STATE OF MINNESOTA

DISTRICT COURT

COUNTY OF HENNEPIN FOURTH JUDICIAL CIRCUIT

- - - - - - - - - - - - - - - - - - - - - - - - -

LEIGH ANN ENGH, DARCENE and GREG LENSING, on behalf of the general public, themselves and all others similarly situated

Plaintiffs

v. Court File No. PI-04-012879

SMITHKLINE BEECHAM CORPORATION, d/b/a GLAXOSMITHKLINE, a Pennsylvania corporation

Defendant

- - - - - - - - - - - - - - - - - - - - - - - - -

(Captions continued on following pages.)

VOLUME 2, VIDEO DEPOSITION of MARTIN B. KELLER, M.D., a witness called by counsel for the Plaintiffs, taken under the provisions of the California Rules of Civil Procedure, before Jill K. Ruggieri, Registered Merit Reporter, Certified Realtime Reporter and Notary Public, at the offices of Robert S. Bruzzi, Esq., 18 Imperial Street, Providence, Rhode Island, taken on Thursday, September 7, 2006, commencing at 10:18 a.m.

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UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF PENNSYLVANIA

PAMELA BLAIN, individually and as personal representative of the Estate of TREVOR KYLE BLAIN, II, deceased, and on behalf of all those similarly situated; TONYA D. BROOKS, individually and on behalf of all of those similarly situated; RONALD BLAIN, individually; LEX BROOKS, individually; CHERYL BROOKS, individually

Plaintiffs

v. Case No. 06-1247 JD

SMITHKLINE BEECHAM CORPORATION d/b/a GLAXOSMITHKLINE, a Pennsylvania corporation

Defendant

THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF ORANGE

BEVERLY SMITH, on behalf of herself and all others similarly situated and on behalf of the general public

Plaintiff

v. Case No. 04 CC 00590

SMITHKLINE BEECHAM CORPORATION, d/b/a GLAXOSMITHKLINE, a Pennsylvania corporation, and DOES 1-100, inclusive

Defendants

APPEARANCES:

Baum Hedlund
George Murgatroyd, III, Esq.
Karen Barth Menzies, Esq.
12100 Wilshire Boulevard, Suite 950
Los Angeles, California 90025
(310) 207-3233 Fax: (310) 820-7444
on behalf of plaintiffs in Blain and Smith and Engh

Pendley, Baudin & Coffin, LLP
Christopher L. Coffin, Esq.
24110 Eden Street
Plaquemine, Louisiana 70764
(225) 687-6396 Fax: (225) 687-6398
on behalf of plaintiffs in Engh

King & Spalding
Todd P. Davis, Esq.
1180 Peachtree Street, N.E.
Atlanta, Georgia 30309-3521
(404) 572-3589 Fax: (404) 572-5137
on behalf of defendant

James M. Green, Deputy General Counsel
Brown University, Office of the General Counsel
110 South Main Street
Providence, Rhode Island 02912-1913
(401) 863-9977 Fax: (401) 863-1120
on behalf of the deponent

Also present: Tamar Halpern, Esq., Phillips Lytle

Videographer: Shawn Budd

P R O C E E D I N G S 10:05:04

THE VIDEOGRAPHER: We are back on the record. Today's date is September 7, 2006, and this is the continuation of the deposition of Dr. Martin B. Keller, and the time is approximately 10:18. 10:16:24 10:16:26 10:16:31 10:16:32 10:16:35

You may continue. 10:16:38

MR. DAVIS: Just a couple of housekeeping issues concerning the deposition exhibits that have presently been marked. 10:16:39 10:16:40 10:16:42 10:16:44

None of those have -- are subject to the protective order that's been entered into the cases, with the exception of Exhibit 24, which was marked, and we had a discussion about it at the end of yesterday's deposition. That is -- that document is subject to the protective order in the case. 10:16:45 10:16:49 10:16:52 10:16:54 10:16:59 10:17:01 10:17:04 10:17:05

In addition, we've had conversations with counsel for plaintiffs and counsel for Dr. Keller off the record, and the plaintiffs have informed the other participants that they will not complete 10:17:06 10:17:08 10:17:11 10:17:15 10:17:17

their questioning of Dr. Keller today, and so we have agreed to reconvene for a third day to finish the deposition.

And at that time, the plaintiffs will finish their questioning. GSK will be entitled to have time with Dr. Keller to ask him questions concerning the issues raised in the lawsuit and the issues raised by plaintiffs' counsel, and then we will finish on that -- on that third day.

MR. GREEN: And I think we agreed that we're going to conclude at 4:00 today; is that right?

MR. DAVIS: That's correct, yes.

MR. GREEN: Okay.

THE WITNESS: Actually, is 3:45 possible, just so I can get to a meeting?

MR. COFFIN: I don't have a problem with that, considering we've all agreed to an additional day. If counsel for GSK and your counsel --

MR. DAVIS: That's fine.

MR. GREEN: Do you want to put on the

record we signed the nondisclosure agreement 10:18:13
as well as Exhibit 24 and that's been given 10:18:15
to the notary and she's going to notarize 10:18:19
it and -- 10:18:21

MR. MURGATROYD: We're going to make 10:18:22
it Exhibit 25. 10:18:22

Do we actually have it handy? 10:18:25

MR. COFFIN: Yes, why don't we do 10:18:29
that. 10:18:29

MR. MURGATROYD: Let's make it 10:18:29
Exhibit 25. 10:18:29

Exhibit 24 will now be officially 10:18:30
part of the pile, but I'm going to reserve 10:18:32
my questions on it for when it's my turn 10:18:34
again. 10:18:37

MR. GREEN: Sure. 10:18:38

(Discussion off the record.) 10:18:38

(Exhibit No. 25 marked for 10:18:38
identification.) 10:18:38

MR. COFFIN: Okay. 10:18:46

So Exhibit 25 to Dr. Keller's 10:18:46
deposition will be the agreement by 10:18:49
Dr. Keller and his counsel to abide by the 10:18:51
protective order specifically in the Blain 10:18:55

case, but also applying to protective orders 10:18:59
in Engh and -- 10:19:04

MR. MURGATROYD: Smith. 10:19:07

MR. COFFIN: -- Smith. Thank you. 10:19:07

MR. MURGATROYD: Did we go through 10:19:11
the dedesignation of all the documents 10:19:12
except for 24? 10:19:14

MR. COFFIN: Yes, Todd just -- 10:19:16
Mr. Davis stated that on the record. 10:19:17

MR. MURGATROYD: Okay. Excellent. 10:19:19

MR. COFFIN: Todd, do you have 10:19:20
anything else before we get started? 10:19:21

10:19:22

MARTIN B. KELLER, M.D., a witness 10:19:22
having been previously duly sworn, on oath 10:19:22
deposes and says as follows: 10:19:22

10:19:22

EXAMINATION 10:19:22

BY MR. COFFIN: 10:19:23

Q Dr. Keller, my name is Chris Coffin. I 10:19:24
represent the plaintiffs in the case 10:19:26
entitled Engh, et al. versus 10:19:28
GlaxoSmithKline. It's in the state court in 10:19:30
Minnesota. 10:19:32

I have, obviously, a number of questions to ask you, and some of them I'm going to begin with are some follow-up questions to some that Mr. Murgatroyd asked you yesterday. 10:19:34 10:19:37 10:19:40 10:19:44 10:19:46

The first thing is, after the deposition concluded yesterday, you stepped out in the hallway and had some discussions with counsel for GlaxoSmithKline, correct? 10:19:46 10:19:48 10:19:51 10:19:53

Mr. Davis? 10:19:55

MR. DAVIS: Incorrect, but you can answer the question -- the witness can answer the question for himself. 10:19:57 10:19:58 10:20:00

A No. 10:20:01

Q You didn't speak to him after the deposition? 10:20:02 10:20:04

A Well, I just said goodbye, and I asked him where is he going to eat dinner. I don't remember -- I don't actually remember if we spoke. 10:20:05 10:20:07 10:20:12 10:20:12

Q You don't remember stepping out in the hall and talking to him? 10:20:13 10:20:15

A Actually, I didn't. 10:20:16

Q Okay. 10:20:17

A I didn't. I mean, I do remember and I didn't speak to him. 10:20:17 10:20:19
Q Okay. 10:20:20
Were you present when he was speaking -- did Mr. Davis speak to your counsel? 10:20:21 10:20:22 10:20:25
A I don't know. I went down -- I went downstairs, and these two gentlemen stayed upstairs. 10:20:25 10:20:27 10:20:30
I have no idea what they did. 10:20:31
Q Okay. 10:20:32
You testified yesterday that you've given a deposition in the past, correct? 10:20:33 10:20:35
A Yes. 10:20:39
Q Okay. 10:20:40
And how many times have you given a deposition, other than in this case or these cases? 10:20:40 10:20:41 10:20:43
MR. DAVIS: Object to the form. 10:20:50
A I think either -- either once or twice. 10:20:51
Q Okay. 10:20:54
And do you recall what the substance of the case was in which -- 10:20:54 10:20:57
A Yes. 10:20:58

Q -- you were giving a deposition? 10:20:59
Wait until I'm finished with my question. 10:21:01 10:21:04
A Oh, I'm sorry. 10:21:05
Q That's okay. It's a new day, so it takes some time. 10:21:05 10:21:07
A Yes. 10:21:07
(Laughter.) 10:21:07
Q Do you recall the substance of the case in with you provided a deposition? 10:21:08 10:21:10
A Yes. 10:21:11
Q And what was the substance of that case? 10:21:12
A Could we go off record? 10:21:15
Q Well, not when there's a question pending. That's the only -- 10:21:18 10:21:20
A I'm not -- it was something that was under a grand jury, and I don't know whether I'm allowed to say so. 10:21:22 10:21:28 10:21:31
It was a highly confidential matter. 10:21:33
Q Okay. 10:21:36
A I can say it had nothing to do -- I mean, it was a very -- had to do -- 10:21:37 10:21:40
I was -- how to put this. I was -- I was represented -- I was -- I was an expert 10:21:42 10:21:47

witness for the United States of America, 10:21:50
who was the plaintiff in a very high-profile 10:21:53
lawsuit having to do with -- with nothing 10:21:58
basically related to what we're doing here. 10:22:02
Q Okay. 10:22:04
A Twice I was the plaintiff for the United 10:22:05
States of America, and they seem to have me 10:22:06
shredding everything as soon as I read it, 10:22:10
so I don't know whether I -- 10:22:12
Q That's fine. 10:22:13
A I mean, you tell me. I don't know whether 10:22:14
I'm allowed to say. 10:22:15
Q No, we don't need to get into that. 10:22:17
Can you tell me -- first of all, you 10:22:19
weren't a party in either of those cases? 10:22:21
A No. 10:22:23
Q Okay. 10:22:23
And was -- was the -- what was your 10:22:26
testimony as -- what were you qualified -- 10:22:29
Were you qualified as an expert in 10:22:31
that case? Let me ask that first. 10:22:33
A Yes. 10:22:35
Q Okay. 10:22:35
And what was the area you were 10:22:36

qualified as an expert in? 10:22:37
A Had to do with a liability of a company 10:22:41
based on a -- what's the word -- based on 10:22:58
the performance of a wholly owned subsidiary 10:23:06
medical company that they had which would -- 10:23:09
which performed medical and psychiatric 10:23:11
examination of one of their employees. 10:23:16
And my expertise had to do with the 10:23:22
quality of the performance of their wholly 10:23:25
owned subsidiary and the conclusion they 10:23:29
made as to the mental state of the employee 10:23:32
and the implications of that for an action 10:23:36
which led to great distress for the United 10:23:40
States of America. 10:23:45
Q Okay. 10:23:46
You -- have you ever been qualified 10:23:46
as an expert in any other cases other than 10:23:49
those that we don't need to talk about that 10:23:51
you mentioned? 10:23:54
A No. 10:23:55
Q Okay. 10:23:56
You've never been qualified as an 10:23:58
expert in child psychiatry, correct? 10:23:59
A Never been qualified -- correct. 10:24:03

Q Do you hold yourself out to be an expert in child psychiatry? 10:24:08 10:24:10

A I'm an expert in the design and implementation of certain types of clinical research related to child and adolescent psychiatry; and based on the fact that I've been a coprincipal investigator and principal investigator on at least, you know, on many -- on at least four or five National Institutes of Health funded research grants since 1980s, so I assume I'm an expert, because it's hard to get grants funded, and they funded them and I did the work. 10:24:17 10:24:24 10:24:30 10:24:35 10:24:39 10:24:42 10:24:45 10:24:51 10:24:54 10:24:59 10:25:02 10:25:04

Q Okay. 10:25:04

Let me go back to the question, and I'll state it a little differently, more specific. 10:25:05 10:25:06 10:25:09

Do you hold yourself out to be an expert in the treatment of children and adolescents in the field of psychiatry? 10:25:09 10:25:10 10:25:13

MR. DAVIS: Objection. 10:25:15

Asked and answered. 10:25:16

A I know an enormous amount about the 10:25:23

treatment of children and adolescents with 10:25:34
mood disorders based on the literature and 10:25:37
performing and designing trials, not based 10:25:47
on my own personal treatment in a clinical 10:25:51
setting of these individuals. 10:25:57

Q Right. 10:25:59

And I think yesterday you testified 10:25:59
you hadn't actually treated a child or 10:26:01
adolescent in at least 20 years, correct? 10:26:04

A Correct. 10:26:08

Q Okay. 10:26:08

So any of your knowledge or 10:26:09
information you have about treatment with 10:26:13
children at least within the last 20 years 10:26:16
has to do with research and/or literature, 10:26:19
correct? 10:26:22

A No. 10:26:24

Q Okay. 10:26:25

Let me say it this way:  Any of your 10:26:26
knowledge regarding treatment of children 10:26:29
and adolescents in the field of psychiatry 10:26:33
at least within the last 20 years is not 10:26:36
gained by your personal treatment of 10:26:39
children or adolescents, correct? 10:26:42

