converted to a testifying expert. Certainly, on a go-forward basis, once someone is designated as a testifying expert, everything is open and fair game. And we're actually -- because there's no there, there's no secret or issue with his consulting work, we were pretty generous with allowing plaintiffs to explore that and talk about the kind of work he did. At the same time, you know, we objected to discovery seeking his e-mail correspondence with us during that time, because we're not required to waive the work-product privilege. We didn't waive it. There was no motion to compel about that. We went through all of this the end of march, beginning of April when his deposition occurred. We sent e-mails back and forth on the case law, and it ended with an e-mail that I sent saying "well, here's our reading of the case law." there was never a motion to compel, never an issue there.

Court. Motion to compel?

Mr. Panish. What?

Ms. Cahan. Documents relating to his consulting file, to the extent that one exists, or correspondence from the consulting phases of his work. And so we think it would be improper to raise that now. The other thing that our motion in limine addresses is, we have no problem with plaintiffs talking about the fact that we funded -- AEG Live funded the study, the amount that was paid, how Dr. Earley feels about having the study published, things like that. But we think that their -- and in fact their opposition confirms that they want to infer that there's some conflict of interest for Dr. Earley in publishing this study at a time when he was retained by AEG Live in a consulting capacity. The study was submitted for publication prior to the testifying expert engagement beginning, although it wasn't published until later because these things take a while. But it was submitted for publication before he was retained as a testifying expert.

Court. Okay. It was published in 2012?

Ms. Cahan. It was march 2013 it was published.

Court. Oh.

Ms. Cahan. He submitted it back in the fall of 2012, and it was January of 2013 when we asked him to testify for us.

Mr. Boyle. He worked on it while he was consulting for them.

Ms. Cahan. Well, essentially his consulting work gathering published articles for us had ended. He finished up the study with his staff, and then -- so it's three really distinct time periods. In any event, he followed the rules of addiction medicine in terms of disclosure. There's no conflict of interest here. We don't want to create this trial within a trial on conflict of interest, where they tried to get into it with Dr. Schnoll, and they tried to get into it with Dr. Czeisler, and so we knew this was coming, which is why we filed the motion. But there is no conflict. And I don't have a problem with calling him to the stand, if plaintiffs want to voir dire him in front of your honor outside the presence of the jury on this issue. That would be perfectly fine. But I don't want to end up with lengthy cross-examination about a supposed conflict of interest that just does not exist where we would have to call in a rebuttal witness to talk about journal publication ethics, and they'd call their own rebuttal witness. And the case law is quite clear that a trial within a trial on something so collateral to a witness's testimony is inappropriate. And plaintiffs' brief focuses on 780 in saying that they should be allowed to do it.

Court. I think the question would be: how did AEG Live get involved with funding propofol?

Ms. Cahan. Because there's, like, no published data about this.

Court. Why would they be interested in this?

Ms. Cahan. Because nobody knew anything about --

Court. Just out of the goodness of your heart?

Mr. Putnam. No.

Ms. Cahan. No, your honor.

Court. There's just no information on propofol, geez, maybe we ought to fund this?

Mr. Putnam. I can tell you exactly, if you can stop smirking for a second so she can have an answer.

Mr. Boyle. I'd like to respond to the motion.

Court. No.

Mr. Putnam. I'm answering a question of the court.

Court. I just find it kind of --

Mr. Putnam. What it was, your honor, at that time, as you know, propofol was something nobody had ever heard of.

Court. Right.

Mr. Putnam. When we tried to look into, you know, what is it, and what is the terms of addiction in terms of death, et cetera, we were getting all this stuff that was talking about health care professionals, as well as stuff that was talking about what the indices were for a person who tends to fall in the category of a person using it. In looking into it, we found a couple people, including Dr. Earley, who were preeminent people on it. So we reached out to him, sort of worked with him, said, "give us some articles, what do you know about it? Can you answer these questions?"

Court. But your interest in it was generated because --

Mr. Putnam. The case.

Court. -- of the case.

Mr. Putnam. Absolutely, no question. The case. Trust me, I wasn't interested in it previously. I hadn't heard of it previously.

Court. I think most of us hadn't.

Mr. Putnam. And so we were talking to him, and at the time we were exploring a number of issues, and during this time we were talking about studies, what studies existed, and there were some studies that were talked about during the criminal trial, things about various animals, sleep studies and stuff like that. And as we asked him about these types of studies and whether he had been involved in them, he said, "well, I've been doing them. I've been doing one for some time on case studies that have already existed. Been working on it for years, but I don't have the funding to finish it at the moment. In fact, if you all, or any medical facility you're affiliated with, are interested..." I said, "I'm not sure we want to do that." we talked back and forth. It turned out to be a de minimis amount, and it could be something -- not sure it was -- could be something that --

Court. Could be helpful.

Mr. Putnam. Or harmful. And at the time we were exploring everything, not the least of which, were we going to have counter-claims, all that kind of stuff. And we said "yeah, go finish it so we can go find out. Send out the thing." we were not involved in it, had nothing to do with it. In the end, it didn't become something relevant to the testimony as an expert at all, but we certainly didn't know that going in, nor was that the reason why we funded it. The reason we did it was because of the dearth of the studies. It could be useful or it could be harmful, and I didn't want to find us being in a place where there would be things out there bad for us or good for us.

Ms. Cahan. And, your honor, there was no issue with them inquiring about bias, the study, funding. In fact, I'm intending to address that a fair amount on direct. But to the extent there was a conflict of interest in the journal publication standards because not that there's anything wrong with the article, not that the article's data is wrong or the analysis is incorrect, but that Dr. Earley --

Court. There is that concept, though, in funding research, right?

Ms. Cahan. Right.

Court. When you have a, quote, "the general concept of private industry funding" --

Ms. Cahan. Right.

Court. -- you know, "research."

Ms. Cahan. And he fully disclosed at the end of the article that we provided unrestricted funding. Importantly, your honor, this is not a prospective experimental study where you say, I want to reach end point x, as, you know, I want to show that propofol addiction is common in certain populations or whatever. There's 22 existing case files --

Court. Right. Case studies.

Ms. Cahan. There's not a way to manipulate the data, even if you wanted to. And Dr. Earley will say that there was no conflict of interest because this is not like a drug company funding a study to get FDA approval for a drug that it wants to market and make money off of. We're not a repeat player in the pharmaceutical industry. It just doesn't -- there is no conflict, and he will explain that. But to allow extensive cross-examination as to whether there was a conflict, especially in light of the other testimony the jury has heard about, a different kind of conflict of interest, it's just going to require calling additional witnesses and an undue consumption of time.

Court. Okay.

Mr. Boyle. Thank you, your honor. Okay. First of all, I don't think the -- let's just start with the conflict of interest in the study. I don't think the cross-examination on that is going to take very long. If you think it's going too long, you can stop us. But it's very clear, while he was working as a consultant for AEG Live in this litigation, he was working on a study that he then -- that was funded by AEG Live, that he then published, that contrary to what was just represented to the court, he testified expressly in his deposition that he relied on that study and information learned while doing that study for his opinions in this case. That is a fact, it's in our brief, I cited it, I quoted it. I showed it to you. That is a fact, OK? Now, he is a member of A.S.A.M., the American Society of Addiction Medicine. He's on the board. He's been on it forever. That is the publication that publishes studies. It's attached to the brief. It's called, *"Addiction to propofol. A study of 22 treatment cases."* now, this was published after he was disclosed as a testifying expert. It was worked on while he was a consulting expert. He clearly was getting paid by AEG Live for work on this litigation while they were funding the study. Now, on the last page of the study that -- and we were surprised to see on the last page of the study, it says, "The authors thank AEG Live, LLC."

Court. Okay. He was being honest about the source of his funding.

Mr. Boyle. Hold on. Yes, OK. Great. The source of his funding. Here's the problem, your honor. That's all we're going to ask him about. What the A.S.A.M. Journal requirement states is, on the front page of the study you're supposed to say if you have any conflict -- I'm going to finish here, Ms. Cahan, just so you know -- if there's any conflicts, and you're supposed to put the source of the funding on the front page, but most importantly is the conflicts. Now, a reader of this study is going to be in the medical community, right? One, they're not going to know what AEG Live is because, as they said, they're not a repeat player, they're a concert promoter.

Court. Well, they wouldn't know that if it was on the front page or the last page.

Mr. Boyle. Well, give me a second, and I'll fix it. But here's what he said: rather than put it affirmatively in the box where you're supposed to put the conflict of interest, here's what he wrote: "the author has no conflict of

interest." what you're supposed to write is: "The funder of this study is AEG Live, LLC. I am also working as an expert witness for AEG Live, LLC, in a case about propofol" so the reader of this study -- and that is clearly put out in the standards. So that's the point. And the study's already in evidence, the standards have been put into evidence. It clearly violates the standards. I don't want to do a mini trial on it. We just want to point out, "hey, Dr. Earley, why didn't you say -- why didn't you disclose in this paper that you were working for AEG Live in a litigation?" that would be like an expert doing a study for R.J. Reynolds tobacco company and not putting on there "oh, by the way, I'm their expert witness in a litigation." that is pertinent information. It's clear. It's not a trial within a trial. It goes to his honesty, his bias. Goes to the effectiveness of his study and that he relies on his study for his opinion.

Court. Why didn't the board point that out?

Mr. Panish. Because they didn't know.