A The -- not in -- that's not entirely correct. 10:26:45 10:26:49

Q All right. 10:26:51

A I also have -- sit in on a periodic basis on case conferences that involve our trainees, residents, psychologists, in which cases are presented and discussed; and I'll often be one of the discussants so that the -- the patient being discussed for supervision by senior people, which would include myself, would be that of a child or an adolescent. 10:26:52 10:27:00 10:27:05 10:27:10 10:27:14 10:27:17 10:27:22 10:27:24

And my expertise is brought in based on the knowledge that I have both from the treatment of adults and also from research, because there is considered to be some carryover. So I do hear the presentation of clinical cases in that type of venue. 10:27:28 10:27:31 10:27:33 10:27:37 10:27:39 10:27:42

Q Okay. 10:27:46

Do you recall anymore clearly when the last time you treated a child or adolescent in psychiatry was, other than the broader answer you've given sometime after the last or prior to the last 20 years? 10:27:50 10:27:55 10:27:57 10:28:01 10:28:06

A Could you please repeat the question? 10:28:12

Q Yes, I'm sorry. That was a difficult question. 10:28:14 10:28:15

The question is, can you say any more specifically when the last time you treated a child or adolescent for a psychiatric issue was? 10:28:16 10:28:19 10:28:21 10:28:24

A When you say treated, if you could just clarify what you mean by treated? 10:28:27 10:28:29

Q Sure. 10:28:31

Evaluated and prescribed some kind of treatment, either psychotherapy and/or pharmacotherapy. 10:28:32 10:28:38 10:28:42

A Okay. 10:28:45

So -- and the question is very -- could you -- 10:28:46 10:28:48

Do you mind just repeating the question? 10:28:50 10:28:52

Q Sure. 10:28:52

The question is, do you recall any more specifically how many years ago it was since you've treated a child or adolescent in the field of psychiatry? 10:28:53 10:28:54 10:28:58 10:29:01

A No. 10:29:02

Q Okay. 10:29:04

So your best answer is sometime over 20 years ago? 10:29:04 10:29:06
A Yes. 10:29:07
Q Okay. All right. 10:29:08
Yesterday there was some -- excuse me. There was some questions about the advisory board meetings that you had with regard to Study 329; do you recall that? 10:29:12 10:29:13 10:29:15 10:29:17
A Yes. 10:29:20
Q Do you recall those questions? 10:29:20
A In generality. 10:29:25
Q Good. That's all I'm looking for. 10:29:27
You attended multiple advisory board meetings that addressed the Study 329, correct? 10:29:30 10:29:33 10:29:37
A No. 10:29:37
Q You did not? 10:29:38
A No. 10:29:38
Q Okay. 10:29:39
Were you involved in a group of investigators that met to discuss the results of -- or, excuse me, the methodology of Study 329? 10:29:41 10:29:44 10:29:46 10:29:50
A Please repeat that. 10:29:56

Q Were you involved in meetings that discussed the design, implementation, methodology of Study 329? 10:29:58 10:30:01 10:30:07

A Yes, but -- 10:30:08

Q And what did you -- 10:30:09

A But just to make sure that your question isn't linked to your previous one, these were not advisory board meetings. These meetings were not sponsored by a third party. 10:30:10 10:30:11 10:30:14 10:30:17 10:30:19

These meetings were meetings that were organized by myself and my peers and colleagues. 10:30:19 10:30:21 10:30:28

Q Okay. 10:30:29

Were those the -- the meetings that you're discussing right now that you said you and your peers and colleagues had, did they include Jim McCafferty from GlaxoSmithKline? 10:30:29 10:30:32 10:30:33 10:30:36 10:30:40

A I don't recall whether he was ever present at any of these meetings. If he was present at any of the meetings, it might have been a meeting or two very long after, you know, well -- well more than a year after we 10:30:41 10:30:44 10:30:49 10:30:50 10:30:59

started meeting and discussing and after we basically had a protocol set and written. 10:31:02 10:31:05

I'm not saying that happened. I'm saying it's possible that it happened; but if it did happen, it happened long after the study was discussed and designed and we had written our own internal -- our own protocol. 10:31:07 10:31:09 10:31:12 10:31:16 10:31:20 10:31:22

Q Okay. 10:31:25

Are those meetings that you just described the same meetings you were talking about where you were presented with prescription numbers or sales figures regarding Paxil? 10:31:25 10:31:28 10:31:30 10:31:34 10:31:36

A No. 10:31:38

Q Okay. 10:31:39

What are those meetings? 10:31:40

A Which meetings? 10:31:44

Q Okay. 10:31:44

Yesterday you testified that at some meetings, I don't know the title of them -- advisory board, investigator meetings -- there were some meetings in which you were provided information from a representative 10:31:47 10:31:49 10:31:50 10:31:52 10:31:57

of GlaxoSmithKline regarding sales figures 10:32:01
for Paxil; is that correct? 10:32:04
MR. DAVIS: Object to the form. 10:32:07
Mischaracterizes the testimony. It's 10:32:08
been asked and answered. 10:32:10
A Could you just say that more succinctly, 10:32:13
please? 10:32:16
Q Have you ever been to a meeting -- have you 10:32:18
ever been to any meeting in your whole 10:32:19
entire life where the results or the sales 10:32:21
figures from Paxil sales were presented to 10:32:26
you? 10:32:30
A I don't recall if I was. 10:32:32
Q Okay. 10:32:36
At the investigator meetings that you 10:32:46
testified about -- 10:32:49
Are we clear on what investigator 10:32:50
meetings are? 10:32:52
A No. 10:32:53
Q Okay. 10:32:53
You got together with groups of 10:32:54
investigators to talk about 329, correct? 10:32:56
A To be precise, the answer is no. 10:33:04
Q Okay. 10:33:05

Did you ever meet -- did you ever meet with Neal Ryan to discuss 329? 10:33:06 10:33:07

A The answer's no. 10:33:14

Q It's going to be a long day, Doc. 10:33:18

A Well, but you need to sharpen your questions; and if you want me to tell you why, it's because I -- I did meet with Neal Ryan and I did meet with other peers, but when we met, we didn't have -- we didn't have anything called Study 329. 10:33:20 10:33:22 10:33:24 10:33:28 10:33:30 10:33:35

We met to talk, as I explained yesterday in detail, about the fact that we thought it would be important to develop a research program to study the efficacy of treating adolescents with antidepressants. 10:33:37 10:33:40 10:33:45 10:33:47 10:33:50

So what I'm trying to do in answering you precisely is to disentangle the evolution and the development of this from something which has become -- became codified at some point in time far after I was -- you know, I have no idea when it became codified as a 329. 10:33:55 10:33:57 10:34:01 10:34:04 10:34:07 10:34:11 10:34:13

The implication -- the linkage there being the 329 was a number given by 10:34:16 10:34:19

SmithKlein Beecham to a study, you know, 10:34:25
that had been evolved. 10:34:29
I'm trying to disentangle it to make 10:34:31
it clear. 10:34:35
Q Okay. 10:34:36
A I'm not trying to be difficult. 10:34:36
Q Well, let's clarify this, because a lot of 10:34:37
my questions I'll ask you about Study 329. 10:34:39
Do you know what I'm referring to 10:34:42
when I say Study 329? 10:34:43
A Yes. 10:34:45
Q Okay. 10:34:45
And in your mind, is Study 329 the 10:34:46
same as the study that you met with 10:34:50
investigators about regarding the use of 10:34:53
paroxetine, Paxil, in children and 10:34:56
adolescents? 10:34:59
MR. DAVIS: Object to the form. 10:35:02
A At -- for a very substantial duration of 10:35:05
time of at least a year, colleagues and I 10:35:17
met to discuss research on the treatment of 10:35:20
depression in children and adolescents. 10:35:25
That resulted in us writing a 10:35:29
protocol, a copy of which I believe is one 10:35:30

of the exhibits. 10:35:32
Q Yes. 10:35:35
A And that protocol didn't have any SmithKline, you know, letters or numbers or anything on it. Okay. 10:35:36 10:35:37 10:35:41
At some point after the group made a decision to develop -- to have a working relationship with SmithKline with regard to the funding and conduct of this grant, it then shifted, in my mind, to, you know -- 10:35:43 10:35:47 10:35:53 10:35:55 10:35:58
I see a -- I sort of -- I see a shift in that process, and then there was -- then it's what I would call 329. 10:36:03 10:36:06 10:36:09
So if you want to -- just for clarity of thought, I just -- I would just make that distinction. 10:36:13 10:36:18 10:36:19
Q That's understandable. 10:36:20
A However you want to put that. 10:36:21
Q I hear your distinction. 10:36:23
What I'm asking is, for the purposes of my questioning today, can we agree that when I refer to 329 and I refer to meetings involving 329, that I'm referring to any time that you met with investigators and/or 10:36:26 10:36:28 10:36:30 10:36:33 10:36:37

individuals from GSK to discuss the study that resulted in the publication of your article on the use of paroxetine in children? 10:36:42 10:36:46 10:36:50 10:36:52
A Okay. 10:36:54
Q I'm just trying to use -- 10:36:55
A Okay. 10:36:57
Q That's exactly what you did yesterday. I'm not trying to -- all I'm asking is for some clarity. It's unbelievable. 10:36:57 10:36:59 10:37:01
All I want to do is make sure that you and I understand what 329 is when I ask you did you meet with Neal Ryan to discuss 329. 10:37:03 10:37:04 10:37:08 10:37:11
Do you understand what I'm asking you there? 10:37:13 10:37:14
A Yes. I'm just trying to make a -- draw a firewall and a distinction between when it was colleagues brainstorming the broadest range of ideas until something formed into an idea. 10:37:16 10:37:19 10:37:22 10:37:26 10:37:29
And the reason that's important is because at various points along the way, we had all sorts of other study designs. 10:37:30 10:37:32 10:37:35

So, you know, if you -- if you had a tape recorder at those meetings, Chris, all the meetings we talked about, some of the designs we were going to do looked radically different. Didn't look anything like what is now 329. 10:37:39 10:37:43 10:37:45 10:37:49 10:37:52 10:37:54

So I just want you to appreciate and understand that. It wasn't as though -- it wasn't as though we had this design that you call 329 and that's what we were talking about. 10:37:56 10:37:58 10:38:04 10:38:06 10:38:08

Eventually something evolved into that. There were many other ideas on the table. 10:38:09 10:38:10 10:38:12

Is that clear? 10:38:15

Q I understand your distinction. 10:38:20

A So it would be fair -- what I'm saying, it would be fair to say that we didn't necessarily -- when we -- when we had for many -- for quite a number of the meetings that we had, we weren't necessarily discussing anything which looked at all like the design of 329. That's all. 10:38:23 10:38:25 10:38:26 10:38:28 10:38:30 10:38:34 10:38:37

Q Okay. 10:38:38

Which exhibit is the initial protocol that you submitted for -- let me ask you this: 10:38:39 10:38:44 10:38:47

You submitted a protocol or a plan for a study to GSK, correct? 10:38:48 10:38:51

A Yes. 10:38:56

Q Okay. 10:38:57

And we admitted that as an exhibit in your deposition yesterday, correct? 10:38:57 10:39:00

A Yes. 10:39:02

Q We marked it, I should say, as an exhibit. 10:39:02

And I believe it's Exhibit 10. Here it is. Okay. Take a look at Exhibit 10. 10:39:05 10:39:25

Do you recognize that document? 10:39:27

(Witness read document.) 10:39:31

A I recognize it, yes. 10:39:42

Q Okay. 10:39:44

And was that document prepared after you met with multiple of your peers about a study to submit to GSK? 10:39:46 10:39:51 10:39:59

A Yes. 10:40:10

Q Okay. 10:40:11

And eventually that study was named 329 by GSK, correct? 10:40:11 10:40:15

A Yes. 10:40:17

Q Okay. 10:40:18

And you had meetings with 10:40:20
investigators, your peers, to discuss this 10:40:21
study that's described in Exhibit 10? 10:40:27

You had meetings with your peers, 10:40:33
investigators, about that, correct? 10:40:35

A Yes. 10:40:37

Q Okay. 10:40:37

And you had meetings with your peers 10:40:38
and investigators and with representatives 10:40:40
from GlaxoSmithKline after you submitted 10:40:41
that to GlaxoSmithKline, correct? 10:40:45

A I don't -- I don't recall if we had meetings 10:40:53
with peers and representatives of SmithKline 10:41:00
prior to the meeting that was -- that took 10:41:14
place after the study was finished, after -- 10:41:18
after 329 was completed, so... 10:41:23

Q You don't recall meeting with Jim McCafferty 10:41:27
and the other investigators on the study at 10:41:30
any time between the time you submitted 10:41:35
Exhibit 10 to GSK and the time that the -- 10:41:37
that the results were revealed? 10:41:40

Is that what you're saying? 10:41:41

A I recall meeting with the other 10:41:44
investigators. I do not recall whether Jim 10:41:46
McCafferty attended any meetings with myself 10:41:50
and the investigators to discuss 329 prior 10:41:56
to the meeting that was held after 329 was 10:42:01
completed that was discussed yesterday and 10:42:07
memorialized in one of the exhibits that's 10:42:10
marked and could probably be found on this 10:42:13
table. 10:42:18
Q What about telephone conferences, do you 10:42:20
recall having telephone conferences that 10:42:23
addressed the issues in the child and 10:42:25
adolescent study that -- that we're 10:42:30
referring to in this case? 10:42:33
MR. DAVIS: Just for reference, the 10:42:35
adolescent study didn't involve any 10:42:37
children, but -- so I object to the form. 10:42:38
A I would make that correction. There was no 10:42:41
children -- no children involved, only 10:42:44
adolescents. 10:42:45
But the answer is -- so the answer is 10:42:46
no to the question you asked. 10:42:49
Q Okay. 10:42:52
A If -- 10:42:53