Mr. Boyle. He's on the board. I don't know. Now I want to talk about consulting --

Mr. Putnam. We know the answer.

Court. Let him finish.

Mr. Panish. Can I say something on this point?

Court. Yes.

Mr. Panish. The standards for publication -- many articles are taken out when this happens. The standards are in evidence of what he was supposed to do. The paper is in evidence. He clearly violated the standard on disclosure in a published article of his conflict of interest. There's no question about that. That certainly goes to the validity of the study and his credibility as a witness. He violated the own standards for which this was published. The editors haven't been notified.

Mr. Boyle. And, your honor, if it's not a conflict, I'm sure he'll tell us. He's on the board of the A.S.A.M., and he can tell us why it's not a conflict, but we should be able to point this out. Okay. On his consulting security -- and this one really gets me ramped up -- so they hired him as a consultant, right? They hired him in -- the case was filed in September of 2010. They hire him as a consultant in 2011, right? They go all the way up, and they disclose experts in February of 2013, OK? At some point in time -- and Dr. Earley doesn't remember exactly when -- and I put it all in the papers, and I put his quotes. And he thought it was strange. He didn't understand it. He got a call from them -- and by the way, we think it was shortly before the disclosure was due. The expert disclosure was due February 2013. He got a call from them and they said, "you're no longer a consulting expert, you're now going to be a testifying expert", OK? Magic, right? And now what they're trying to do is cut us off from inquiring about his two years of work. Now, Ms. Cahan just represented to the court there's no there, like there's nothing they're trying to hide. If that's the case, I don't see why we can't ask. The case that they're relying on is this *national steel* case. And what that case was about, an expert worked for a different client in a consulting capacity. Did a report. There was a subsequent litigation. This expert was hired by a new client, and the plaintiff in that case tried to get his report from the prior client. The court in that case actually held, "well, I'm going to do an in-camera review. The trial court should do an in-camera review." but this is so beyond that. This is the same party in the same litigation hired for purposes of litigation, doing work for two years, that they're now trying to cut off with a magic phone call converting him from consulting to testifying. Now in every trial, apparently you hire experts as consulting, then the day before disclosure, you say, "you're magically now testifying, and now the other party can't ask for anything for two years." that is outrageous.

They're just trying to game the system. And if there's no there anyway, why can't I ask him about it? I asked him if there was a report in his depo. They tried to cut him off but he blurted out, "I don't remember." so there might not have ever been a prior report we were trying to get. I just want to ask him, "hey, you worked for them for two years on propofol" -- oh, I should also add he testified in his depo -- and I cited it and gave it to the court -- that information he learned while consulting he relied on for his opinions.

Court. You mentioned that.

Mr. Boyle. It's all fair game. So -- and also the study before. But he got both things: while doing the study he got info he relied on, while doing consulting work he learned info he relied on. So this is all his opinion. I'm sorry I'm getting so emotional, but this is the most obvious topic of cross-examination ever, both of these.

Mr. Putnam. Since we're doing the mode of "ramped up" here, I would like to make one somewhat collateral, but I think it's an important statement. There is a period called discovery where you get to do all kinds of stuff, which includes bringing motions to compel and everything else. And the reason you do that is so when you get to trial you can actually try the matter. Throughout this case, plaintiffs have been permitted to demand things during trial that should have been demanded, were they going to do it, during discovery. And this is but the latest example. And I can go through the litany of what has occurred during this trial, doing additional discovery --

Court. What additional discovery is he asking for?

Mr. Boyle. I'm not asking for anything. I just want to ask him about the stuff.

Mr. Putnam. If he wanted to compel this material, if they wanted to go into this arena -- this is something that we did back and forth at the time. And we said, "as a definitive matter, no, you're actually looking at the case law wrong, and let me explain to you the following," which we provided in march. And having not heard a word since doing that until we get here now, and I would implore the court that things not be permitted to work this way. If they were so ramped up on the issue, it would have been helpful if they would have been ramped up in march before we get to trial. I will let her do her argument. But I just wanted to say, throughout the course of this trial, everything is being looked at anew by plaintiffs. It shouldn't happen this way.

Mr. Boyle. Your honor, so we can cut this off, I'm not asking for any e-mails between Dr. Earley and Mr. Putnam. Maybe there's some embarrassing e-mail that Mr. Putnam doesn't want to come out. I don't know. What they're trying to do is prevent me from asking about the consulting work. That's what we're talking about here. This isn't a discovery motion. This is cross-examination at trial. We made the decision. All right. They told us there was nothing there anyway, so we didn't bother the court with a motion to compel documents, but I want to ask him about it.

Ms. Cahan. And we have no objection to them asking about it to the same extent that it was asked about at his deposition, which is, "what did you do as a consulting expert?" and at a high level, he will say, "I got a phone call" -- and this is going to come out on direct -- "I got a phone call. They said, 'hey, we understand you know a lot about propofol.'" he said, "well, to the extent anybody knows anything, I do." "hey, can you put together some materials for us? Whatever there is out there." "sure, I can do that." "send them along." that's the extent of the consulting relationship. There's no report. There's no secrecy. This idea of two years of work. He Billed, I think, 30 hours of a consulting expert prior to being hired as a testifying expert. His work on this study was not in a consulting capacity for us. It wasn't in a testifying capacity for us. It was funded by AEG Live, but it was -- that's his work as a scientist, and it was not part of the consulting scope of employment. And as far as the study goes, they're saying he should have disclosed it on the front page. And when he comes in, he

will explain he disclosed what he was supposed to disclose. There's a form you fill out when you submit something for publication. The information gets reformatted when it's published. So the fact that there's not a banner black-box warning on the front page of the study as published, doesn't mean that he didn't follow the journal rules. He absolutely followed the journal rules. And this smoking-gun footnote that says "there's no conflict of interest," that's because there's no conflict of interest under the standards. He's on the board of the American society of addiction medicine. He's a fellow of the society. He knows what conflict of interest is in this sphere, and he assessed it and determined there was no conflict of interest. And so --

Court. I'm going to allow the plaintiffs to explore it. If there's no conflict, he can tell us there's no conflict.

Ms. Cahan. Okay.

Court. Anything else?

Mr. Boyle. Really briefly, your honor. We were given some exhibits today they intend to use. I don't want to waste much time. I want go through a couple of these. Do you have a set of these?

Ms. Cahan. I believe it was handed up.

Court. Yes. "Propofol for sleep"?

Mr. Boyle. Yeah. That's the first one.

Court. Says "Rowe" on it?

Ms. Cahan. That's the big board we brought in last week that we didn't use with the doctor.

Mr. Boyle. The only problem I have with that one, I think it can be fixed quick, if you look at the bottom row, on a couple of these, they have like a double leg that would indicate that there are things -- that this happened twice.

Ms. Cahan. Huh-uh.

Mr. Boyle. Because other ones were a single leg.

Court. You talking about the tiny writing at the bottom?

Mr. Boyle. Where it says, like, "box of propofol."

Court. I don't have my glasses. I can't --

Mr. Putnam. We have the big one here, your honor.

Court. That's all right. Let me look at -- OK. So what about the two rows at the bottom?

Mr. Boyle. Where it says, "Quinn for propofol." the two on the further-most right.

Court. Where it says, "Rogers trial transcript"?

Mr. Boyle. No, no. I'm sorry. The purple row. The years --

Court. Oh, the purple row.

Mr. Boyle. Right.

Court. Okay.

Mr. Boyle. My point is, those two indicate that those things happened twice, which is not what the evidence is. They should just change it to one line down, because all the other ones are one line down, and this happened here. I'm saying, it's kind of misleading.

Ms. Cahan. And, your honor, he will testify --

Court. Are you talking about -- hold on. You're talking about the triangle that goes down to 2009?

Mr. Boyle. No, no.

Court. I'm confused.

Ms. Cahan. You may not be looking at what they're looking at, your honor. It's this right here on the board they're complaining about.

Mr. Boyle. And this.

Ms. Cahan. And what that is, it indicates where a witness testified something might have happened in a 2-year period.

Court. Oh, I see.

Ms. Cahan. It's just bracketed to show it's somewhere in that time period. It's a single note, and the witness will explain what the evidence actually is there, so I don't think it's going to be confusing to the jury.

Mr. Boyle. Okay. If they straighten it out.

Court. It happens twice, one winds down --

Mr. Boyle. Right.

Ms. Cahan. Because those witnesses were not sure of the exact year. So the testimony -- so this will make clear it's a single incident.

Mr. Boyle. If they clear that up, that's fine.

Court. I think that's fine.

Mr. Boyle. And if we go to -- if you go to, your honor, no. 5. It's kind of hard to see the numbers. The numbers are on the lower right-hand corner of the blue box.

Court. Yes.

Mr. Boyle. Okay. "propofol steep dose response."

Court. No. 5. Yes.

Mr. Boyle. Okay. Your honor, so Dr. Earley is an addiction medicine specialist, but he is not an anesthesiologist. So he's not qualified to give this. This is sort of similar to when we had Dr. Czeisler, and we wanted to talk about a sleep study. And the court said Dr. Czeisler is a sleep expert, but he's not anesthesiologist, so we had to bring Brown.

Court. You brought Brown in.

Mr. Boyle. So we had to bring Brown in. So the same thing with Earley. Earley is not qualified on his own to talk about the actual physiological effects of propofol on the body, just like Dr. Czeisler wasn't. So I don't think they can use this slide.