Q Can you and I agree that when we talk about the --
The study that you published an article on, that was -- ultimately was 329 at one point, correct? 10:42:54 10:42:56 10:42:59 10:43:01 10:43:07
A Yes. 10:43:08
Q Can we agree to when I ask you about conversations regarding Study 329 that we're talking about the meetings including prior to your submission of the protocol to GSK, meetings that occurred -- strike that. 10:43:09 10:43:12 10:43:14 10:43:17 10:43:23
In your meetings regarding Study 329, do you recall -- and whether it was before you submitted Exhibit 10 or after, do you recall discussing the use of SSRIs for treatment of psychiatric illness in children and adolescents with your -- with your coinvestigators? 10:43:30 10:43:34 10:43:37 10:43:41 10:43:47 10:43:49 10:43:51
MR. DAVIS: Object to the form. 10:43:54
A In the spirit of moving this along and being helpful, I think it -- it's important that don't include children, that you just say adolescents, because no children were included in the design and the 10:44:01 10:44:04 10:44:07 10:44:10 10:44:14

implementation of this study and for a lot 10:44:16
of reasons. There are differences between 10:44:21
children and adolescents. 10:44:23
So if you would restate it and 10:44:25
restrict it to adolescents, then it would be 10:44:26
easier for me to answer. 10:44:30
Q Okay. Well, let's just clear that up. 10:44:31
What was the age group of the 10:44:33
individuals included in the study? 10:44:34
A I think it was 13. I'm not exactly sure 10:44:38
whether we did -- how we staged it, but I 10:44:43
believe 13. 10:44:45
Q How do you define the difference between a 10:44:46
child and an adolescent? 10:44:48
A It's -- it's a distinction that is not 10:44:50
codified and universally accepted, you know, 10:44:55
with criteria that everybody would agree to. 10:44:58
As a convention, it's typically 10:45:03
approached in one of two ways: One is to 10:45:04
just pick an age, typically 13, and the 10:45:07
other is to do pubertal staging. And 10:45:10
it's -- if you -- 10:45:15
So I find either acceptable, either 10:45:21
picking an age, such as 13, to make that 10:45:29

distinction, or to do pubertal staging. 10:45:33

Q At the time that you met with your colleagues who helped you prepare Exhibit 10, were you personally aware at that time that SSRIs were being prescribed to children and adolescents? 10:45:42 10:45:46 10:45:49 10:45:52 10:45:55

A I was aware that SSRIs were being prescribed to adolescents. I don't recall whether I had awareness that they were being prescribed for children, since the focus of what we were dealing with had to do with adolescents. 10:46:07 10:46:11 10:46:15 10:46:18 10:46:21 10:46:23

Q Okay. 10:46:25

And in that response you just gave, how do you define children and how do you define adolescents? 10:46:25 10:46:27 10:46:29

A One of two ways: Either by using an age cutoff of 13, if you -- if you're younger than 13, you would be a child. If you're older -- 13 or above, you would be an adolescent. Or you can do pubertal staging to see what stage of puberty you're in. 10:46:34 10:46:38 10:46:42 10:46:45 10:46:47 10:46:51

Q No, that's not -- what I'm asking you is you just gave me a response, and your terms were 10:46:54 10:46:56

that you -- 10:46:58

You said you were aware that SSRIs 10:46:59
were being prescribed to adolescents, but 10:47:01
you don't recall whether you were aware that 10:47:04
they were being prescribed to children. 10:47:07

Is that correct? 10:47:09

A Yes. 10:47:12

Q Okay. 10:47:12

My question is, in your response, how 10:47:13
do you distinguish between children and 10:47:16
adolescents? 10:47:18

A I thought -- I thought I answered it 10:47:23
perfectly fine. I said one of two ways. 10:47:24

Q All right. Let me ask you this: 10:47:27

When -- when you were preparing 10:47:29
Exhibit 10 with your colleagues, were you 10:47:31
aware that SSRIs were being prescribed to 10:47:35
individuals the age of 13 and older? 10:47:41

A Yes. 10:47:45

Q Were you aware at the time that you prepared 10:47:46
Exhibit 10 that you submitted to GSK that 10:47:49
SSRIs were being prescribed to individuals 10:47:54
12 and younger? 10:47:58

A I don't recall. 10:48:01

Q Okay. 10:48:04
A I do have a -- a clarification here. 10:48:04
When we talk about the preparation of 10:48:06
Exhibit 10, what I just noticed was that at 10:48:08
the bottom of Exhibit 10, there's all sorts 10:48:13
of -- there's this whole thing about 10:48:17
confidential, subject to protective order, 10:48:20
produced by GSK, so on and so forth. 10:48:24
We didn't -- I didn't prepare 10:48:27
anything that had that on it. 10:48:28
Q Right. 10:48:29
That's -- that's something that 10:48:30
GlaxoSmithKline stamps for the 10:48:31
confidentiality of the documents in this 10:48:34
case. 10:48:36
A Okay. I'm just trying to be precise. 10:48:36
Q I got you. I -- I appreciate that. 10:48:38
Going back to my questions about your 10:48:41
awareness of prescriptions to children and 10:48:43
adolescents, were you aware that at the time 10:48:48
you -- you prepared this with your 10:48:55
colleagues, were you aware that adolescents 10:48:57
were being prescribed Paxil for the 10:48:59
treatment of depression? 10:49:03

A I don't recall, because -- I'm going to answer it. I'm not just going to say I don't recall and then waste your time by having to fumble in giving an answer. 10:49:13 10:49:19 10:49:21 10:49:23

The reason I don't recall is because when I look at 1992 here and we started meeting earlier than that, this may have preceded when Paxil was approved by the FDA as an antidepressant. 10:49:27 10:49:29 10:49:33 10:49:35 10:49:39

So I don't -- and I -- I have some -- I have a vague memory that in the discussions we had about whether or not -- about which medications to use in the study, there was an issue of which medications were approved, at what time and not at what time. 10:49:41 10:49:45 10:49:48 10:49:50 10:49:55 10:49:57

So it's im -- it's possible that the FDA -- I just don't -- I don't remember that, when that date occurred. 10:50:01 10:50:06 10:50:08

Q Okay. 10:50:10

A So if, in fact, you know, whatever -- whatever discussions took place regarding this, if that preceded the FDA's approving the use of paroxetine as a treatment for depression in adults, if it preceded that, 10:50:10 10:50:14 10:50:17 10:50:20 10:50:24

then I would have no reason to think that the drug was being prescribed for adolescents or children or adults, for that matter, other than for investigational purposes. 10:50:28 10:50:32 10:50:36 10:50:39 10:50:41

Q Okay. 10:50:42

In light of your answer there, at what point do you recall gaining an awareness that Paxil was being prescribed to children and adolescents? 10:50:45 10:50:47 10:50:55 10:50:59

A I don't remember. 10:51:00

Q Well, certainly you're aware of that today, correct? 10:51:02 10:51:03

A Yes. 10:51:06

Q Okay. 10:51:07

And do you know whether you knew it prior to GSK accepting for submission Exhibit 10? 10:51:07 10:51:14 10:51:21

A I don't remember. 10:51:22

Q Okay. 10:51:26

A Because the -- the distinction -- at some point it occurred. It just -- it just looks to me -- 10:51:26 10:51:29 10:51:32

1992 looks to me in a very vague 10:51:34

memory somewhere around the time that 10:51:37
paroxetine was approved; but I also have a 10:51:42
memory that it may have been approved after. 10:51:46
I just simply don't remember. 10:51:49
Q Right. 10:51:51
A It's in that ballpark. 10:51:51
Q Right. 10:51:53
A And so if it had been approved in 1988, I 10:51:54
would remember. If it was -- wasn't 10:51:57
approved until 2000, I would remember. This 10:51:58
was -- 10:52:01
Q I'll represent it was approved at the very 10:52:01
end of 1992, end of December 1992. 10:52:03
All right? 10:52:06
A After this. 10:52:07
Q That's correct. 10:52:08
So -- but I'm -- and that's fine. 10:52:09
I'm trying to get clear -- 10:52:11
So after Paxil was approved by the 10:52:14
Food and Drug Administration for use in 10:52:19
adults, did you then become aware that it 10:52:20
was also being used for treatment of 10:52:26
depression in children and adolescents? 10:52:30
A At some time, yes, is the answer. 10:52:34

Q Okay.

And do you know when that was in relation to its approval in -- at the end of 1992?

A When it was that I became aware?

Q Correct.

A No.

Q Okay.

Do you recall discussing the -- the issue of Paxil being used in the treatment of adolescent depression with the other investigators that you were working on Exhibit 10 with, either prior to or after submission to GSK?

A Could you --

Q Sure.

A -- clarify?

Q Do you ever -- do you ever -- do you ever recall discussing with the other investigators the trends in prescriptions of Paxil to children and adolescents?

A No.

Q Okay.

What's your understanding of -- let

me ask you this: 10:53:55
What's your understanding of the 10:53:56
current state of prescriptions that are 10:54:01
provided to child -- children and 10:54:05
adolescents for the treatment of -- excuse 10:54:07
me. 10:54:11
What's your current understanding of 10:54:12
the prescriptions for Paxil that are 10:54:14
provided to children and adolescents for the 10:54:15
treatment of depression? 10:54:19
A I don't understand your question. 10:54:24
Q Do you know today that -- you said you have 10:54:27
a -- you at some time gained knowledge that 10:54:29
Paxil was being prescribed to children and 10:54:32
adolescents, correct? 10:54:34
A Correct. 10:54:36
Q Okay. 10:54:36
And you don't know when that was? 10:54:36
A Correct. 10:54:38
Q Was it more than ten years ago that you 10:54:38
gained that knowledge? 10:54:40
A I can't recall specifically. I think it's 10:55:00
likely that it was. 10:55:02
Q Okay. 10:55:03

Your -- your article that -- that appeared in the Journal of the American Academy of Child and Adolescent Psychiatry was published in July of 2001, correct? 10:55:04 10:55:07 10:55:11 10:55:14

Do you want to see the exhibit? 10:55:20

A Yes. 10:55:25

Q Okay. 10:55:26

Prior to the publication of this article that's marked as which exhibit? 10:55:26 10:55:28

MR. GREEN: 13. 10:55:33

A 13. 10:55:33

Q That's marked as Exhibit 13, did you have knowledge that Paxil was being prescribed for the treatment of depression in children and adolescents? 10:55:34 10:55:36 10:55:39 10:55:40

A I can't recall specifically now. I assume so, but I just can't recall. 10:55:46 10:55:50

Q And you can't recall any discussions about whether or not Paxil was being prescribed to children and adolescents for the treatment of depression prior to the publication of this article; is that correct? 10:55:53 10:55:58 10:56:02 10:56:04 10:56:06

A I don't recall, which doesn't mean I didn't have a conversation, doesn't mean I did. 10:56:09 10:56:11

It means I don't remember such conversations. 10:56:14 10:56:18
Q Okay. 10:56:29
Yesterday Mr. Murgatroyd asked you about the analysis of the data that was obtained from Study 329; do you recall that? 10:56:44 10:56:47 10:56:52
A Yes. 10:56:55
Q Do you know what I'm referring to when I say "the data obtained from Study 329"? 10:56:56 10:56:57
A Yes. 10:57:01
Q Okay. 10:57:01
And you -- you testified that the variables -- that you believe that the variables used in Study 329 to analyze the data were decided prior to the breaking of the blind, correct? 10:57:05 10:57:09 10:57:12 10:57:21 10:57:24
A Yes. 10:57:25
Q Okay. 10:57:26
Do you know when the data was analyzed? 10:57:27 10:57:28
A Actually, if I could -- can I -- 10:57:29
Q Sure. 10:57:31
A -- qualify that statement? 10:57:31
Q Sure. 10:57:34

A Any variable which was stated to be an a 10:57:41
priori variable in any writeups that we had, 10:57:44
any such designation, meant that the 10:57:49
variables were identified prior to doing 10:57:51
the -- the breaking of the blind. 10:57:54
It's possible, though I can't tell 10:57:59
you whether, in fact, happened -- or if it 10:58:02
happened which variables, it's possible that 10:58:05
certain variables which were not part of the 10:58:07
data analytic plan and not subsequently 10:58:09
labeled as, you know, a priori, were -- 10:58:14
someone decided to analyze these after the 10:58:19
blind -- 10:58:22
Q Okay. 10:58:22
A -- was broken. 10:58:23
These things happen in what's called 10:58:24
exploratory analyses in all sorts of 10:58:26
research. 10:58:29
Q Okay. 10:58:29
Do you recall any specific variables 10:58:30
that you or any of the other investigators 10:58:33
decided on after the data had been initially 10:58:38
obtained and the blind was broken? 10:58:42
A No. It -- no, to that question. 10:58:43

Q Okay. 10:58:47
How about the CGI of 1 or 2, do you 10:58:49
remember if that was decided before or after 10:58:53
the blind was broken? 10:58:57
MR. DAVIS: Objection. 10:59:00
Asked and answered. 10:59:00
A That was decided before the blind was 10:59:01
broken. 10:59:03
Q Okay. 10:59:03
And how about the K-SADS nine-item 10:59:03
depression scale, do you know whether that 10:59:07
was determined prior to or after the blind 10:59:09
was broken? 10:59:12
MR. DAVIS: Objection. 10:59:13
Asked and answered. 10:59:15
A Yes. 10:59:15
Q And when was it? 10:59:16
A Before the blind was broken. 10:59:17
Q And you don't recall any that were decided 10:59:20
after the blind was broken? 10:59:22
A No. 10:59:23
What I do know, though I cannot be 10:59:24
specific, is that at some point in the past 10:59:26
several years when the FDA asked for -- set 10:59:29

up a process whereby there was a reanalysis of data from most, if not all, pediatric studies, you know, a reanalyses occurred. 10:59:38 10:59:41 10:59:44

I was not part of that process per se, but I have some general awareness that analyses were done with all the datasets. 10:59:49 10:59:50 10:59:56

I'm assuming that also occurred with 329, but I don't know the specifics. 11:00:00 11:00:03

Q Do you know when the initial analyses of the data obtained from Study 329 was conducted? 11:00:06 11:00:12

A No. 11:00:16

Q Were you involved in the initial analyses of the data from Study 329? 11:00:18 11:00:21