Ms. Cahan. He's amply qualified to talk about it. He's a propofol expert. He's a neurologist by training and a physician.

Court. Physician and Neurologist?

Mr. Putnam. Yes.

Court. Okay.

Ms. Cahan. Yes. He understands and studies the methods of propofol. And he, in studying propofol and looking at the populations that have it -- he understands the pharmacology, first of all, and the pharmacokinetics. I will lay a very clear foundation, and it's clearly within his scope of his expertise. And he talked about this at his deposition.

Mr. Panish. He's never given propofol in his life. I mean, how can he be qualified --

Court. Well, Czeisler, what was his specialty?

Ms. Cahan. SLeep. And he's not a practicing -- he's not licensed in Neurology at all.

Mr. Panish. He was trained in Neurology, just like him. He was trained, and he didn't give propofol --

Ms. Cahan. And he readily -- sorry.

Mr. Panish. And he wasn't allowed to talk about it. Brown is a practicing Anesthesiologist. Dr. Earley has never given propofol in his life.

Ms. Cahan. Dr. --

Mr. Panish. He doesn't give propofol. Now, he can read articles.

Court. The difference between Czeisler is Czeisler didn't know anything about propofol.

Ms. Cahan. And he readily admitted that.

Mr. Panish. No.

Court. And you have Earley here who --

Mr. Panish. How is he an expert -- he's a self-proclaimed expert on propofol.

Ms. Cahan. As is every expert.

Court. This area is not as well developed. That's why.

Mr. Panish. He has never administered the drug. How can you be an expert on the administration of propofol if you've never administered it nor been qualified or certified to do that? And he is not qualified --

Mr. Boyle. That's on patients. He has no idea what the effects are of patients on propofol because he's never had a patient that had propofol.

Mr. Panish. Ever in his career.

Ms. Cahan. Not true at all, your honor. And this is something, if they wanted to move in limine to exclude him, this was asked about at his deposition. He talked about his foundation for this, and it is ample.

Mr. Panish. What has he given propofol for?

Ms. Cahan. Excuse me, Mr. Panish.

Mr. Panish. Well, you just said he's given it.

Ms. Cahan. I did not. And if you would let me finish a sentence, you would hear what my point is. Your honor, and so he was asked about this at his deposition. He testified about the foundation. This is something that he has studied and worked on. He knows how it works. If they want to cross him on it, that's fine. If they didn't think he was qualified, they would have moved to exclude him, as we did with a number of their experts, and they didn't do that. And the reason it came up with Dr. Czeisler --

Court. He had no experience --

Ms. Cahan. And he hadn't talked about it at his deposition, so wasn't allowed to talk about it.

Court. I'm going to allow it.

Ms. Cahan. Thank you, your honor.

Mr. Putnam. And, your honor, if I may, the concern we have, we're starting -- new month, new season. In light of something about what happened last week with Ms. Strong, if the cat calls from the other side during our arguments and when we're talking could be brought down to a minimum, that would make it easier for us to hear the court and hear the witnesses. So I would ask the court to direct the parties to try to keep their comments about what other people are saying to a minimum while they're saying it.

Court. Okay. Well --

Mr. Panish. Well, I interrupted her twice.

Mr. Putnam. Not the interrupting. The cat calling. "that's not what happened," or "that's not the evidence," I would ask he not do that.

Court. Okay.

Mr. Panish. If we're going to talk about collateral matters, as I approached the court today, Mr. Putnam was having a discussion with two people on this side within two feet of the jurors, and I went up to him and said "Mr. Putnam, it's not appropriate." and he told me he was not talking about the case. And I heard him talking. I thought about it. Not appropriate to even be talking around jurors, within two or three feet. If we're going to get into all this stuff, I don't come in here and whine every time they do something that I don't like, OK? They seem to want to whine about it. I don't come in and do that. But these things are happening all the time, just haven't been burdening the court. I will not say anything. I will write a note to Mr. Boyle, as long as they do the same thing when we're questioning.

Court. And just keep your voice down. You have a voice that carries sometimes.

Mr. Panish. All right.

Court. Just keep your voice down. And try to -- if you have a discussion, not near the jurors.

Mr. Putnam. It wasn't. I moved when he asked me to. And it wasn't two to three feet from them. I think, as the court reporter will note, I was welcoming her back from her vacation.

Mr. Boyle. On that, I will say they do every day at the lunch break, they stand at the corner right there by the jurors in the hallway. I know veronica has asked them to move at least once in the past. I don't think they should be standing in the jury hall every day. But that was it. Back to this last point, there's four slides that can all be dealt with at once.

Court. So there's more on the slides?

Mr. Boyle. Yes. Really quick. Maybe they can explain why. Starting at slide 6 that says --

Ms. Cahan. 7.

Mr. Boyle. First one is 6.

Ms. Cahan. Okay.

Mr. Boyle. Okay. Do you see this one, your honor?

Court. Slide 6?

Mr. Boyle. Yes. It's 6, 7, 8, 9, and then it just quotes a bunch of trial or depo testimony.

Court. Okay.

Mr. Boyle. So the question is, it's warnings to Michael Jackson, and I don't understand how this fits in with what his opinion is. He testified at trial -- I mean, sorry, at his deposition that he doesn't believe Michael Jackson was -- he doesn't have enough information to know if he was addicted to propofol. He may have had a physiological dependence and that ultimately what his opinion is with the final slide is his prognosis is grave. So I just don't understand what all these warnings to Michael Jackson have to do with the ultimate opinion in the case. You know what I mean? What does it have to do -- and it's just argumentative.

Court. It is a little bit argumentative, but, anyway.

Ms. Cahan. It goes directly, your honor, to the life expectancy piece, and the way Mr. Jackson was using propofol. He was warned repeatedly, "this is not safe," "this is dangerous." and the record is clear, he wanted to pursue it year after year, tried to get it from a number of people. And so I think it fits into Dr. Earley's testimony about life expectancy. And even though he doesn't say there's enough evidence that rises to the level where he can be, as a clinician, confident that there was absolutely an addiction, he does say there's abuse here, and this is part of the abuse, and it's a reckless sense of one's own health, and it's part of his opinion about Mr. Jackson's prognosis and life expectancy.

Mr. Panish. It's argumentative as warnings of Michael Jackson. I mean, if he wants to say this is evidence supporting his opinion that he's in grave risk, fine.

Ms. Cahan. Well, they were all warnings, your honor. All the testimony's in the record.

Mr. Boyle. Warning's a medical term. I mean, there's warnings on drugs, it's the whole -- FDA gets involved. To say Dr. Cherilyn Lee saying that's not something you should use at home is a warning, or if Debbie Rowe says, "What happens if you die?" Is that a warning? Is that a medical warning?

Court. Sounds like a warning.

Mr. Putnam. In terms of addiction, your honor, that's precisely what it is. I think the jury understands what a warning is. But in terms of addiction, and in terms of one's propensity, and, therefore, what the life expectancy is, it goes to the issue of, you're told not to do something, you're warned what the results will be, and you do it anyway. The recklessness issue is precisely what he was talking about, and they were warnings. You heard what Cherilyn said. It was a warning. You heard what Debbie Rowe said. She said "Not on my watch, you're not doing this." That's a warning. And one of the terms, he's not going to heed the warnings by both those they love and the medical providers, it's going to the recklessness that forms his opinion.

Mr. Boyle. Not something he testified to in his deposition.

Ms. Cahan. It is.

Court. I'll overrule the objection. You can use the slide and use the word "warning."

Ms. Cahan. Your honor, can I step out a minute to advise the doctor about his rulings? Thank you.

Mr. Putnam. Thank you, your honor.

JURY ENTERS COURTROOM

Court. Good morning, everybody. Welcome back.

The jury. Good morning.

Court. Can you make your appearances?

Mr. Panish. Yes. Good morning. Brian Panish for the plaintiffs.

Mr. Boyle. Good morning. Kevin Boyle for the plaintiffs.

Ms. Cahan. Good morning. Kathryn Cahan for the defendants.

Ms. Bina. Jessica Stebbins Bina for the defendants.

Mr. Putnam. And Marvin Putnam for the defendants.

Court. Okay. I reviewed what's left of this trial, and it looks like we're getting close to the end. Maybe a week, week and a half, for the defense case, and then maybe half a week or so for the plaintiffs. So it's getting close. Of course, then we have closing arguments and then deliberations. But I wanted to let you know that that's where we are. We're actually pretty close. There are other things we have to talk about, but let's hold off on that for now. I'll let you know when we're ready. It has to do with deliberations, and we don't need to talk about that quite yet. And I want to read you a jury instruction before we start. "throughout this trial, many witnesses have become emotional. Although it is a natural human reaction to console such a witness, attorneys may not be permitted to approach the witness on the stand due to certain rules of court. You are not to view the attorneys with disfavor simply because they fail to approach or console an emotional witness." thank you. Defendants, you may call your next witness.

Ms. Cahan. Thank you. At this time, defendants call Dr. Paul Earley. Dr. Paul Earley, called as a witness by the defendants, was sworn in.

Court. Thank you. You may begin.

Ms. Cahan. Thank you, your honor.

DIRECT EXAMINATION BY MS. CAHAN

Q. Good morning, Dr. Earley.

A. Good morning.

Q. What do you do for a living?

A. I'm an addiction medicine physician.

Q. And are you currently employed?

A. I am.

Q. Where do you work?

A. I work in Atlanta, Georgia, and I have two positions: I'm the medical director of the Georgia physicians health program, and I'm in private practice in a small firm that's just me. It's called Earley consultancy.

Q. Can you move the microphone closer to you? The background is --

A. I will try. Okay.

Q. Thank you. And what do you do, generally speaking, as an addiction medicine doctor?

A. Addiction medical physicians take care of the medical, the psychological, the psychiatric, the emotional, the family aspects of individuals that suffer from addictive diseases of all sorts.

Q. How long have you been working in the field of addiction medicine?

A. I'm in my 30th year now.

Q. And you're here to testify today as an expert witness?

A. I am.

Q. I just want to spend a couple minutes talking about your background. Where did you attend college?

A. I went to college at a small school in Oregon called Reed college.

Q. When did you graduate?

A. 1974.

Q. What year -- what degree did you receive?

A. A bachelor of arts in biology.

Q. Did you then go on to medical school?

A. I did. I did a year of graduate-level research and then went on to medical school.

Q. Where did you attend medical school?

A. University of Cincinnati in Cincinnati, Ohio.

Q. Is that your hometown?

A. That is my hometown.

Q. And what year did you graduate?

A. In 1980.

Q. After graduating from medical school, did you do an internship?

A. I did.

Q. Where?

A. In Portland, Oregon, at the good Samaritan hospital as a rotating internal medicine internship.

Q. And did you then go on to a residency?

A. I did. I did a residency in neurology.

Q. And where was that?

A. At the university of Oregon health sciences center in Portland, Oregon.

Q. When did you finish that residency?

A. '84.

Q. And after you completed your residency, did you do any further training in your field?

A. I did. At the time I entered the field, there was really no formalized fellowship program, residency training in addiction medicine, so you had to cobble together things. I was in supervision with analysts for six years in terms of my therapy. I have several degrees in psychotherapy and from what's called experiential psychotherapies. And I had supervision in the field from my mentors, and that was really all that was available at the time in that time.

Q. And what year did you begin taking care -- you said 30 years in addiction medicine, so you began taking care of patients with addiction disorders in 1983?

A. 1984.

Q. '4? Okay. And so that was when you finished your residency, you started doing that work?

A. Right.

Q. Where are you currently licensed to practice medicine?

A. Currently licensed -- I have an active license in Georgia, and I have an inactive license, meaning I can't practice, but I've got a -- it's just kind of like a holding in Oregon still.

Q. Okay.

A. Have thoughts about returning home there sometime.

Q. And is -- why is your license in Oregon inactive?

A. When you leave a state for a period of time, if you have a low probability of returning, you inactivate your license, quite frankly, for financial reasons. An active license is more expensive.

Q. Is there presently a board certification for addiction medicine?

A. There is.

Q. And is it an American board of medical specialty board or some other board?

A. It's currently the American board of addiction medicine who underscores that specialty. And much like any field, when it's a new field coming along, the American board of medical examiners doesn't absorb you into their fold, so to speak, until there's sufficient time and training and experience and that sort of thing. Much like emergency medicine. Where emergency medicine was 10 or 12 years ago, where there was emergency medical physicians, but there was no a.b.m.e. Certification. But there is a board, and I'm part of that organization, that's helping move addiction medicine forward so there will be a fully-understood board. It's the only board in addiction medicine, basically, right now.

Q. And are you certified under that board?

A. I am. I helped design the test and helped bring that forward.

Q. Are you currently board certified in any other specialties?

A. I am not.

Q. After you completed your training, what did you do next for work?

A. Well, actually, I was working while I was in that addiction medicine training. I started off at a small addiction facility in Georgia and worked there for several years. That was an eating-disorder program as well as a substance-abuse program. Did that for three years. And then I went on to be the medical director of a small program in Atlanta called Parkwood Hospital, which I did for several years. I then moved to a program for 15 years called Ridgeview Institute in Atlanta. That program has -- it's a large complex, multi-tiered program, that I was medical director for 15 years. And then after that, I moved to a program called Talbott Recovery Campus, where I was a medical director for five years. And both those last two programs specialized in treatment of addicted health care professionals and airline pilots.

Q. So let me just make sure I got all the pieces of that.

A. It's a lot.

Q. So you -- and in each of those three roles, you took care of patients with addiction disorders?

A. Full time.

Q. And you were also medical director at Ridgeview and Talbott?

A. That's correct.

Q. And what is a medical director?

A. Medical director, I supervise basically -- it's like the head of the clinical services at an addiction facility. I supervised other physicians, I would help clinicians understand how to work best with addicted patients. I provided therapy skills, detoxification skills, et cetera.

Q. And I think you said at Ridgeview, you focused -- sort of had a sub-focus in treating impaired professionals?

A. Yeah. That's -- we like the term "addicted health care professionals" better in terms of --

Q. Okay.

A. Yeah. But Ridgeview was one of those programs, as was the other program that I worked at later.

Q. At Talbott?

A. At Talbott, yes.

Q. So you had sort of a focus on treating health care providers, physicians, nurses, people in the health care field who suffered from addiction?

A. That's correct.

Q. And at some point did you leave Talbott to go to your current position as medical director of the Georgia professionals health program?

A. Right. Every state, with a couple of exceptions -- actually, I think California is one of them right now, one of the exceptions -- has a program that works in concert with the medical board to divert physicians that have addictive disorders and supervise them, make sure they have a high quality of care, high-quality programs, make sure they're monitored for years to make sure they're safe to return to practice so they would create no public risk of harm. And we helped bring that legislation forward in Georgia. And then, finally, once it came to fruition, we looked around, the people that were promoting it, and someone said, "who is going to run this thing?" and someone said, "well, you're going to." and so that's what I did.

Q. So if a physician in Georgia has an addiction problem, and it's recognized, he or she will go get channeled through the program where you currently work?

A. That's correct.

Court. Does that include alcohol addiction?

A. yes, it does. Alcohol is the primary substance that everyone is addicted to, including physicians and attorneys.

Ms. Cahan. Approximately how many patients have you seen and treated for addiction in the course of your 30 years, if you can estimate?

A. Personally have been the personal attending physician on probably, I would guess, a thousand physicians. And -- a thousand patients. I'm sorry. Not all physicians. Because that's -- although I did that. I took care of all types of individuals. And then in the facilities I supervised the care for -- my guess, it would be north of 5,000 patients.

Q. Okay. So fair to say, you've a lot of experience with people with addictions from all walks of life, although you have a special focus on health care providers?

A. Right. In all of those facilities, in those last two facilities, all types of patients can come, but we would have kind of specialty programming for physicians. And we would also -- and -- but I took care of housewives and people that worked in all types of fields, and young adults, and that sort of thing as well. Yeah.

Q. Ever take care of any -- without telling me anything specific, have you ever taken care of any virtually wealthy individuals?

A. Yes, I have.

Q. Any famous people?

A. Yes. Quite a few -- both of those facilities, because when you get known as a place doctors go, then the doctors tend to refer their complicated cases to us. So we were what you would call a tertiary care facility and often would get people in the music or the -- primarily music industry, but also some in the film industry and politics, and that sort of thing.

Q. So outside side of your 30 years of treating patients, have you also published scholarly work in the field of addiction?

A. I have. I'm one of the authors of the American society of addiction medicine, that's the parent organization, textbook, and I have contributed to several other publications that deal with types -- what we call treatment typology, describing the different types of treatment that are given. And I've published several papers on understanding addiction and physicians. I also do a fair amount of training in that regard.

Q. And the training, does that include presentations to health care providers and the general public?

A. All of the above. One of the things I found that I like to do is to speak and to train. And so I tend to pontificate more than I should.

Q. Are you able to estimate about how many presentations you've given over the years?

A. 50, I would guess.

Q. And have you also spoken in the media about addiction?

A. I have. I've had some interesting experiences in that regard. I was consulted and interviewed on two specials called -- they were called "turning point." they were prime time, hour-long specials on addiction. One was about the epidemic of heroin in high schools, one was about substance abuse and how it's changing its character in the united states. That was in the '90s. I also was a consultant to -- which was actually a wonderful experience -- to Bill Moyers in a five-part series called "close to home," where he looked at the politics and science of addiction treatment. And we were -- our work was kind of underscored in the treatment end, which was a wonderful experience working with that crew.

Q. And have you also been a guest on the Oprah Winfrey show?

A. Yeah, I have. I've been on the Oprah Winfrey show twice, and that was an interesting experience.

Q. And in other media venues, other programs of that nature?

A. Yes.

Q. And I think you mentioned you were a member of the American society of addiction medicine. How long -- are you a fellow, also?

A. I'm a fellow, which basically means when you get old there, they give you this certification saying "you've been hanging around long enough, let's give you a fellowship."

Q. And did you found the Georgia chapter of the American society of addiction medicine?

A. I did. And I've been on the board of a.s.a.m. 12 years. And when I was part of that organization, it was just a fledgling organization. Now it's really the primary voice of medicine concerning addiction issues. So it's been a wonderful experience to watch that grow over the years.

Q. Dr. Earley, in the course of your work taking care of health care professionals with addiction issues, did you come to learn anything about propofol and propofol addiction?

A. I did. And that was -- I did. That was primarily because I was taking care of a lot of health care professionals, and health care professionals are overwhelmingly the highest percentage of people that get into trouble with propofol and propofol addiction.