A I don't know what you mean by involved in the analyses of the data. 11:00:25 11:00:26

Q Did you ever review the data that was obtained from Study 329 at all? 11:00:32 11:00:34

A Yes. 11:00:40

Q Okay. 11:00:40

And at what point did you first review that information? 11:00:41 11:00:42

A I don't remember. But I was also -- 11:00:44

Q And what -- 11:00:46

A I was also involved in thinking and 11:00:48

discussing what the data analytic plan would be and the process -- and, you know, how the data would be analyzed. 11:00:51 11:00:54 11:00:58

And there's a distinction between that and my actually analyzing the data. The data analyst would do that, you know, programmer, someone like that. 11:01:01 11:01:03 11:01:07 11:01:11

So -- so that you understand the distinction, it's one thing to conceptualize what analyses one will do. It's another thing to actually write the program and the code that you would have for a computer to actually perform the analysis. 11:01:15 11:01:16 11:01:19 11:01:22 11:01:27 11:01:29

I'm not a code writer. I'm a conceptualizer. 11:01:31 11:01:34

Q Did you contribute to decisions about which variables would be used to test the data and -- that was obtained from Study 329? 11:01:37 11:01:40 11:01:46

A Yes. 11:01:49

Q Okay. 11:01:50

You're aware that Mr. Jim McCafferty was deposed in -- in these cases? 11:01:52 11:01:54

A It may have been mentioned yesterday. His name was mentioned yesterday in relation to 11:02:09 11:02:11

a deposition. 11:02:13
Q Okay. 11:02:14
Well -- 11:02:14
A Which is the first time I knew that. 11:02:15
Q Okay. 11:02:18
He was deposed in these cases. And in Mr. McCafferty's deposition, one of the things he mentioned multiple times was that there were multiple discussions amongst himself and the investigators, including you, with regard to which endpoints to use, which variables to use for the analysis of the data obtained in 329. 11:02:19 11:02:22 11:02:25 11:02:30 11:02:31 11:02:37 11:02:42 11:02:44
Do you recall that there were multiple discussions regarding which variables to use to analyze the data? 11:02:47 11:02:48 11:02:51
A I don't have specific recall of those conversations; however, as I mentioned earlier in describing the process, I assume that we had many conversations about how to -- you know, how to plan the analyses and how to do them. 11:03:04 11:03:06 11:03:11 11:03:17 11:03:23 11:03:27
It's just that I can't remember the -- any of the actual conversations. 11:03:28 11:03:29

We -- we wrote the plan, we wrote the grant, 11:03:32
and, indeed -- so -- 11:03:36
But, again, you understand the 11:03:39
distinction I'm making. 11:03:40
Q Is there anything that sticks out in your 11:03:42
mind with regard to the decisions made by 11:03:43
you and the other investigators to 11:03:49
include -- of which variables to include? 11:03:51
Is there anything that sticks out in 11:03:58
your mind about your conversations about 11:03:59
those variables? 11:04:01
A Only that we always tried to do the right 11:04:02
thing, to do it properly, to figure out 11:04:05
what's the -- what's the proper way to 11:04:08
analyze the data to achieve the goal of 11:04:10
testing the hypotheses and aims of the 11:04:15
study. 11:04:19
That's the abiding, you know, ethos 11:04:19
that drives our decision-making, and -- and 11:04:24
that's -- it's -- it's often not easy. 11:04:28
It's often complicated to figure out 11:04:32
what's the most parsimonious, efficient and 11:04:35
best way to analyze it. 11:04:38
Q Okay. 11:04:41

A So, you know, with those parameters in mind, 11:04:41
those are the parameters that we always bat 11:04:46
around. 11:04:50
What's the best way to do it? What's 11:04:51
the best way to get there? What's the 11:04:53
proper way to do it? 11:04:55
Other than that, the guiding 11:04:56
principles, I can't recall the specifics of 11:04:57
any of the discussions. 11:04:59
The goal is to complete the 11:05:08
science -- complete the scientific project 11:05:09
using the integrity of the scientific 11:05:14
design. 11:05:16
Q Right. 11:05:16
And you mentioned that you had wanted 11:05:17
to test the hypothesis to determine whether 11:05:18
or not it was successful, correct? 11:05:21
A Yes. 11:05:25
Q And what was the hypothesis with regard to 11:05:26
Study 329? 11:05:29
A If you let me -- 11:05:32
(Witness read document.) 11:05:33
A There were four hypotheses listed in the 11:05:51
agreement. If you would like, I can read 11:05:55

those to you. 11:06:00

Q Sure. 11:06:01

A Number one, we hypothesized the following: 11:06:02

Number one: Paroxetine will be significantly superior to placebo at the end of the eight-week treatment trial. 11:06:06 11:06:08 11:06:11

Number two: IMI, capital I-M-I, which is an abbreviation for imipramine, those are my -- that's -- IMI will be significantly superior to placebo at the end of the eight-week treatment trial. 11:06:13 11:06:19 11:06:24 11:06:29 11:06:30

Number three: There will be fewer dropouts and adverse events among patients on paroxetine compared to patients on imipramine. 11:06:32 11:06:34 11:06:37 11:06:40

Number four: Responders to the eight-week experimental phase who are maintained on their study treatment for six months will experience significantly fewer MDD, which is an abbreviation for Major Depressive Disorder, relapses on IMI, I-M-I, and paroxetine than on placebo. 11:06:41 11:06:43 11:06:47 11:06:49 11:06:52 11:06:57 11:07:02

There are also two secondary aims. 11:07:08

would you care for those to be read? 11:07:12

Q No, that's okay. 11:07:14
The first one you read there, first 11:07:18
hypothesis, was that paroxetine, Paxil, 11:07:19
would be shown to be significantly superior 11:07:23
to placebo with regard to effectiveness, 11:07:27
correct? 11:07:33
A It says -- what was said was, Paroxetine 11:07:34
will be significantly superior to placebo at 11:07:36
the end of the eight-week treatment trial. 11:07:38
Q Okay. 11:07:41
A We didn't have the phrase "with regard to 11:07:41
effectiveness" in there. 11:07:44
Q Okay. 11:07:45
That -- that particular hypothesis 11:07:49
failed, correct? 11:07:51
MR. DAVIS: Object to the form. 11:07:52
A No. 11:07:54
Q It didn't? Well, let me ask you this: 11:07:54
Was paroxetine -- was Paxil shown to 11:07:58
be statistically superior to placebo on 11:08:00
either of the primary endpoints? 11:08:07
Do you know? 11:08:12
A No. 11:08:15
It was significantly superior to 11:08:15

placebo on the HAM-D total score of less 11:08:20
than or equal to 8, the HAM-D depressed mood 11:08:23
item, the Kiddie K-SADS-L depressed mood 11:08:26
item and the CGI score of 1 or 2. 11:08:31
And on the basis of those, variables 11:08:42
being positive, the conclusion of the 11:08:45
investigators, as well as the reviewers who 11:08:47
reviewed the paper, as well as people who 11:08:51
have seen it, all agreed that paroxetine was 11:08:53
significantly superior than placebo at the 11:08:58
end of Week 8. 11:09:02
Q None of those variables that you read are 11:09:04
primary endpoints, correct? 11:09:06
A My -- none of the four that I just read are 11:09:15
among the two primary endpoints listed in 11:09:19
the protocol, the exhibits that you showed 11:09:26
me. 11:09:27
Q Right. 11:09:28
So the question was, neither of or 11:09:28
none of the endpoints that you just listed 11:09:32
were primary endpoints in Study 329, 11:09:35
correct? 11:09:41
A They weren't primary endpoints listed in the 11:09:43
protocol, but they were judged by the 11:09:45

investigators to be important endpoints in 11:09:50
the determination of the subject's response 11:10:00
to paroxetine. 11:10:05
And I believe most experts 11:10:16
knowledgeable would also agree that these 11:10:19
are clinically and research-relevant 11:10:22
endpoints to use in determining efficacy of 11:10:30
treating depression. 11:10:33

Q All right. 11:10:35
Well, Mr. Murgatroyd will get into 11:10:35
that a little bit later, and we'll see what 11:10:37
the experts actually do think. 11:10:39
Let me ask you to turn to -- let me 11:10:41
ask you this first: 11:10:43
Yesterday with regard to question 11:10:45
about your expectations for Study 329, do 11:10:47
you recall that you testified that you 11:10:55
didn't have any expectations, you and the 11:10:57
other investigators didn't have any 11:10:59
expectations with regard to the outcome of 11:11:02
329 when you began the study? 11:11:03
Do you recall that? 11:11:05

A I don't recall exactly what I said, so I'd 11:11:07
appreciate having what I said about 11:11:10

expectations being read back to me so I can make sense -- 11:11:12 11:11:14

Q How about this: 11:11:15

Why don't you tell us, what were your expectations when you began Study 329? 11:11:16 11:11:18

What were your expectations of the outcome? 11:11:24 11:11:28

A Well, as I stated to you very shortly ago, our expectations were the following hypotheses: 11:11:33 11:11:42 11:11:45

Number one: Paroxetine will be significantly superior to placebo at the end of the eight-week treatment trial. 11:11:48 11:11:49 11:11:50

Number two: Imipramine will be significantly superior to placebo at the end of the eight-week treatment trial. 11:11:52 11:11:58 11:11:59

Number three: There will be fewer dropouts and adverse events among patients on paroxetine compared to patients on imipramine. 11:12:01 11:12:04 11:12:06 11:12:09

Number four: Responders to the eight-week experimental phase who are maintained on the study treatment for six months will experience significantly fewer 11:12:10 11:12:12 11:12:14 11:12:16

MDD relapses on imipramine and paroxetine than on placebo. 11:12:18 11:12:22

Those were the expectations. 11:12:24

Q Okay. 11:12:37

Can you tell me, do you know what a reprint is? 11:12:37 11:12:39

A Yes. 11:12:45

Q Okay. 11:12:45

What is a reprint? 11:12:45

A Well, my understanding of a reprint is when a -- an article appears in a journal, and I'm most familiar with scientific journals, but I believe -- I assume this is the case with the broad range of journals, the journal makes available for a fee the production or the -- the whatever, the publisher of the journal makes available for a fee copies of the article. 11:12:49 11:12:56 11:13:04 11:13:06 11:13:08 11:13:11 11:13:18 11:13:22 11:13:24

I'm trying to think of the right word. Will produce for you a -- the article without Xeroxing it, so it's some type of freestanding independent copy that's been printed -- that's been specifically printed by the publisher. 11:13:33 11:13:34 11:13:43 11:13:48 11:13:50 11:13:53

Q Okay. 11:13:55
A And typically it's bound with a staple, and 11:13:55
that's what we generally refer to as 11:14:00
reprints. 11:14:03
That's my understanding. 11:14:03
Q Okay. 11:14:05
A From journals. 11:14:05
Q Okay. 11:14:06
And what -- do you know what -- 11:14:06
what's your understanding -- 11:14:09
A As opposed to this, which I wouldn't call a 11:14:11
reprint. I would say that someone took -- 11:14:13
made a Xerox copy of something. 11:14:17
Q Okay. 11:14:19
What is your understanding of the 11:14:20
purpose of reprints? 11:14:21
A Currently, I see -- I think there's minimal 11:14:35
to no purpose for reprints, because most 11:14:37
journals have mechanisms whereby things can 11:14:44
be obtained through the Internet. 11:14:46
In the good old days, back in the 11:14:50
early '90s when I was still in high school 11:14:53
and people didn't have that ability to 11:15:00
transmit, you know, manuscripts and 11:15:03

articles, the re -- what would happen -- it 11:15:07
was a way of communicating information. 11:15:12

Typically, the author -- first author 11:15:16
of an article would be asked at the time an 11:15:18
article was I guess accepted at some point 11:15:20
or about to -- about to be published, they 11:15:25
would -- you would get a form from the 11:15:27
journal asking you if, and if so, how many 11:15:29
reprints you would like, which you had to 11:15:34
pay for. 11:15:36

And I certainly did, and mostly all 11:15:37
my peers did, to the extent that we could 11:15:40
afford it. 11:15:42

We would order a certain number of 11:15:42
copies, and then what would usually happen 11:15:45
is peers would send us a postcard or 11:15:47
sometimes a letter asking if we would send 11:15:49
them a reprint of our article. 11:15:52

Or if I went to a scientific meeting, 11:15:55
people would ask for reprints, because it's 11:15:57
my understanding, though I don't -- I'm not 11:15:59
a copyright attorney, that you're not 11:16:01
allowed to -- you're not allowed to take a 11:16:03
bound journal and make a Xerox of it 11:16:08

So that -- I understood that was the only legitimate way to give someone a hardcopy of it. 11:16:10 11:16:13 11:16:17

Q Okay. 11:16:19

And your understanding, from what I understand you've just said, is that the purpose of a reprint was basically to disseminate information that was contained in the article, correct? 11:16:20 11:16:25 11:16:26 11:16:28 11:16:30

A Yes. 11:16:33

Q And did you do that when you had reprints that were provided to you? 11:16:34 11:16:36

A Rarely. And after a while, I just stopped, because it just -- it was expensive and time-consuming and -- 11:16:42 11:16:44 11:16:51

Q Expensive? In what sense? 11:16:53

A As the first author, I had to buy the reprints myself. The journal sold me the reprints, so I had to spend money to do it and with -- so that was expensive. 11:16:56 11:16:58 11:17:04 11:17:10

And if someone sent me a postcard and asked me for it, I had to mail them a copy of it, and that was both costly for the stamp and time-consuming. 11:17:14 11:17:18 11:17:21 11:17:26