Q. Is propofol -- I understand that health care professionals are the ones that tend to have propofol addiction, but is propofol addiction common among health care professionals as an addiction disorder?

A. It's not. Our work shows that only -- that even in health care professionals, approximately only 1.6 percent of them have any experience or addiction to propofol. So it's unusual even in the health care professions.

Q. And in your experience taking care of or being involved with the care of thousands of patients, about how many have you seen that have suffered from propofol addiction?

A. We've seen north of 25, 26 cases. The -- and that formed the basis of a study that we did.

Q. And that's total over 30 years?

A. That's total over 30 years. Although I do want to say that probably there were times when, frankly, I missed it, because probably there were people using the drug and not talking about it while they were in treatment because they were using other drugs.

Q. Did most of the patients that you see who have propofol addiction have other drugs of abuse as well?

A. Absolutely. Commonly alcohol, commonly opioids, commonly benzodiazepine drugs you've been hearing about in this trial. So rarely is anyone strictly using propofol. Actually, I've had maybe two cases, or, geez, probably two or three cases -- I don't know the exact number -- that are propofol alone.

Q. Have you personally ever had a case of someone abusing propofol who was not a health care provider?

A. I have not personally had a case that was not a health care provider.

Q. Is there a lot of literature, or at least scholarly literature, about propofol and the addictions?

A. There's not. There's a very scant body of literature, especially about the addiction itself, its treatment, something about the types of people that get it, how you best help them. That literature is remarkably sparse.

Q. Why is that?

A. I think primarily it's a numbers game, the fact that there's so few cases of it. And also there's a tendency, even if you're a health care provider, to not talk about the propofol that you're using, if you're also using a drug like fentanyl or alcohol or something like that. I think there's also a tendency not to talk about it. As I said earlier, there's also a bias. I think patients drifting in and out of my treatment perhaps 10 or 12 years ago, I did an intake interview, and I didn't specifically ask the question: "did you ever abuse or use propofol" probably until the last 15 years or so. Early on, it would have gone right over my head. So it's also the fact that we really weren't looking for it.

Q. Is there a consensus in the field of addiction medicine that propofol is an addictive drug?

A. There is a consensus, yes.

Q. And is it that propofol is an addictive drug?

A. Yes. Sorry about that.

Q. Sorry. It's one of those lawyer questions.

A. Right. Okay.

Q. And you mentioned a couple minutes ago that you published a study about propofol addiction.

A. I did.

Q. Can you just tell us a little bit about that?

A. Well, what we did was we -- this was from our cases at the last place I worked, the place called the Talbott recovery campus. It was one of those things, the other five physicians who worked there, we'd get a case in,

and we'd scratch our heads and say, "how many of these have you seen?" and so when I first got there, we would write down case numbers and kind of had a curiosity about it. And we found that when we were looking, surprise, surprise, we started finding more. And then at some point, one of the other physicians said to me, "you need to publish on that." and, you know, I guess I follow instructions. And so at that point we began to think about looking seriously at the data and figuring out whether we could -- you know, how you learn in medicine is you get a bunch of cases, and you go back and look at them retrospectively and say, "what did we see there?" and that's really the first thing you do in research, is you say "what does it look like?" "what are the presentations?" "what do we know about those types of people?" that sort of thing.

Q. So ultimately you put together a paper for publication. Was that paper published?

A. It was. It was published in the *journal of addiction medicine*, which is one of the better journals, and I was pleased to have it do so.

Q. And was that a -- how did you get funding for the work that was necessary to publish that paper?

A. Up until -- as I said, earlier in the days, we were just kind of keeping track of the cases. And I was a Full-time clinician seeing patients all day long, supervising staff, didn't really have the time to devote to that. And at some point, during the -- when I was working with O'Melveny & Myers, the question came up. I think I was speaking with Mr. Putnam, and he said, "well, what do we know about this?" and I said, "well, we don't know much." and he said, "well, how come?" and I said, "well, it's just not really well known. I've gotten a few things." and he said, "well, would it help if you knew more?" and I said, "yes." and he said, "well, let us see what we can do to help you."

Q. And did there come a time when AEG Live agreed to give you the funding to finish the study?

A. It did.

Q. Before that, this wasn't the only thing you spoke to Mr. Putnam about, right?

A. Oh, no. This was not the first thing, no.

Q. So when did we first reach out to you to talk about propofol?

A. It was in approximately 2010, if my dates are right on that. Or was it 2011? It was 2011. That's right. It was 2011. I received a call from Mr. Putnam, and he said, you know, "we need some help in understanding propofol addiction."

Q. And it was at or around that time in early 2011? Does that sound right?

A. That sounds right.

Q. Did -- were you retained to help us learn about propofol?

A. That's correct. That was -- the initial call was, because nothing is known about it, you know, Mr. Putnam said, "well, what do you know about it?" and I said, "well, I don't know much. I treated more patients than anyone else." and he said, "well, OK." so at that point we went back and reviewed the literature, and they retained me as a consultant to review the literature, to take a look at the neurochemistry, how it works with other drugs in the neurochemistry setting to understand what were the other cases -- was there any literature

on what the cases looked like, what was the lethality of the drug, how toxic was the drug. That sort of thing. And I was doing that kind of literature search for probably six months, I would guess, off and on. When a question would come up, we'd go back and forth with it.

Q. And about how much time over that six months, how many hours do you think you spent in doing that kind of work?

A. My guess is about 30 hours of, again, library research, sitting the library, reading journals. Actually e-mailing colleagues, because some of these things were published in journals in Germany and Korea, and we had to get the actual articles.

Q. And did any of what you learned in that capacity form the basis for something you're going to be offering an opinion on here in trial today?

A. Only -- the only thing I learned at that point was, I learned more about the neurochemistry from that work. I learned more about the science of propofol. I'm a curious kind of guy, and it really helped me understand that piece. So in terms of my knowledge base, it expanded my knowledge base.

Q. But nothing specific that you learned that was part of the basis for an opinion you're offering here?

A. No.

Q. And then at some point there was another conversation with Mr. Putnam where you said, you know, "I'm working on this research, and I need some" -- you know, "I don't have the resources right now to publish it", is that fair?

A. Yeah. It was after -- say, it was early 2011. It was probably -- it was actually quite a ways down the road.

Q. Summer of 2012 sound about right?

A. That sounds about right.

Q. And do you remember how much you told AEG Live you would need to get the staff and resources necessary to finish the study?

A. Right. What they asked was, you know, "what would it take?" so I put together a team of folks, my coauthor, Dr. Torin Finver, a research assistant, statistician, called up a couple editors. I'm not particularly an academic writer, so I had to hire somebody to type up the form, especially the statistician. We put together the numbers and sent a proposal off.

Q. And the dollar amount, do you know how much that totaled?

A. Total for all of us for about half a year's work was $53,000.

Q. And AEG Live provided that money?

A. That is correct.

Q. And did AEG Live tell you anything about how they wanted the study to come out?

A. No.

Q. Did you agree to give AEG Live any information about your work as you were doing it?

A. No.

Q. In fact, did you tell AEG Live that you wouldn't do that to us?

A. Yeah, absolutely. I mean, that was part of the decision. And, again, this is an academic paper, you know. It's typifying propofol, and how it looks, and what it's like. That sort of thing.

Q. And so for that paper, you looked at existing case files, crunched numbers, analyzed it, and wrote up

A. Report on your findings?

A. Yeah. The bulk --

Q. I'm sorry. I don't mean to minimize the amount of work that's involved, it's just outside of my expertise.

A. That's fine. That's not a problem. The bulk of the time really was spent going back in the archives of the past 20 years in the treatment center and digging out charts and reading charts and all of us sitting down in the bowels of this place in the dark -- it was -- you know, you just read charts, and the charts are thick and only so much that's relevant. So we spent time reading all these charts and trying to find other cases, which we actually did turn up a few more cases. Compiled all that information. And this was patients that had already been treated, their outcomes had already been determined years before. And we decided we were going to go back for 20 years so we could get an idea of not only, is this a common illness, so we could get enough cases, but has the incidence of the propofol addiction increased in health care professionals?

Q. So once AEG Live agreed to provide funding, you didn't discuss the work that you were doing?

A. No.

Q. You didn't show -- did you show any drafts of your paper to AEG Live --

A. No.

Q. -- or the lawyers or discuss it with us at all?

A. The only discussion was, "how's it going?" and I -- I would say some sort of grumbling, whining, "this is taking" -- no. That's not true. It was, "how's it going?" "it's going fine."

Q. And that was "going" in terms of timing, not content?

A. Timing. Yeah. Yeah.

Q. And did there come a time when you completed a draft of the paper and sent it off to the journal of addiction medicine?

A. Right. We completed our first draft October of -- somewhere in October of 2012.

Q. Okay. And was there then some back-and-forth process to finalize it for publication?

A. Absolutely. When you send something in to a peer-review journal, you usually get it back, and the author -- they get paid to look at it critically. And so we had to have three full rewrites of the article. And, actually, it improved the article dramatically in doing that in its clarity.

Q. And, again, did you discuss with us or the defendants anything about what was in the article, or the revisions you were making, or show us anything that you were working on --

A. No.

Q. -- while you were doing it?

A. No.

Q. And at some point -- you said there were three full drafts that you went through.

A. Right.

Q. Was it accepted finally for publication at some point?

A. Yes. Early January of 2013 it was accepted for publication.

Q. And it was submitted originally back in October?

A. Yes.

Q. And in that same beginning of 2013 time period, did we come back to you again and say, you know, "we'd be interested in having you come testify as an expert in this case"?

A. You did.

Q. And was that because of -- well, you may not know this. Let me ask a better question. At the time that we asked you to be a testifying expert witness, had we seen the publication that was published?

Mr. Boyle. Objection. No foundation.

Court. Overruled.

Ms. Cahan. Did you send it to us?

Court. You may answer.

A. OK. I'm sorry. I didn't hear. No, we didn't send it to you.

Ms. Cahan. Okay. And it didn't get published until march of 2013?

A. That's correct.

Q. But we came to you and said, "we'd like to have you testify as an expert witness." did we have you sign any paperwork at that point?

A. Yes. There was -- I'm sorry. I don't know the exact -- there was some sort of a thing that allows confidentiality of documents. I'm sorry I don't know what you guys call it. But you had me sign that and said, "by the way, now you're an expert witness." and I -- "OK."

Q. And the thing that we had you sign, did we have you sign that so we could send you materials from this case?

A. Yeah. I'm sorry. I wasn't clear about that. That's exactly why that was signed.

Court. When did that occur?

Ms. Cahan. January 2013.

A. yeah. The end of January.

Ms. Cahan. And was that the first time you were provided any medical records or detailed information about the evidence in this case?

A. Yes. That was the first time I -- I knew hardly anything about the case besides what I would read in the media occasionally.

Q. And did you agree to -- you agreed to be a testifying witness for us?

A. I did.

Q. And at what rate did you -- what rate schedule did you set?

A. For record review, I think it was 375 an hour, for deposition, it was 500, and to be here today, it's 850 an hour.

Q. And that 375 an hour, is that the same rate you charged for the consulting work you did back in 2011?

A. That's correct.

Q. Okay. And about -- since you've been asked to be a testifying expert witness, about how many hours have you worked on this case?

A. There's an enormous number of charts. Probably about -- I would guess 85 to 90 hours, I would guess.

Mr. Boyle. Object, your honor, if it's calling for speculation if he's guessing, or if that's his real testimony.

Court. I think he said, "about." that's an estimate. Overruled.

Mr. Boyle. He said he would guess.

Ms. Cahan. Are you able to estimate?

A. I'm able to estimate 85 to 90 hours.

Q. Thank you, Dr. Earley. So you were paid for your work as a consulting expert, AEG Live agreed to fund the study that you were working on, and you've also been paid for your time as a testifying expert?

A. That's correct.

Q. And do you believe that you're able to offer independent opinions here today, even though AEG Live provided study -- funding for the study and is paying you for your time?

A. Absolutely.

Q. And why is that?

A. Well, I mean, for many reasons. One of the things you learn in medicine is, you get paid for your services, and yet you have to -- you also have to render a judgment about patients, and you don't alter the -- that sort of thing happens all the time. Secondly, the research study was -- the data was the data, you know. This is past patient data. It's just -- all we did was compile it and publish it. And although it was satisfying to have the article there, and all it did was talk about the treatment of propofol dependence and about how to diagnose it, to some degree.

Q. So just to be clear, you didn't show us the final published -- to-be-published paper until after we had hired you as an expert -- testifying expert witness?

A. That's correct. In fact, when you submit it to the referee journal, you have an agreement that stays between you, Dr. Finver and myself, those are the two authors, and the journal until they bless it.

Q. So we -- you don't leak the final thing to anyone before it's published, is that the idea?

A. Yeah. If I leaked it, I can't imagine anyone interested in reading it, aside from us geeky people.

Q. And you didn't show us any drafts in process or anything like that? You didn't submit it to us before you submitted it for publication?

A. No.

Q. I'm sorry. For the record, if you could speak up.

A. I'm sorry. No.

Q. Okay. So let's talk about the materials you reviewed when you were -- started doing your work to prepare to offer opinions here in court --

A. Okay.

Q. -- back earlier this year. Did anybody tell you that they wanted you to come with any particular conclusions?

A. No.

Q. Did we talk about, generally speaking, what areas we wanted you to offer opinions in?

A. Yes, we did.

Q. Okay. What are those areas, generally speaking?

A. Generally speaking, the issues were about whether there was addiction present of any substances in Michael Jackson's history, my diagnostic impression of whether that was present. The number two was, if so, which drugs? The number three was, you know, why do you have that opinion? And then the last one was, how would this affect Michael Jackson's health and life going forward based upon the earlier conclusions?

Q. Okay. And we'll talk through each of those today. First I want to just cover what you looked at. So generally speaking, what types of materials did you review in order to reach your conclusions in this case?

A. I reviewed medical records, although they were sporadic and scant. I mean, all the medical records came, but still, over the length of time, they were surprisingly short, I reviewed testimony of many of the individuals that had been deposed previously to my being retained, both physicians, people like Ms. Rowe, I reviewed some hospital records, Santa Ynez hospital's records, I reviewed interviews or depositions with family. That sort of thing.

Q. Okay. And at some point you also reviewed some trial testimony after this trial had started?

A. Yeah. After the trial -- I'm sorry. I thought you were talking about early on. Yeah.

Q. And you said the medical records were scant. Do you know whether you were provided only a subset of the medical records that were available in this case or if there were only certain medical records available covering certain time periods?

A. Right.

Mr. Boyle. Objection. No foundation.

Court. Sustained.

Ms. Cahan. Did you ask to see all the medical records that were available in the case?

A. I did.

Q. And do you have any reason to believe that those were not provided to you?

A. I do not.

Mr. Boyle. No foundation.

Court. Overruled.

Ms. Cahan. And did you -- was there an initial set of materials provided to you?

A. Yes, but in the volumes, I couldn't tell you what was in the initial and what wasn't.

Q. That's OK. I'm not going to -- it's not a test on that. But then did you get further materials at some later point in time?

A. Yes. They just kept on coming.

Q. And are you relying on some of the materials you've reviewed for opinions that you're offering here today?

A. I do. I did.

Q. And do you have a list up there with you of the materials --

A. I do.

Q. -- that are most pertinent to your opinions?

A. I do. Somewhere in this stack.

Ms. Cahan. And if counsel would like, I can share a copy of that as well.

Mr. Boyle. Thank you.

Ms. Cahan. And can you just read for us the medical records -- you don't have to read the exhibit numbers, but just the names of the medical records that you're principally relying on for your testimony here today?

A. I will. The Baxley Production, Farshchian Production, Forensic Consultants Medical Group Production, Fournier Production, Gordon Production, Klein records, Koplin Production, Letelier Production, Metzger Production, Murray medical records, Murray LAPD Interview, Nutrimed Healthcare Production, Odabashian Production, the Palluck/Tadrissi Production, The Santa Barbara County Sheriff's Office Production, Santa Ynez Valley College Hospital Production, Sasaki Production, Sasaki summary of treatments, Slavit Production, Van Valin Production, Coroner's report and toxicology report.

Q. And are there -- is there deposition testimony that you reviewed that's also particularly pertinent to the opinions you're offering? And for the depositions, to the extent that they've been -- excerpts of them have been played at videos in trial, have you also reviewed those depositions?

A. I have.

Q. Can we list the depositions, and the jury will remember the ones they've seen so we don't have to do it twice?

A. Okay. And I'm just going to read --

Q. The witness list?

A. -- the witness list, I guess, is that right? Dr. David Adams, Ellen Brunn, Dr. Alimorad Farshchian, Dr. Stuart Finkelstein, David Fournier, Maritza Shulman Glassman, Dr. Stephen Gordon, Prince Jackson, Randy Jackson, Michael Laperruque, Cherilyn Lee, Dr. Allan Metzger, Dr. Christine Quinn, Dr. Neil Ratner, Debbie Rowe, Dr. Gordon Sasaki, Dr. Scott Saunders, Dr. Sidney Schnoll, Dr. Myer Shimelman, Dr. David Slavit, Dr. William Van Valin, Dr. Carl Virgil, Roland Williams.

Q. Is there also trial testimony that you've reviewed that's particularly pertinent to the opinions that you're offering?

A. You're asking me to read that as well, I take it?

Q. Yes, please, and then we'll be done.

A. Okay. Dr. Charles Czeisler, Dr. Sidney Schnoll, Dr. Petros Levounis, Karen Faye, Kenny Ortega, Travis Payne, Michael Laperruque, Katherine Jackson, David Fournier, Debbie Rowe, Prince Jackson, Dr. Christine Quinn, Cherilyn Lee, Daniel Anderson, Christopher Rogers and Richard Senneff.

Q. So in addition to all these materials that -- by the way, is that everything that you reviewed in the case?

A. No. No. It's just -- it's a long list, but it seems like it was a lot -- I'm joking. There was a lot more.

Q. Okay. In addition to those materials that you've just read for us, are you also relying on your education, your training, your experience for the opinions that you're offering here today?

A. I am.

Q. You said, "I've had a chance to review the testimony of Dr. Levounis who testified here last week."

A. Yes.

Q. Did you review the part of his testimony where he talked about whether Michael Jackson suffered from addiction?

A. I did.

Q. Is the question of whether Mr. Jackson suffered from addiction important to the opinions that you're going to be offering here today about risk factors that affected Mr. Jackson's life expectancy?