So after a while, I stopped and at 11:17:28
some point stopped ordering reprints and 11:17:32
just said I don't have reprints. Here's the 11:17:35
reference. Read the article. 11:17:38
Q So what -- tell me this: 11:17:40
What was the -- when you did in your 11:17:43
past -- when you did receive reprints, what 11:17:46
was the usual ballpark figure, number of 11:17:51
reprints you would -- you would request? 11:17:55
A Well, it -- it varied enormously, and I 11:17:59
can't remember the exact amount. 11:18:08
The principle when I was first 11:18:09
starting out as a researcher and I was 11:18:11
extremely excited, thrilled and proud that 11:18:13
one of my papers was in a journal, I assumed 11:18:16
that thousands of people would ask me for 11:18:18
copies. 11:18:21
And if it was -- and if I thought it 11:18:22
was a really seminal article, I might order 11:18:25
couple of hundred. I think at one point I 11:18:28
might have even ordered a thousand. 11:18:31
After I noticed that the requests 11:18:32
were far fewer, I started ordering the 11:18:36
minimal amount, and my thinking was at least 11:18:39

we'd have some copies that we could keep on file locally for -- in memoriam. 11:18:44 11:18:46

But the process of -- the process that I described to us of people requesting -- requesting them was for me, even with my finest of research, was always a -- was always very minimal. 11:18:49 11:18:51 11:18:52 11:18:57 11:19:01

So I just kind of stopped, you know? 11:19:03

Q Okay. 11:19:05

Let me -- do you -- 11:19:09

A But I cannot remember the last time I requested -- I ordered reprints, and I frankly don't remember -- I don't. I don't actually recall. 11:19:10 11:19:12 11:19:15 11:19:19

I don't know the extent the journals still send that offer to you anymore, so... 11:19:21 11:19:23

Q Okay. 11:19:37

A But we also didn't have BlackBerrys then. 11:19:37

Q Do you recall requesting any reprints of your article -- 11:19:40 11:19:43

A No. 11:19:43

Q -- that was published in July of 2001 -- 11:19:43

A No. 11:19:46

Q -- regarding -- 11:19:46

A No. 11:19:49
Q -- Study 329? 11:19:49
A Sorry. No. 11:19:51
Q Okay. 11:19:52
(Exhibit No. 26 marked for identification.) 11:19:52 11:19:52
BY MR. COFFIN: 11:19:52
Q Let me show you what's been marked as Exhibit 26. 11:19:52 11:19:54
MR. DAVIS: Can I see that? 11:19:55
(Counsel read document.) 11:19:56
MR. COFFIN: And, Todd, while you're at it, can you dedesignate the confidentiality -- 11:20:08 11:20:09 11:20:11
MR. DAVIS: Yes, I can. 11:20:12
This is not subject -- Exhibit 26 is not subject to the protective order. 11:20:13 11:20:14
BY MR. COFFIN: 11:20:16
Q Can you just take a look at that document? 11:20:16
(Witness read document.) 11:20:18
Q Actually, it's a series of emails, so the first one starts at the end, but read it how you -- how you like. 11:20:19 11:20:22 11:20:25
(Witness read document.) 11:20:26

Q Okay. 11:21:17
Can you identify that document? 11:21:17
A I'm not sure -- 11:21:24
Q What is the document? 11:21:25
A It's a series of, I guess, emails between individuals talking about the request that I am said to have made, it doesn't specify whether it was verbal or in writing, to have -- 11:21:27 11:21:34 11:21:42 11:21:47 11:21:51
(Witness read document.) 11:22:00
A I'm trying to see here. 11:22:00
Ask if -- it says, Dr. Keller was wondering if GSK will fund the purchase of these -- of reprints of 329. 11:22:07 11:22:11 11:22:15
Q Okay. 11:22:18
And what's the date of that email? 11:22:19
A Well, there are many dates. One is -- one date is 4/27/2001. One date is 4/25/2001. I guess there are two dates. 11:22:24 11:22:28 11:22:35
Q Okay. 11:22:38
Does that appear to be a true and correct copy of the email? 11:22:42 11:22:44
A I have no idea. 11:22:46
Q Do you have any reason to doubt that it's 11:22:46

not what it purports to be? 11:22:48

MR. DAVIS: Objection. 11:22:54

I don't think this witness can 11:22:54
authenticate another document that's not 11:22:56
involved in. 11:22:58

A I'm not a documentation -- I'm not a 11:22:58
document authenticator, so I have no reason 11:23:01
to either believe it or not believe it. 11:23:04

I have no idea. 11:23:06

Q Okay. 11:23:06

Can you turn to -- actually, it's the 11:23:13
bottom of the first page and the concluding 11:23:15
on the second page, does that appear to be 11:23:17
an email from Sally Laden? 11:23:20

A Yes. 11:23:32

Q Okay. 11:23:33

And can you please read that middle 11:23:33
paragraph there that Ms. Laden writes that's 11:23:36
referring to you specifically so we don't 11:23:41
get confused on which paragraph? 11:23:45

A Well, there are six paragraphs. 11:23:48

Q Okay. 11:23:49

Do you see any referring to you? 11:23:50

A I do. 11:23:51

Q Okay. 11:23:52

Could you read the one that refers to 11:23:52
you, please? 11:23:54

A "Marty Keller is a corresponding author and 11:23:55
will need a supply of reprints. I 11:23:58
anticipate that he will need a sizable 11:24:00
quantity because of the importance of this 11:24:02
paper. Probably in the vicinity of 500 11:24:04
reprints. Dr. Keller is wondering if GSK 11:24:06
will fund the purchase of these reprints." 11:24:09

Q Okay. 11:24:11

Do you recall asking either Sally 11:24:12
Laden or someone at GSK whether they'd fund 11:24:16
the purchase of reprints of your article? 11:24:20

A I don't recall asking them, which isn't to 11:24:26
say that I didn't or did. I just don't 11:24:28
recall. 11:24:29

Q Do you know one way or another whether they 11:24:31
actually paid for the reprints for you? 11:24:33

A No. 11:24:36

Q Well, according to your testimony before, 11:24:37
you always paid for your own, correct? 11:24:38

MR. DAVIS: Object to form. 11:24:40

A No. 11:24:41

Q That's not what you said? 11:24:41
That's okay. 11:24:43
A I -- I think that's a mis -- what you did is a mischaracterization of what I said. I said it was expensive. 11:24:44 11:24:46 11:24:49
Q Okay. 11:24:50
Well, what did you -- 11:24:51
A I said it was expensive to pay for them. 11:24:52
Q Okay. 11:24:55
A And actually had I extended it, I would have said the sources of revenue that are used to pay for them, you know, vary. 11:24:55 11:24:59 11:25:01
So sometimes if it's a grant, you pay for them off a grant or by departmental funds. 11:25:02 11:25:05 11:25:07
I didn't -- I didn't -- I never -- I didn't pay for them out of my own. I've always been in a position where I've either had grants or discretionary research funds that would be used to pay for them. 11:25:08 11:25:10 11:25:14 11:25:18 11:25:21
So I never took money out of a bank account that was a Martin Keller's personal money; however, in terms of my stewardship of resources, I've tried to be efficient in 11:25:24 11:25:26 11:25:29 11:25:35

stewarding resources and to be careful not to spend dollars of grants or discretionary funds unless it was absolutely necessary. 11:25:39 11:25:43 11:25:46

And in that context, it would have been perfectly reasonable for me to try to identify a source of money to pay for the reprints so that I could save other resources. 11:25:49 11:25:53 11:25:57 11:26:01 11:26:06

Q Okay. 11:26:07

So your prior testimony, you didn't mean to imply that the ordering of reprints was a financial burden for you personally; is that right? 11:26:08 11:26:09 11:26:13 11:26:14

A Not from my -- from my own personal dollars, but I am the steward of dollars, and stewardship of those dollars is something -- of dollars, of money, is something I take very seriously. 11:26:15 11:26:20 11:26:25 11:26:27 11:26:29

Q Okay. 11:26:30

Take a look at what's been marked as Exhibit 27, if you would, please. 11:26:31 11:26:33

(Exhibit No. 27 marked for identification.) 11:26:34 11:26:34

(Witness read document.) 11:26:41

A I've looked at it. 11:26:55
Q Okay. 11:26:57
And what's that document that you 11:26:58
have in your hand? 11:26:59
A It's a letter in Sally Laden to Jim 11:27:01
McCafferty. 11:27:03
Q Okay. 11:27:04
And are you referenced in that 11:27:05
letter? 11:27:06
A Yes. 11:27:06
Q Okay. 11:27:07
Could you please read the letter? 11:27:07
A "Dear Jim: 11:27:08
"I am pleased to enclose a small 11:27:09
supply of reprints of the 11:27:12
paroxetine-imipramine adolescent depression 11:27:13
paper that was recently published in the 11:27:13
Journal of the American Academy of Child and 11:27:15
Adolescent Psychiatry. GSK funded the 11:27:18
purchase of reprints. A total of 300 went 11:27:20
to Marty Keller, who is corresponding author 11:27:22
on the paper, and the balance being sent to 11:27:25
Zach Hawkins for distribution to the 11:27:27
Neuroscience sales force. Samples are also 11:27:29

being sent to Rocco and Neal." 11:27:33

Next paragraph, "The paper looks excellent and demonstrates the commitment of GSK to the field of psychiatry. Thank you for your support. 11:27:35 11:27:37 11:27:40 11:27:42

"Sincerely, Sally Laden -- Sally K. Laden, MS, Associate Editorial Director." 11:27:43 11:27:45

Q Okay. 11:27:48

Does that refresh your recollection that you received 300 reprints of the article you published? 11:27:49 11:27:50 11:27:53

A No. 11:27:55

Q Okay. 11:27:56

Does it -- okay. 11:27:56

Do you know whether or not you received 300 reprints? 11:27:59 11:28:00

A No. I -- 11:28:01

Q You don't have any reason to disagree with that? 11:28:06 11:28:08

A I don't have any reason to disagree, but -- 11:28:08

Q Okay. 11:28:09

A -- if you're asking me if I remember receiving a package that contained 300 reprints, I have absolutely no recall of 11:28:09 11:28:15 11:28:18

that. 11:28:20

Q Okay. 11:28:20

And does that refresh your recollection that you did not pay for out of your funds or your stewardship funds the copies of the reprints that you requested? 11:28:21 11:28:22 11:28:24 11:28:28

A No. 11:28:31

Q Okay. 11:28:32

You just don't recall that, correct? 11:28:32

A Correct. 11:28:34

Q Okay. 11:28:34

Do you know that your article was used by GSK to send out to doctors who made inquiries about Paxil's use for the treatment of children and adolescents? 11:28:35 11:28:39 11:28:44 11:28:46

MR. DAVIS: Object to the form. 11:28:49

A No. 11:28:50

Q You don't know whether that was done or not? 11:28:50

A No. I have no recall that it was done. 11:28:52

Q Okay. 11:28:59

A It was -- as a matter of fact -- 11:28:59

No awareness that it was done. No recall. 11:29:01 11:29:02

Q Okay. 11:29:04

Did you ever receive any inquiries about your article on Study 329? 11:29:04 11:29:07

A Could you be more specific about what you mean by inquiries? 11:29:15 11:29:16

Q Do you know what an inquiry is? 11:29:19

A Not -- 11:29:22

Q You don't? 11:29:23

A Most words have a lot of meaning, so why don't you just tell me what you mean and don't ask me -- 11:29:24 11:29:26 11:29:28

Q Do you know what a question is? 11:29:29

A Yes. 11:29:30

Q Okay. 11:29:31

Did you ever receive any questions with regard to the article you published on Study 329? 11:29:31 11:29:34 11:29:38

MR. DAVIS: Object to the form. 11:29:39

A I don't remember. 11:29:45

Q Did any doctors ever call or write to you and ask you to provide them with a reprint of your study on article -- on Study 329? 11:29:45 11:29:52 11:29:54

A No memory of that. 11:30:00

Q Okay. 11:30:01

A I'm not saying they didn't, but I just don't 11:30:02

remember it. 11:30:04
Q Okay. 11:30:05
Do you ever recall any physicians 11:30:05
asking you either verbally or in writing 11:30:07
about the results that were obtained from 11:30:12
Study 329 that you had published? 11:30:16
A I don't recall. 11:30:26
Q So you don't recall anyone -- any physicians 11:30:27
ever asking you about the results of Study 11:30:31
329 that you published in your article; is 11:30:35
that correct? 11:30:39
A That's correct. 11:30:40
Q Okay. 11:30:40
A I have -- I certainly have had -- 11:30:41
I can't recall any of the recall any 11:30:49
of the specifics, but I know that I have 11:30:54
discussed, which maybe isn't and answer to 11:30:58
your question, but I know I've discussed the 11:31:00
results of 329 of fairly extensively with my 11:31:03
colleagues. 11:31:13
And one of the specific reasons that 11:31:13
I can recall that is that a group of 11:31:18
colleagues and I submitted a grant to the 11:31:22
National Institute of Mental Health for 11:31:25

funding, which is currently ongoing, called 11:31:28
the Treatment of Depression-resistant 11:31:30
Adolescent -- something to that effect. 11:31:36

And as part of the background, a 11:31:39
significant section of that grant, as we 11:31:43
described the choice of treatments that we 11:31:45
would use in that NIMH protocol, we included 11:31:49
the findings from 329. 11:31:56

Now, I believe that preceded the 11:32:01
publication. In other words, I believe that 11:32:06
the submission of that grant preceded the 11:32:08
publication of the article referred to in 11:32:12
Exhibit 13, though we had the results. 11:32:18

And that required a lot of discussion 11:32:23
as to what is the most proper way to, you 11:32:25
know, include material in an application for 11:32:27
another grant to the NIMH of results, you 11:32:33
know, which are known perhaps in a draft of 11:32:36
an article but not yet citeable -- but not 11:32:39
yet -- but where the material is not yet in 11:32:46
print. 11:32:49