A. It is.

Q. Prior to looking at Dr. Levounis's testimony, based on your own review of the records, had you already come to an independent conclusion about whether Mr. Jackson suffered from any drug addiction?

A. I had.

Q. And what was your --

Mr. Boyle. I'm going to object to the next question as being cumulative.

Court. Overruled.

Ms. Cahan. It's based that he knows my next question.

Court. Need to hear the question.

Ms. Cahan. What do you believe Mr. Jackson was addicted to?

Mr. Boyle. Cumulative. Already talked about Mr. Levounis's opinion. Now they're going to ask him if he has a separate opinion on the same topic. That would be a cumulative expert opinion.

Ms. Cahan. One question, your honor. Trying to not recover ground but to establish foundation for independent opinions, and then we'll move on to the life expectancy.

Mr. Boyle. Two experts on the same topic.

Court. It is cumulative to, I guess, certain addictions.

Ms. Cahan. Which is why we're not going to spend time on it.

Court. Okay. Then don't spend any time on it. Let's just get to the new stuff.

Ms. Cahan. Fair to say that you agree with Dr. Levounis's testimony that Mr. Jackson was addicted to opioids?

Mr. Boyle. Again, objection. That's cumulative.

Court. Sustained.

Ms. Cahan. Did you reach any conclusions about Mr. Jackson -- the substances Mr. Jackson was addicted or not addicted to that differed from Dr. Levounis's, what he testified to here?

Mr. Boyle. Again, same way to try to elicit the same thing, which is --

Court. Overruled. I think she's asking a different question.

A. could you repeat the question?

Ms. Cahan. Sure. Because I'm trying not to recover ground that we covered with Dr. Levounis.

A. Got it.

Q. So in your assessment of the records, did you reach a conclusion that Mr. Jackson was addicted to or not addicted to any categories of drugs that differs from what Dr. Levounis came in and talked about at trial last week?

Mr. Boyle. Object. Calls for cumulative. She can just ask him what his opinions are.

Ms. Cahan. You don't want me to ask what his opinions are.

Court. Overruled.

A. My opinions did not differ as to the drugs he was addicted to.

Mr. Boyle. Move to strike.

Court. The answer is stricken. That's not --

Mr. Boyle. Move counsel be admonished for eliciting that.

Mr. Putnam. Your honor, she didn't elicit that. She asked a different question.

Court. She asked a different question. He elicited a different answer. So you need to ask him questions -- I thought you asked the prior question. He volunteered.

Ms. Cahan. "yes" or "no," did you come to a conclusion --

Court. Why don't you lead him at this point?

Ms. Cahan. Okay.

Mr. Putnam. Thank you, your honor.

Ms. Cahan. Do you believe that Mr. Jackson suffered from addiction to drugs of abuse that is different --

Court. No. That's not leading.

Mr. Panish. It's the same thing.

Court. Let's go to sidebar.

(the following proceeding was heard at sidebar)

Court. All right. A leading question, "did you come to the conclusion that he was addicted to propofol?"

Mr. Putnam. Thank you.

Ms. Cahan. I thought the objection --

Court. That's the question. Well, because of the nature of the answer that was given -- and I'm not saying you asked an inappropriate question. I thought it was obvious what you were trying to ask, based on what was going on. Perhaps the witness didn't understand it. I said, "go ahead and lead him." that's what I meant. I understand you didn't know what to do. But now that you know --

Ms. Cahan. Yes.

Court. Counsel didn't object. I assume that was the question that I intended that she ask. You weren't going to object on leading, because I just said you could lead.

Mr. Boyle. That's exactly right. I was worried that -- I mean, that what they were trying to do was have two separate opinions. Giving an opinion that Michael Jackson was addicted to opioids. She first brought out it was based on Levounis, but then there was a series of questions to say he independently came to the same conclusions.

Court. Right.

Mr. Boyle. That's the problem.

Court. Okay. And I sustained your objections, so --

Ms. Cahan. And your honor, I was just confused about what they were objecting to. I thought they didn't want me to elicit from him -- I thought they wanted me to have Dr. Earley say I reviewed Dr. Levounis, I don't disagree, let's move to the life expectancy piece. I'm happy to ask a new question, was he addicted to propofol.

Court. Right. Apparently the way you were trying to get him to do it won't work.

Ms. Cahan. Right.

Mr. Panish. So the question is: "do you have an opinion as to whether or not Mr. Jackson was addicted to propofol?"

Ms. Cahan. Yes.

Court. That way he won't be confused and volunteer something else.

Mr. Boyle. Right. I think his agreeing with the other guy's opinion, he apparently is relying on Dr. Levounis's opinion later.

Court. Right. And I see the opinions that are sort of coming down the pike.

Ms. Cahan. Goes to life expectancy, so doesn't go to this.

Court. I understand.

Ms. Cahan. Thank you, your honor.

(the following proceeding was heard in open court)

Court. Okay. You may continue.

Ms. Cahan. Thank you, your honor.

Ms. Cahan. Dr. Earley, did you reach a conclusion as to whether Mr. Jackson was addicted to propofol?

A. Yes.

Q. And what was your opinion?

A. There was insufficient evidence to indicate that he was addicted to propofol from in the medical records.

Q. Did you see evidence in the record that Mr. Jackson abused propofol?

A. I did.

Q. And why do you say that?

A. There was -- because he was given propofol initially for appropriate medical procedures, but at some point began seeking out physicians who would administer propofol to him in a methodical fashion, and because it was causing difficulties in his life as a result.

Q. Okay. And we'll come back to that. Did you form an opinion about whether or not Michael Jackson's addiction and drug use affected his life expectancy?

A. I did.

Q. And what is your opinion?

A. That it negatively affected his life expectancy.

Q. And what drugs do you believe Mr. Jackson -- strike that. Do you hold that opinion to a reasonable degree of medical certainty?

A. I do.

Q. And which drugs do you believe, to a reasonable degree of medical certainty, created serious risks that affected Mr. Jackson's life expectancy?

A. Three categories of drugs: propofol, the opiate categories of drug or opioid category of drugs, and the benzodiazepine category of drugs.

Q. Are you offering a number for Mr. Jackson's life expectancy?

A. I'm not.

Q. Are you an actuary?

A. No.

Q. So is it fair to say that you're not going to tell the jury that Mr. Jackson had a 75 percent chance of living a certain number of years, or anything like that quantifying his life expectancy?

A. No. Although I understand basic statistics, that is a very complicated thing. I don't know anything about that.

Q. And that's outside your expertise?

A. That's outside my expertise.

Q. Were you ever asked to come up with that kind of a number?

A. I was not.

Q. So what expertise do you have that's relevant to life expectancy?

A. I have expertise in that 30 years of experience in dealing with patients that have addiction problems and their outcomes, and following them over prolonged periods of time. I certainly have lots of experience in terms of the literature of substance abuse, and the types of things which portend for negative outcomes which would affect life expectancy. I have expertise in understanding the effects of propofol on the body, and the effects of not only acute but also prolonged affects of propofol on the body and how that might affect life expectancy. I have expertise in understanding what's called a synergy or the interaction between all of those drugs and how that can affect life expectancy. And then benzodiazepines as well. And it comes from 30 years of experience, reading and writing in the literature, training other clinicians about this, and really following patients for decades.

Q. As a clinician who treats patients, do you hear the term "prognosis"?

A. I do.

Q. And what is a prognosis? Do you use the term?

A. A prognosis is something that physicians are always called upon, whether you go in and have a -- whether you have a chest cold, or whether you have cancer. It means the outcome of what's going to happen next. It's predicting in the future what's going to happen next.

Q. So even though you're not offering a specific number, do you have an opinion, to a reasonable degree of medical certainty, about what Mr. Jackson's prognosis was in light of his drug use?

A. I do.

Q. And at the time of his passing, what was Mr. Jackson's prognosis?

A. Mr. Jackson's prognosis was grave in regards to his -- the consequences to his life expectancy resulting from his poly-substance dependence.

Q. And what does "grave prognosis" mean?

A. Grave prognosis is a term we use in medicine which means you talk about excellent, good, fair, poor and grave. And those -- it's a scale that one uses to determine and to really impart to your patients what's going to happen in the future. And in Mr. Jackson's case, all of the data points to the fact that his prognosis was grave.

Q. Did you put together some slides to use in your testimony here today?

A. I did.

Q. Okay. And do you have a slide about -- sort of summarizing your points about why Mr. Jackson's prognosis was grave?

A. I do. That's the first slide we have here.

Ms. Cahan. And I believe it will be -- it's slide 1 in the set. I believe it's exhibit 13,563. Put it up for counsel before the witness first, please. Any objection?

Mr. Boyle. No objection.

Mr. Panish. And just -- I'm sorry. Could you tell us the exhibit number again?

Ms. Cahan. 13,563.

Mr. Panish. Thank you.

Ms. Cahan. And can you just explain what you're saying in this slide?

A. Yes. There are four categories that I felt contributed to his grave prognosis. The first is the inappropriate use of propofol. That means the setting and the set, and the reason that the propofol was administered. The second one was consequences of his opioid addiction, and how that would affect his prognosis. The third item is what's called the synergy or interaction between the drugs. And synergy just means that the effect is not just additive, but there's interaction between the drugs in terms of outcome. And that synergy worsens the prognosis. And finally, extensive obstacles that, tragically, Mr. Jackson would have to have overcome even to get into a state of recovery or remission of his illness, and those obstacles, unfortunately, were large and daunting.

Q. So drug synergy, you said it's not just additive. People sometimes say "1 plus 1 equals 3 in terms of synergy"?

A. That's one way of putting it, yes.

Q. So the effect of c drug is just the affect of drug 1 and drug 2, it's something more than that?

A. Right. And that's why, when you go to the doctor, they ask you what drugs you're on. Because drugs have interactions. If drug a does this, drug b causes this, you put them together sometimes and get a third thing, which can be troublesome. And that's actually a big problem in medicine, especially today, because people are on so many drugs, and for good reason, if they're on lots of these drugs, but there's a negative effect when you put them together.

Q. Let's talk a little bit --

Ms. Cahan. Pam, you can put that down.

Ms. Cahan. Let's talk about propofol. What is propofol?

A. Propofol is an anesthetic agent. It was initially released as what's called an induction agent to put you to sleep but not to hold you to sleep. Initially, that was used to just put you to sleep so they wouldn't have to have a gas mask over their face and have it be scary. And after it was initially brought on the market, it was then used for short-term procedures, and pretty soon it was used more often for longer term anesthetic procedures, or for procedures where you wouldn't go completely unconscious. What is called a twilight sleep. If you have a particularly painful oral surgery, you're not completely asleep, you can give a lighter dose, and people would be in a twilight sleep state. So when it was initially introduced, it was just an induction agent. But it was found to be so effective and so well tolerated that its use kept on increasing, and anesthesiologists felt that it was a wonderful drug for anesthesia. And so it's now the most commonly popular -- most commonly used anesthetic agent worldwide.

Q. Does that mean that propofol is safe?

A. When used in the proper setting and set with the -- by the proper individuals, propofol is a safe drug.

Q. Did you review the testimony of nurse anesthetist, David Fournier, in this case?

A. I did.

Q. Did you see his testimony about the equipment required to safely administer propofol?

A. I did. And, actually, we have a slide on that one.

Ms. Cahan. Right. And Pam, I'd like you to put up, please, the slide Mr. Fournier used to talk about the safe way to use propofol, which was previously marked as exhibit 13,472.

Mr. Boyle. Object. This witness has never administered propofol before.

Court. Overruled.

Ms. Cahan. And is this consistent with your understanding of what's required to safely administer propofol?

A. It is. There's an extensive set of instruments and things, like the capnograph measures co2 levels. So it makes sure you're actually breathing properly and that sort of thing. So all of these things have become the standard when someone undergoes general propofol anesthesia.

Q. Is there a difference that's significant to you in the equipment that's required to safely administer propofol versus the other types of drugs we've been talking about in this case in terms of opioids and benzodiazepines?

A. Different. Opioids and benzodiazepine drugs, depending on the route of administration, essentially require almost nothing in comparison to this kind of encyclopedic reference of things to use.

Q. Do you have a slide of that as well?

A. I do. That's the next slide.

Ms. Cahan. That would be -- any objection to us putting it up? It's no. 3 of the set-up.

Mr. Boyle. No objection.

Ms. Cahan. Okay. And that will be exhibit 13,564.

Ms. Cahan. Is this your illustration of the differing amounts of equipment that are required?

A. It is. And on the left-hand side, you see this litany of things that are required for administration of propofol safely. And, obviously, at the top of the list is a trained anesthesiologist. And on the right, if you take an opioid pill, you need a glass of water. Or if you're taking an injectable form of an opioid, you need a syringe and an alcohol prep pad, and that is injected into the body, and then you're done. And as long as the dosing is correct, and as long as the physician knows exactly what medicines you're taking, that administration is safe.

Q. And are there other things in your experience, as an addiction medicine specialist who has taken care of some people with propofol dependency, that stands out as different about propofol abuse and abuse of opioids and benzodiazepines?

A. Yes. There are some notable changes in how the drug affects the body. It's -- and I think there's a slide on that. Yes, we have a slide on that in the next slide.

Q. What's the number on that one?

A. That's 4 or --

Ms. Cahan. Any objection to us putting up slide 4?

Mr. Boyle. Based on the court's prior rulings, no objection.

Ms. Cahan. 13,565 is the exhibit number.

A. so what you see in this slide, the first one we're going to explain in the next slide, because it's a pharmacological thing. But once you see it graphically, you'll understand it. How propofol works in the body is, there's very, very small changes in the dose to produce profound changes in the alertness of the individual, and it goes from being -- you go from anesthesia to stopping breathing with very small doses. We'll see that next. The next is the administration where the administration took place. If -- from Mr. Jackson's history, we know that he had propofol administered in Germany from Karen Rowe's testimony. That was done, actually, with a very complete, almost operating room amounts of equipment. But by the end, he was administered propofol in 2009 in an unsafe setting.

Ms. Cahan. So these are the risk factors that you see -- let me just stop you.

A. Yes.

Q. These are the risk factors you saw with the way Mr. Jackson was using propofol?

A. Yeah. I'm sorry. I wanted to get into the details.

Q. And just before we do that, are there things about the abuse of propofol that are sort of, generally speaking, qualitatively different than abuse of opioids and benzodiazepines? I know you said it's more rare. Are there other things about it that make it stand out?

A. Well, yeah. There are several things that stand out. The first is, it's generally not available. You can't go to a pharmacy with a prescription that says give me propofol. Retail pharmacies don't even carry it. In contrast, if you worked in an operating room, there are boxes of propofol sitting in the corner because it's a liquid, and you can't store it in small vials. If you go in the operating room, you'll see boxes stacked up in the utility room. So access is high in the operating theater but low in the general public. And those are the general issues that are involved in it. Access is a big issue.

Q. And since we have the lunch break coming up, let's pause on the predispositions you mentioned, so we can cover that so we make sure I understand it before the break. You said you had a slide on that. It's slide no. 5?

Ms. Cahan. Any objection?

Mr. Boyle. No objection.

A. I have it as slide 6. Slide 6.

Ms. Cahan. It's this slide.

A. that slide, right.

Mr. Boyle. What's the number?

Ms. Cahan. That will be exhibit no. 13,566.

Mr. Boyle. Okay.

Ms. Cahan. Can you just explain to us this steep dose-response process, please?

A. Yes, I sure can. If you look on the left, you can see what happens with benzodiazepine drugs, the valium/xanax types of drugs and with the opioid drugs, the oxycodone, those sorts of drugs. What happens along -- I guess I don't have a pointer, but along this bar you see that the effect changes in response to dose. And as you increase the dose, you go from having the effect that you want, to if you take too much of it, which is what we see in our culture today, people can actually take enough of the oral form of opioids to die, oxycodone, or something like that. But first you become unconscious, but you see how that curve is flat. Does that make sense?

Ms. Cahan. Your honor, may I approach to give him a laser pointer?

Court. Yes.

Ms. Cahan. And I will tell you, it will not work on that tv screen but will work on that big display screen.

A. OK. Hopefully I won't blind myself here. On the right-hand side, you'll see what happens in propofol. You notice how the curve here is steep. That means with small changes in dose, the effect on the patient changes dramatically. Now, that's -- that means that if you're in an operating room, and someone is being given propofol -- and this happens all the time. They undergo anesthesia, and as they undergo anesthesia, sometimes literally you'll stop breathing. And the anesthesiologist just reaches over and pushes the ambu bag a little bit, turns down the propofol just a notch, and you're fine. So the fact that one stops breathing on propofol is -- you know, it probably happens 20 times a day in the operating room when you're undergoing anesthesia, but because you have an anesthesiologist who is looking at all the instruments saying, "oh, look, he stopped breathing." they'll turn down the propofol, give a squeeze to the ambu bag, and you'll start breathing spontaneously very rapidly. No harm, no foul. No damage to the body. But that change, the small changes in the dose, have you move from unconsciousness -- which is, obviously, what you want to be when you're having surgery, right? The difference between unconsciousness and death is very narrow, a very narrow range. And if that wasn't enough, from time to time, people's responses to propofol will change based on how much sleep you had the night before, your nutrition, how much coffee you drank. So sometimes if you gave a dose x of propofol to a person, they would go completely unconscious, other times you would give that same dose to that same person on a different day, and either nothing would happen, or they would go completely unconscious and stop breathing. So not only is that dose response curve steep, but, also, people respond differently from time to time. That means the drug is -- has to be managed by someone who has a really clear idea about the effect of the drug, and to monitor that.

Ms. Cahan. And is that variability from person to person and time to time why there's no numbers listed under the dosage there?

A. Yeah. I mean, it's --

Q. This is just an illustration?

A. It's just an illustration. Exactly.

Q. Okay. But the idea is that there's -- a small change in the dosage of propofol can have a big effect, more so than opioids or benzodiazepines, is that fair?

A. Absolutely. And the reason it's flatter here is, as you increase the dose, you have to have wider doses of change that make you go from being awake and maybe have no pain to before you go unconscious. That sort of thing.

Ms. Cahan. I think this is probably a good place to stop, if that's OK with your honor.

Court. Okay. 1:30, back to the courtroom. Thank you. Have a good lunch.

(the jury exited the courtroom at 12:04 p.m.)

Court. Just remember not to have any discussions just until the jury is completely out of the room.

A. I'm sorry.

Court. That's OK. Most people don't know that, but the lawyers are quiet because you need to stay quiet.

A. OK.

Court. Okay. Thank you. See you at 1:30.