If it's in print, the rules are that 11:32:50
you're allowed to include a copy the -- of a 11:32:51
reprint of the article as part of the NIMH 11:32:56

grant submission. 11:33:01
If it's not in print, you're allowed 11:33:02
to discuss it in your preliminary study 11:33:03
section. 11:33:08
So there was a lot of discussions 11:33:10
about that. 11:33:13
Q Outside of that particular study from NIMH 11:33:14
that you're talking about, you don't recall 11:33:18
discussing -- you might not want to break 11:33:22
that -- 11:33:28
(Laughter.) 11:33:28
Q You don't recall any -- any other 11:33:28
discussions with physicians about the 11:33:32
prescribing of Paxil to children or 11:33:33
adolescents in the context of the article 11:33:35
you published? 11:33:39
A No, I don't recall the conversation -- I 11:33:41
guess the short answer is no. I mean, 11:33:43
again, a lot of discussion -- lots of 11:33:45
discussion with regard to the grant, you 11:33:47
know, the grant was submitted. I don't 11:33:49
think it was funded. I don't think it was 11:33:53
approved for funding on the first 11:33:54
submission. 11:33:56

You know, we then get comments back from the reviewers of grant. We have to modify the grant, so on and so forth. 11:33:57 11:33:59 11:34:01

So that was a -- a rather extensive and lengthy process about that. 11:34:03 11:34:06

And there also came to be a time following the publicity surrounding, which started in Great Britain with the British Medical Council which led to this grant which -- that I'm referring to, which is under a cooperative agreement with the NIMH which led to a halting of the grant and a lot of deliberation as to whether or not we would continue with the -- you know, with the design that included Paxil and so on and so forth. 11:34:07 11:34:09 11:34:15 11:34:19 11:34:23 11:34:25 11:34:28 11:34:32 11:34:36 11:34:40 11:34:43

So there's an enormous -- there's been an enormous amount of discussion about the issues, but as the only -- those that I remember are all in the context of the research. 11:34:45 11:34:46 11:34:48 11:34:53 11:34:56

(Exhibit No. 28 marked for identification.) 11:34:56 11:34:56

BY MR. COFFIN: 11:34:56

Q Okay. 11:34:58
Let me show you one other exhibit. 11:35:01
We're going to have to change the tape in 11:35:03
just a second. 11:35:04
So let me just close up on the 11:35:05
reprint issue. That's Exhibit 28. 11:35:07
Could you identify that? 11:35:10
A That's a letter from Sally Laden to me. 11:35:11
Q Okay. 11:35:14
And do you -- can you read the date, 11:35:17
please? 11:35:19
A August 7, 2001. 11:35:20
Q Do you recall receiving that letter? 11:35:22
A No. 11:35:25
Q Does that appear to be a true and correct 11:35:25
copy of a letter from Sally Laden to you? 11:35:27
A You know, to be fair, I can't authenticate 11:35:33
the letter. 11:35:35
Q Actually, you can. 11:35:36
Is it -- 11:35:37
A How? 11:35:37
Q Does it appear to be a letter? 11:35:37
Have you ever seen a letter before? 11:35:39
A Have I ever seen a letter before? 11:35:41

Q Yes. 11:35:44

A Is that what some people would call a facetious or smart-ass comment? 11:35:45 11:35:47

Q Well, I mean, if -- you give me a facetious response, Doctor. 11:35:48 11:35:49

I'm just trying to ask you to identify a document. It's very simple. 11:35:50 11:35:51

A But you're an attorney. I ask you to keep your composure and not be a smart-alec. 11:35:52 11:35:54

Q It's very simple. 11:35:57

A I can't authenticate the letter. People make up letters. My signature isn't on here. 11:35:57 11:35:59 11:36:01

If my signature were on here, I could recognize my signature. I can't recognize this person's signature, and I can't tell you that this was an authentic letter or not an authentic letter. 11:36:01 11:36:03 11:36:05 11:36:07 11:36:09

That's a simple, straightforward answer, which I think is valid. 11:36:12 11:36:13

Q I have a question to ask you about this, Doc. 11:36:17 11:36:19

Could you please read the letter? 11:36:19

(Witness read document.) 11:36:21

A "Dear Marty: 11:36:22

"Enclosed please find a supply of reprints of the adolescent depression study that was recently published in the Journal of the American Academy of Child and Adolescent Psychiatry. Purchase of the reprints was funded by the Paxil Product Management group at GSK. 11:36:23 11:36:25 11:36:27 11:36:30 11:36:31 11:36:32 11:36:34

"Thank you very much for your patience and support as this difficult project was finally completed. 11:36:36 11:36:36 11:36:38

"Sincerely, Sally K. Laden." 11:36:40

Q Does that refresh your recollection of who paid for the reprints received? 11:36:44 11:36:45

A No. 11:36:47

MR. COFFIN: All right. Let's go off the record. 11:36:50 11:36:51

THE VIDEOGRAPHER: The time is 11:38. We're off the record. 11:36:52 11:36:54

(Recess.) 11:36:56

THE VIDEOGRAPHER: We're back on the record. This is Tape No. 2. The time is 11:56. 11:54:42 11:54:43 11:54:45

BY MR. COFFIN: 11:54:48

Q Dr. Keller, do you recall receiving any comments from practitioners regarding your publication of the results of Study 329? 11:54:50 11:54:58 11:55:03
A Only those individuals who I engaged in research with, some of whom I believe, but I don't know, also have clinical practices, presumably, small to modest ones. 11:55:12 11:55:20 11:55:26 11:55:31
So they would consider themselves perhaps clinicians, whatever you called them, practitioner scientists, scientist practitioners. 11:55:36 11:55:38 11:55:42 11:55:46
Q Okay. 11:55:47
Do you recall that you and the other investigators submitted a copy of the manuscript for what became the article for 329 to JAMA? 11:55:47 11:55:52 11:55:58 11:56:02
A No. 11:56:04
Q Can you tell the jury what JAMA is? 11:56:05
A It's the Journal of the American Medical Association. 11:56:08 11:56:09
Q And you just don't recall one way or another whether the abstract -- or, excuse me, the manuscript was submitted to JAMA; is that correct? 11:56:12 11:56:15 11:56:19 11:56:21

A Yes. 11:56:22

Q Okay. 11:56:22

What -- what's your understanding of the reputation of JAMA in the medical community? 11:56:23 11:56:27 11:56:31

A I think it's well regarded as a journal which goes out to a broad range of practitioners, not -- not typically read -- it's -- it's -- 11:56:34 11:56:41 11:56:48 11:57:00

It's rarely subscribed to or read by specialists such as psychiatrists -- by psychiatrists, and I believe by many other specialists. 11:57:03 11:57:06 11:57:09 11:57:12

Tend -- it would tend to be most widely subscribed to and read by people in internal medicine. 11:57:14 11:57:16 11:57:19

Q And do you know why the manuscript for 329 was submitted to JAMA? 11:57:27 11:57:35

A I don't recall, but the logic that I go through and that of my peers at times when we think of submitting an article which has to do with psychiatry or psychiatric illness to JAMA is -- 11:57:38 11:57:46 11:57:49 11:57:52 11:57:57

Excuse me. 11:57:59

(Telephone interruption.) 11:57:59

MR. DAVIS: Want to go off the record? 11:58:01 11:58:02

THE WITNESS: No, it's all right. During the next break. 11:58:02 11:58:05

A But sometimes we wonder -- we think that perhaps this would be of -- even though it's specifically about psychiatry, we think maybe it would be an interest to the general medical community. 11:58:08 11:58:12 11:58:16 11:58:21 11:58:26

Very often, the editor of JAMA will send things back to us and to peers of mine in other specialty areas of medicine, such as OB, rheumatology or whatever, and say thanks for sending us your article, but I think it would be more appropriate to a specialty journal. 11:58:27 11:58:31 11:58:33 11:58:37 11:58:41 11:58:45 11:58:46

Oftentimes the reviews that come back deal with what they consider to be the fit of the material for JAMA and not -- if it's a specialty article and not just the substance, you know, of what's in the article. It's a suitability/fit issue. 11:58:48 11:58:51 11:58:57 11:59:01 11:59:03 11:59:06

Q Okay. 11:59:10

You do know that the article that you 11:59:13
prepared for publication and that your 11:59:18
colleagues helped you prepare was not 11:59:20
accepted by JAMA, correct? 11:59:22
A I don't remember that. If you have a 11:59:23
document that says it wasn't and you show it 11:59:27
to me -- 11:59:29
Q Let me ask you this: 11:59:30
You know that your article was not 11:59:31
published in JAMA, correct? 11:59:33
A Yes. 11:59:34
Q Okay. 11:59:35
Do you recall ever seeing any of the 11:59:36
reviews by reviewers who -- at JAMA who 11:59:39
looked at your article submission? 11:59:42
A I believe that Skip asked me this question 11:59:47
yesterday, and what I said was I don't 11:59:51
recall seeing any of the reviews, and then 11:59:53
went on to explain how if, indeed, we had 11:59:55
submitted it, I am sure I would have either 12:00:01
gotten a letter -- 12:00:02
You know, it would be unheard of to 12:00:05
not receive a letter back from the editor 12:00:07
either saying that, you know, thanks a lot, 12:00:09

but we've decided not to review it or we've sent it out to review. 12:00:12 12:00:14

And if it's sent out to review, it would be unheard of not to get letters back from reviewers, and if I got them I certainly read them, but I don't recall that. 12:00:16 12:00:18 12:00:20 12:00:22 12:00:24

So it was quite an extensive amount of discussion, which is on the record from yesterday. 12:00:25 12:00:27 12:00:29

Q Okay. 12:00:57

Do you recall -- do you recall submitting the manuscript -- manuscript for publication to the American Journal of Psychiatry? 12:00:57 12:00:58 12:01:01 12:01:01

A No. 12:01:03

MR. COFFIN: Can we go off the record for just a few minutes? I need to sort some things out. 12:01:09 12:01:10 12:01:12

THE VIDEOGRAPHER: The time is three minutes after 12:00. We are off the record. 12:01:13 12:01:14

(Recess.) 12:01:16

THE VIDEOGRAPHER: We're back on the record. The time is ten minutes after 12:08:18 12:08:19

12:00. 12:08:21

BY MR. COFFIN: 12:08:22

Q Okay. 12:08:23

Dr. Keller, we were talking about whether you recalled receiving reviews from publications you had submitted a manuscript to. 12:08:23 12:08:25 12:08:32 12:08:36

Do you recall that questioning? 12:08:36

A Yes. 12:08:37

Q Okay. 12:08:37

Do you recall reviewing any reviews from individuals at JAMA? I believe you already answered that, actually. 12:08:38 12:08:43 12:08:46

A Yes. 12:08:49

Q And do you recall reviewing those? 12:08:49

A No. 12:08:53

Q Okay. All right. 12:08:54

(Exhibit No. 29 marked for identification.) 12:08:54 12:08:54

BY MR. COFFIN: 12:08:54

Q Let's look at what's been marked as Exhibit 29. 12:08:55 12:08:56

MR. DAVIS: Okay. We'll dedesignate this as subject to the protective order. 12:09:03 12:09:06

That's Exhibit 29. 12:09:08

MR. MURGATROYD: So the record's clear, all of them have been dedesignated with the sole exception of 24 thus far, correct? 12:09:11 12:09:11 12:09:14 12:09:17

MR. DAVIS: I believe that's true. 12:09:18

MR. COFFIN: That is correct. 12:09:20

MR. MURGATROYD: Okay. 12:09:21

MR. GREEN: And we would like to make sure of that at the end since we both signed affidavits we wouldn't disclose anything. 12:09:23 12:09:25 12:09:27

I want to know exactly what I'm not disclosing 12:09:29 12:09:31

MR. MURGATROYD: Yes, so far it's only one page. 12:09:32 12:09:33

MR. GREEN: Okay. 12:09:34

MR. COFFIN: Makes it easy. 12:09:36

MR. GREEN: Yes. Don't want to be going down to Pennsylvania and get in trouble with the judge. 12:09:37 12:09:38 12:09:39

(Witness read document.) 12:09:57

A Do you want me to read the whole thing? 12:10:17

Q No, I just wanted you to familiarize yourself with it. 12:10:19 12:10:22

I'll ask you some specific questions, but, you know, you don't have to read every word, unless you'd like to. 12:10:23 12:10:25 12:10:28

A Pretty interesting. 12:10:31

(Witness read document.) 12:11:25

A Okay. 12:11:34

Q Have you ever -- do you recall ever seeing that document? 12:11:36 12:11:37

A No. 12:11:39

Q Okay. 12:11:40

Do you know one way or another whether you received that document? 12:11:42 12:11:44

A My -- my assumption is that it was sent to me since it's reviewing -- it's a review by JAMA of the article, I'm a corresponding author, I'm assuming it was sent to me; and I'm assuming I read it carefully at the time I received it. 12:11:52 12:11:56 12:12:03 12:12:09 12:12:12 12:12:14

I just can't remember. 12:12:16

Q Considering -- considering you're the primary author on the article, would it be the normal course and practice for you to receive comments on the article from reviewers of a journal such as JAMA? 12:12:18 12:12:20 12:12:24 12:12:28 12:12:29

A Yes. 12:12:33
Q Okay. 12:12:33
And you don't have any reason to doubt that that happened in this case, I assume? 12:12:35 12:12:37 12:12:39
A No reason to doubt. 12:12:39
Q Okay. 12:12:42
I want to ask you some questions outside of this before I get to the specifics of this document that's been marked as 29. 12:12:43 12:12:46 12:12:48 12:12:50
Study 329 included a supportive therapy component for each participant in the study, correct? 12:12:55 12:13:00 12:13:03
A Yes. 12:13:04
Q Do you recall that? 12:13:04
A Yes. 12:13:06
Q Okay. 12:13:06
And can you explain what the supportive therapy component entailed? 12:13:07 12:13:10
A I can give you a general explanation and rationale, but there's a specific -- 12:13:17 12:13:20
I believe that we used a specific manual that set up the -- codified the -- 12:13:26 12:13:30

how the supportive therapy was to be performed. I seem to recall that we had that. 12:13:38 12:13:40 12:13:41

And so in order to give you the specifics that should be part of the, you know, the grant, the procedure materials for the grant -- so if you want specificity, if you gave that to me, I could go through it with you. 12:13:42 12:13:46 12:13:48 12:13:53 12:13:57 12:13:59

Q Well, it would be in the protocol for the study? 12:14:00 12:14:01

A It should either be in -- it wouldn't be in -- in one of the -- 12:14:05 12:14:08

The exhibits that I received were relatively short, you know, descriptions of the study. 12:14:10 12:14:13 12:14:20

It would be an appendix to -- it's typically in -- it's typically what we call an appendix, and it's a manual. 12:14:21 12:14:23 12:14:26

And I'm not sure that we used the manual, but there is a manual for supportive treatment that's commonly used in placebo-controlled pharmacologic studies, which we may have adopted at that particular 12:14:31 12:14:32 12:14:35 12:14:40 12:14:43

study. 12:14:45
I seem to recall that. I just don't 12:14:46
remember for sure. 12:14:47
Q Okay. 12:14:48
Well, without going back through all 12:14:49
those documents, the point is that there was 12:14:51
supportive psychotherapy, if you will, 12:14:55
provided to patients in the study, correct? 12:14:57
A Just -- I just don't remember for sure 12:15:00
exactly what we did. 12:15:03
Q Okay. 12:15:05
A I mean, that's clearly a matter of -- you 12:15:06
know, a fact that we could easily determine, 12:15:10
so... 12:15:12
Q Okay. 12:15:15
A Depends whether you want to spend the time 12:15:18
digging through the stuff. 12:15:20
Q Well, actually, I can -- let me see if I can 12:15:23
refresh your recollection just by using a 12:15:26
document that we already have marked as 12:15:27
Exhibit 13, which is the article that you 12:15:29
published. 12:15:35
Maybe this will help us without going 12:15:35
specifically back into all the protocol and 12:15:37

so on. 12:15:39
A Sure. 12:15:40
Q If you read the first -- excuse me, the second full paragraph under Limitations on page 770 of Exhibit 13. 12:15:42 12:15:45 12:15:48
You don't have to read it out loud. I just want to see if that refreshes your recollection. 12:15:52 12:15:54 12:15:56
(Witness read document.) 12:15:59
A It's the second sentence which is germane, so I've read that. 12:16:05 12:16:08
Q Okay. 12:16:09
So based on that, can you give an explanation of the -- of the type of therapy that was provided? 12:16:09 12:16:12 12:16:16
A Again, what this says is that we had weekly supportive case management sessions, so -- and as I was saying earlier, which I guess is on the record, I believe, but I'm not sure, that we had a manual which specified what would be done. 12:16:18 12:16:21 12:16:27 12:16:30 12:16:32 12:16:35
But in general, the principal is that you're -- you're being empathetic, you're being warm in your interaction, you're 12:16:36 12:16:46 12:16:53

listening to their problems. 12:16:56

So in that case you're being supportive of them, listening in a -- in a caring way. 12:17:02 12:17:04 12:17:06

But what you're not doing is you're not doing what's traditionally known as psychotherapy, whereby you are, you know, making an effort to understand the causes or contributing factors to their depression or other psychiatric troubles. 12:17:08 12:17:11 12:17:15 12:17:20 12:17:28 12:17:32

You're not trying to get to understand why those have occurred from a psychological perspective, nor are you then making suggestions as to how using psychological processes they could improve themselves. 12:17:35 12:17:36 12:17:39 12:17:42 12:17:48 12:17:51

It's much more than as I described to you. 12:17:52 12:17:54

Q It's much more supportive? 12:17:55

A Supportive -- 12:17:58

Q Hence supportive therapy? 12:17:59

A Without being prescriptive. 12:18:00

Q Okay. 12:18:02

Understandable. 12:18:03

A And the efforts made to standardize it so that all the patients would be, you know, in clinical trials. 12:18:06 12:18:09 12:18:12

That's what I'm saying, the effort is to have that be very standardized. So obviously you can't, you know, from individual to individual, you can't be exact, but there are certain things you can say and cannot say. 12:18:13 12:18:15 12:18:18 12:18:20 12:18:24 12:18:28

Q Okay. 12:18:30

You recognize that the use of supportive therapy can contribute to positive outcomes for individuals who have depression. 12:18:31 12:18:32 12:18:37 12:18:39

Do you recognize that? 12:18:42

A Yes. 12:18:44

But what I'm -- what this says here, and, again, Chris, to the extent that it's important, you might well want to go back to the manual. This says "supportive case management sessions" as opposed to saying "supportive psychotherapy." 12:18:44 12:18:46 12:18:49 12:18:52 12:18:54 12:18:57

Q Okay. 12:19:01

A There is such a -- just so you know, I'm not 12:19:02

trying to be overtechnical. 12:19:04

Q I understand. 12:19:06

A When you talk about types of 12:19:07
psychotherapy -- 12:19:09
Someone asked me yesterday if I did 12:19:11
psychoanalysis, or maybe today, that was 12:19:12
you, there is something called supportive 12:19:15
psychotherapy -- 12:19:18

Q Right. 12:19:20

A -- in which you're there primarily to 12:19:20
support the person and so on and so forth. 12:19:21
But this isn't supportive 12:19:26
psychotherapy. This is helping to manage 12:19:28
the situation. 12:19:33

Q Okay. 12:19:34
How would you term what you're 12:19:35
referring to? You're pointing to in the 12:19:37
article. 12:19:39

A In order to be more specific, I would really 12:19:40
have to get the manual, because there are 12:19:42
different -- there are different support -- 12:19:44
there are different supportive therapies -- 12:19:47
There are different supportive 12:19:50
different ways of providing support in 12:19:55

different psycho -- in different 12:19:59
psychopharmacologic designs. I don't 12:20:00
remember which ones we used. 12:20:03
Just to give you an example of the 12:20:05
differences, there's a manual for a 12:20:08
nonspecific supportive therapy that's used 12:20:10
to test whether cognitive behavioral therapy 12:20:13
is effective. So that's -- that's one type. 12:20:16
And then there's a nonspecific 12:20:19
supportive management procedure in 12:20:22
pharmacologic trials. 12:20:25
There are many of them, but there are 12:20:27
at least -- those would be the two 12:20:29
distinctions. I'm not -- I just don't 12:20:30
remember which of those were used. 12:20:32
Among the different ones, some are 12:20:36
much more active than others in their 12:20:39
approach. 12:20:41
Q Okay. 12:20:42
Well, let me ask you this: You 12:20:46
recognize that case management therapy, as 12:20:47
we've been discussing, can also improve a 12:20:49
person's -- person's depression? 12:20:54
A It may. 12:21:01

Q And, in fact, yesterday, actually, you testified that sometimes when you visit with patients and you're seeing them, you're not actually performing psychotherapy, that you see an improvement with them; is that correct? 12:21:02 12:21:05 12:21:11 12:21:13 12:21:15 12:21:17

A Yes. 12:21:19

But to clarify, I don't believe what I'm seeing is something which is reversing a major depression. 12:21:19 12:21:22 12:21:25

I believe that when -- at least my understanding of what happens, sometimes when people come to see me, because they'll tell me that themselves, that they'll think that I've understood their problems. 12:21:29 12:21:33 12:21:34 12:21:36 12:21:39

They'll think that I have some -- have covered some material that wasn't covered, you know, by the -- by the treating therapist, that I have some ideas, perhaps, of things that they should explore. And they end up -- 12:21:41 12:21:43 12:21:46 12:21:48 12:21:52 12:21:55

It's not universal. It doesn't always happen, but sometimes they end up saying they're feeling more optimistic and 12:21:57 12:21:59 12:22:01

positive that -- that on the basis of this, 12:22:03
they might move forward, and things might 12:22:07
work out better with their therapist. 12:22:10
So they feel better. They feel 12:22:12
better. It's been helpful. 12:22:14
Rarely -- I mean, I can't recall 12:22:16
seeing that I've reversed someone who was in 12:22:18
a very, very bad state and they're all 12:22:21
better. 12:22:25
Q Right. 12:22:26
And you're saying that you've seen 12:22:27
this improvement without actual 12:22:30
psychotherapy? 12:22:34
Is that what you're saying? 12:22:34
A Yes. 12:22:36
Q Okay. 12:22:37
And you've seen it without actual 12:22:37
pharmacotherapy? 12:22:39
A Yes. 12:22:41
Now, it's also true that what makes 12:22:42
it very hard to interpret what that means, 12:22:45
which is why you need to go double-blind and 12:22:48
not just rely on your what your impression 12:22:53
is, is that the natural course of depression 12:22:56

is -- in children and adolescents as well as 12:22:58
in adults, though we now are studying 12:23:03
bipolar disorder in children, is to be one 12:23:07
that's fluctuating so that there's a 12:23:10
confounding, which is why you need to 12:23:14
double-blind and why what the clinician 12:23:16
believes happens with the patient isn't 12:23:18
always -- you know, isn't accepted by a 12:23:22
regulatory body as evidence, because the 12:23:26
onus can fluctuate, can wax and wane. 12:23:31
And you -- given a person that I've 12:23:37
seen -- or yesterday you might have been 12:23:39
feeling really pretty depressed, and today 12:23:41
you may feel better without having seen me 12:23:45
or seen anyone just without there being a 12:23:47
reason that we can understand why. 12:23:50
And that can last for a week or a few 12:23:51
weeks or whatever, and that's known as a 12:23:54
natural course of depression. 12:23:55
Indeed, a high proportion of people 12:23:57
change. You know, their state fluctuates 12:24:00
even without treatment, gets worse, gets 12:24:06
better, so on. 12:24:10
So it just -- that's what confound 12:24:10

being able to -- to interpret with 12:24:11
confidence the meaning of the change agent. 12:24:13
Q Okay. 12:24:18
Just so I'm clear, I understand your 12:24:22
lengthy explanation that you gave. 12:24:24
My question was, you have seen 12:24:31
improvement in individuals who come to visit 12:24:33
you but who you do not treat with 12:24:36
pharmacotherapy, correct? 12:24:39
A I've seen improvement in how they're 12:24:41
feeling. 12:24:43
Q Right. 12:24:45
A I -- I make a distinction between that and 12:24:45
saying -- I don't necessarily mean that 12:24:48
they've recovered -- 12:24:50
Q Right. 12:24:51
A -- from their depression. 12:24:51
Q I'm not suggesting that you've cured them. 12:24:53
A I just wanted to make sure we understand -- 12:24:55
Q Right, okay. 12:24:57
A People mean different things when they say 12:24:58
"improvement." 12:24:59
Q Okay. 12:25:00
The point is, you've seen improvement 12:25:00

with people who visit you who you haven't 12:25:02
provided pharmacotherapy to? 12:25:04

A Yes. 12:25:06

Q And you've also seen improvement with people 12:25:06
who have visited you who you have not 12:25:08
provided psychotherapy? 12:25:11

A Yes. 12:25:13

Q Okay. 12:25:13
Let's look at the article -- 12:25:14
what's -- Exhibit No. 20 -- 12:25:15

MR. GREEN: 29. 12:25:18

Q 29, okay. 12:25:19
And this appears to be -- actually, 12:25:20
can you just read the heading of that? 12:25:24

A "Comments from three JAMA reviewers and 12:25:26
suggested revisions to be made before 12:25:28
submitting to American Journal of 12:25:30
Psychiatry." 12:25:30

Q Okay. 12:25:32
And these comments appear from this 12:25:33
document to be comments on the manuscript 12:25:37
that was submitted to JAMA, correct? 12:25:39

A Yes. 12:25:42

Q Okay. 12:25:42

Now -- 12:25:42

MR. DAVIS: Excuse me, did you mean 12:25:45
JAMA or the other journal? 12:25:46

MR. COFFIN: Well, actually, these 12:25:48
are comments from three JAMA reviewers, as 12:25:49
he just read; but it appears -- 12:25:53

MR. GREEN: Oh. 12:25:56

MR. COFFIN: -- that the comments 12:25:57
from the JAMA reviewers were used to then 12:25:58
create a submission to the American Journal 12:26:02
of Psychiatry. 12:26:04

BY MR. COFFIN: 12:26:05

Q Is that correct? 12:26:05

A I'm not sure if that's true. 12:26:08

Because, see, what happened is -- I 12:26:11
don't know if it was submitted to the 12:26:13
American Journal. If you know, you can tell 12:26:15
me. 12:26:17

But what -- what JAMA often does is 12:26:17
they often -- they often, actually, offer to 12:26:22
sent it along to another journal for you. 12:26:29

There's a -- there's a consortium of 12:26:33
journals under the aegis of the American 12:26:36
Medical Association. So oftentimes JAMA 12:26:38

will say we think this is appropriate for this journal. And, indeed, it -- here's the -- these are the suggestions made by our reviewers, and you might want to go ahead and take those and send it to that journal. 12:26:42 12:26:44 12:26:47 12:26:49 12:26:51

I don't know that we went ahead and did that next. We might have decided instead to just not take their suggestion and just submit it to the JA -- journal that it was published in. 12:26:53 12:26:56 12:26:59 12:27:03 12:27:10

I just don't remember. 12:27:11

(Exhibit No. 30 marked for identification.) 12:27:12 12:27:12

BY MR. COFFIN: 12:27:12

Q Okay. 12:27:12

Let me ask you to take a look at Exhibit 30, and maybe we can clear this up. And take a read over that. 12:27:13 12:27:15 12:27:19

(Witness read document.) 12:27:21

MR. DAVIS: Chris, is that the letter from JAMA to Dr. Keller? 12:27:40 12:27:41

MR. COFFIN: That's the letter -- no, actually, I don't believe that's correct. He'll show it to you when he's done. 12:27:44 12:27:45 12:27:47

A Should I hand it -- 12:27:57
Q Sure. 12:28:00
MR. DAVIS: Thank you, Doctor. 12:28:01
(Counsel read document.) 12:28:07
MR. DAVIS: Thank you. 12:28:08
MR. COFFIN: Okay. 12:28:09
MR. MURGATROYD: Did you dedesignate that one? 12:28:11 12:28:13
MR. DAVIS: It's been accidentally designated subject to the confidentiality order. We withdraw it. 12:28:13 12:28:14 12:28:17
MR. COFFIN: Okay. 12:28:18
BY MR. COFFIN: 12:28:18
Q Dr. Keller, that's letter, correct? Appears to be? 12:28:19 12:28:22
A Yes. 12:28:23
Q Okay. 12:28:23
And who is the letter to and from? 12:28:23
A It's to Jim McCafferty from Sally Laden. 12:28:26
Q Okay. 12:28:31
And are you referenced in that letter? 12:28:31 12:28:33
A Yes. 12:28:34
Q Okay. 12:28:34

Does this refresh -- refersh your recollection as to submissions that were made to JAMA? 12:28:37 12:28:38 12:28:43

A No. 12:28:44

Q Okay. 12:28:45

Well, just -- how about this. Just read the first paragraph. 12:28:45 12:28:47

A Okay. 12:28:49

"Enclosed is the draft rebuttal to the JAMA reviewer comments for PAR329. As was agreed in the conference call with Drs. Keller, Ryan and Strober on November 15, we will seek -- we will, one, seek approval from the authors on the plan revisions to be made. Two, we will make the revisions. And three, we will submit the manuscript to the -- to American Journal of Psychiatry." 12:28:49 12:28:52 12:28:57 12:28:59 12:29:02 12:29:04 12:29:07 12:29:10 12:29:13

Q Okay. All right. 12:29:15

So now let's look back and -- at the document that was marked prior to that which is comments from the three JAMA reviewers. 12:29:16 12:29:21 12:29:23

A Yes. 12:29:26

Q Now, if you read that in conjunction with the letter that I just put in front of you, 12:29:26 12:29:28

it appears, does it not, that these -- there 12:29:33
are suggested revisions to the article based 12:29:38
on comments from JAMA reviewers, correct? 12:29:43

A Yes. 12:29:45

Q Okay. 12:29:46

Let's look at Reviewer No. 1, if you 12:29:47
could turn to that page. I believe it's 12:29:53
page 2. 12:29:57

Are you on -- 12:29:58

A So done. 12:30:01

Q Okay. 12:30:01

Could you please read -- have you 12:30:02
read over this paragraph? Look at No. 1 12:30:04
under Reviewer No. 1. 12:30:06

A Okay. 12:30:11

Q Look at the sixth line down, begins with 12:30:20
"readers of this paper." 12:30:22

Could you please read that into the 12:30:24
record? 12:30:26

A "Readers of this paper might receive the 12:30:26
wrong impression and believe that a 65 to 70 12:30:29
percent response rate could be achieved with 12:30:33
paroxetine without the education and support 12:30:36
of psychotherapy that the placebo-treated 12:30:37

patients in the study received." 12:30:41
Q Go ahead and continue. 12:30:44
A "That outcome is particularly worrisome in this area of health cost containment. Thus, this study could do more harm than good unless the authors devote much more attention in their discussion to the fact that the bulk of the effect of the study was the result of good clinical management and not the medication." 12:30:44 12:30:47 12:30:50 12:30:53 12:30:55 12:30:56 12:30:58 12:31:00
Q Okay. 12:31:01
Now, do you agree that -- with this reviewer from JAMA that -- with the statement that he makes or she makes that this study could do more harm than good unless the authors devote more attention in their discussion to the fact that the bulk of the effect of the study was the result of good clinical management and not the medication? 12:31:04 12:31:08 12:31:12 12:31:13 12:31:18 12:31:20 12:31:22 12:31:25 12:31:27
A I disagree strongly. 12:31:28
Q Okay. 12:31:30
And I assume you disagree with the JAMA reviewer's comment that the bulk of the 12:31:31 12:31:33

effect of the study was the result of good 12:31:36
clinical management and not the medication? 12:31:39

A Right. The reviewer has no -- there's no 12:31:42
scientific basis to support what this 12:31:44
reviewer said. 12:31:46
The only way that he could 12:31:47
possibly -- that that could be supportive is 12:31:48
if you did a controlled -- if you had two -- 12:31:50
if you had two different types of 12:31:52
nonpharmacologic activities going on so that 12:31:56
if you -- if you had a multicell design and 12:31:59
some people received the -- what's described 12:32:04
as the -- you know, whatever type of 12:32:07
management we gave and another group, you 12:32:11
know, received nothing, that's the only way 12:32:13
you could parse out and determine whether it 12:32:15
had an effect. 12:32:18
So this is an ill-informed statement 12:32:19
scientifically. 12:32:21

Q Well, wouldn't it also be true that you 12:32:26
can't make a statement as to whether or not 12:32:28
the psychotherapy or the supportive case 12:32:30
management contributed significantly or did 12:32:33
not contribute significantly to the effect 12:32:35

of the stuff that's shown in the study? 12:32:38

MR. DAVIS: Object to the form. 12:32:42

A What you're saying is partially correct. 12:32:52

Q Okay. 12:32:56

The distinction is -- which is -- 12:32:57

First of all, we did say in the manuscript that a probable contributing factor was a -- weekly supportive case management sessions which may have contributed to the clinical improvement of patients in the placebo and active treatment group. 12:32:59 12:33:01 12:33:03 12:33:05 12:33:07 12:33:08 12:33:12

So the pertinent thing, Chris, which I believe is responsive to your question to me, is that -- that subjects in both the placebo group and the active medication group received, you know, what we're assuming was a similar -- the same type of supportive case management treatment. 12:33:13 12:33:18 12:33:20 12:33:27 12:33:30 12:33:34 12:33:37

Despite that, there was still a difference between the two groups. So that on whole, there was an effect of the medication relative to placebo that was statistically significant on the -- in the 12:33:40 12:33:42 12:33:46 12:33:51 12:33:54

four depressive measures that we've talked about. 12:33:58 12:34:00

Now -- so that -- so that's where -- that's where the value of the medication is shown. 12:34:02 12:34:08 12:34:10

Now, it is correct that the both -- the placebo both -- the subjects on either placebo or medication may well have received meaningful benefit from the psycho -- from the case management, but even with that benefit, they were -- they were significantly better off to have received the medication and the management compared to placebo and the management. 12:34:11 12:34:14 12:34:17 12:34:22 12:34:25 12:34:32 12:34:34 12:34:36 12:34:39

Q But you don't actually know that -- 12:34:42

A Yes, you do. 12:34:44

Q -- as you just testified, because -- 12:34:44

A No. Of course you do. Of course you do. 12:34:46

What I'm saying is -- 12:34:48

Q Well, you don't know the effect that the -- that the psychotherapy or case management had on each individual patient? 12:34:49 12:34:51 12:34:52

A But that's not -- that's not relevant here. The relevant thing is in measure -- in 12:34:54 12:34:56

making a judgment as to whether medication, 12:35:00
in this case, paroxetine, was beneficial 12:35:05
relative to placebo. 12:35:12

The fact that the subjects on placebo 12:35:13
and -- I should talk to the jury. I'm 12:35:17
sorry. I shouldn't be looking at you guys. 12:35:20
I don't mean to be rude 12:35:22

But the fact that the -- that the 12:35:24
subjects in the study on the placebo and 12:35:26
paroxetine both -- all received the same 12:35:30
type of supportive treatment and yet there 12:35:35
was still a difference between the 12:35:39
medication and placebo that was 12:35:40
statistically significant is an indication 12:35:41
of the efficacy of the treatment for 12:35:45
depression in adolescents in this trial. 12:35:49

It doesn't matter -- you know, to 12:35:54
whatever extent the -- the supportive 12:35:59
treatment contributed -- I can't tell -- we 12:36:01
can't -- we can't say -- 12:36:04

A goal of this study was not to say 12:36:06
how much of the effect was a result of the 12:36:09
case management sessions. But taking 12:36:16
into -- that into consideration, we still 12:36:22

saw a statistically significant difference. 12:36:24
Is that clear? 12:36:27
Q I understand what you're -- I understand 12:36:28
your response. I understand your response. 12:36:30
So you -- you disagree with the 12:36:33
statement that the bulk of the effect of the 12:36:37
study was the result of good clinical 12:36:39
management and not medication? 12:36:41
A Absolutely. There's no basis to say this. 12:36:42
Q Well, when the reviewer -- in the normal 12:36:45
course and practice, is it your 12:36:49
understanding that a reviewer for a journal 12:36:51
article like JAMA reviews the manuscript and 12:36:54
the data that you provide in the manuscript? 12:37:00
A I sure hope so. 12:37:04
Q You would think so, right? 12:37:07
That's why they're called a reviewer, 12:37:08
correct? 12:37:09
A Right. 12:37:10
On the other hand, sir, as an editor 12:37:11
of several journals and as someone who has 12:37:14
published probably 400 articles, I see 12:37:20
reviews as an editor that are absolutely 12:37:23
totally off base. 12:37:25

Moreover, just -- perhaps not to -- not to -- if you were to say to me how do you know they're off base, I often get totally contradictory reviewers. 12:37:29 12:37:31 12:37:33 12:37:35

So as an editor when I send a manuscript out to anywhere between three and seven people, depending upon the manuscript, I'll get one reviewer whichd that says, Accept as-is. You know, the greatest thing since sliced bread. And I'll get another reviewer which is highly critical, rips it to shreds and says, Don't accept. I don't want to see it again. 12:37:37 12:37:40 12:37:42 12:37:44 12:37:46 12:37:49 12:37:52 12:37:55 12:37:58

And you can get those opinions on the same article. 12:37:59 12:38:00

Q Do you discount either of those opinions? 12:38:01

A Sometimes. 12:38:03

Q Okay. 12:38:05

And on what basis? 12:38:06

A Well, as the editor, I have to move forward with life and make a judgment, and I then -- and the reason -- 12:38:09 12:38:11 12:38:17

You know, I just have to weigh it out. 12:38:18 12:38:19

Q You consider both of them, correct? 12:38:19
A I certainly consider them. I don't always agree with them. 12:38:21 12:38:25
But -- but what I want to make clear is, the fact that any given reviewer has a criticism of an article or a grant, for that matter, which is -- which is very consistent with the same line of thinking, and that a grant -- 12:38:26 12:38:28 12:38:30 12:38:34 12:38:38 12:38:42
You know, an article can be turned down by three journals and end up being, you know, a prize-winning article, if you will. It can go down as having a major positive impact in the field. 12:38:42 12:38:43 12:38:47 12:38:49 12:38:52
A grant can be turned down three times before it's funded on then go on and produce science which is fantastic. 12:38:53 12:38:54 12:39:00
So the fact that something is criticized, A, doesn't mean the criticism is valid; and, B, doesn't mean that with some modification after in response to the criticism, either partial or complete, you don't have something which is the better product for it. 12:39:03 12:39:05 12:39:08 12:39:10 12:39:13 12:39:16 12:39:17

So I just hope that's -- you understand it. 12:39:20 12:39:22
Q You recognize that in clinical practice, individuals who are receiving antidepressant therapy don't usually have weekly supportive therapy that goes along with that? 12:39:23 12:39:27 12:39:32 12:39:35
A I don't know that that's true. 12:39:36
In -- in my own practice, however currently limited, but at one point in my career after I was done with my training, I saw as many as 20 hours of patients a week. 12:39:41 12:39:46 12:39:51 12:39:54
I saw people -- I pretty much -- I pretty much saw everybody on as close to a weekly basis as possible, even if they were also on medication. 12:39:57 12:40:01 12:40:04 12:40:06
I happen to think that's the ideal way for patients to be treated. 12:40:09 12:40:12
Q Are you familiar with the prescribing practices of general practitioners with regard to antidepressant therapy? 12:40:13 12:40:16 12:40:20
A I don't know what you mean by am I familiar. 12:40:29
Q Have you read literature or have you heard presentations regarding the prescribing habits of general practitioners in -- with 12:40:31 12:40:37 12:40:39

using antidepressants? 12:40:43

A I haven't read literature or heard 12:40:45
presentations about the prescribing, 12:40:52
whatever word you used, practices of general 12:40:57
practitioners. 12:40:58

Q Okay. Okay. 12:40:59
What's your -- what's your general 12:41:00
understanding of the prescribing practices 12:41:04
of general practitioners with regard to 12:41:06
antidepressant therapy, if you have an 12:41:09
understanding? 12:41:14

A I know that a meaningful proportion -- and I 12:41:19
can't tell you what, but a meaningful 12:41:21
proportion of antidepression medication is 12:41:23
prescribed by general medical physicians, be 12:41:33
it an internist, a family practice doctor or 12:41:40
a primary care doctor. 12:41:43

Q Does that include prescriptions to children 12:41:45
and adolescents? 12:41:48

A I don't know that. 12:41:49
It's my impression -- actually, based 12:41:54
on an experience of one, when I once gave a 12:41:56
talk to the American Academy of Family 12:42:01
Practitioners, that just during the question 12:42:05

and answer -- and I can't tell you how long 12:42:10
ago it was, when it was. It was warm in the 12:42:13
winter. 12:42:17

And it was their academy meeting and 12:42:17
they asked me to talk about depression and I 12:42:20
was talking generally, and I do know that I 12:42:22
just remember -- it just made an impression 12:42:30
on me that they were -- felt far more 12:42:32
comfortable seeing and treating adults than 12:42:36
they did adolescents. 12:42:38

Now, of course, I do know that within 12:42:40
family -- within general medicine, there is 12:42:42
a specialty called adolescent medicine so 12:42:44
that certainly, you know, primary care 12:42:46
doctors do -- can choose to get training in 12:42:49
adolescent medicine, so I don't think it was 12:42:52
that group. 12:42:55

But I think those that don't have -- 12:42:55
you know, those general medical 12:42:57
practitioners who don't have specialty 12:42:59
training I think are less comfortable, it's 12:43:02
my impression, in treating adolescents and 12:43:04
children with mental illness than they are 12:43:10
in treating adults. 12:43:12

Q How about with regard to individuals practicing psychiatry, what is your impression of the prescribing habits they have they have with regard to prescribing antidepressants to children and adolescents? 12:43:17 12:43:19 12:43:21 12:43:25 12:43:30
A Please be more specific, Chris, in asking the thing about prescribing habits. 12:43:32 12:43:35
Q Yes. 12:43:44
Have you ever read any literature or heard any presentations discussing the -- discussing the prescribing practices of psychiatrists with regard to antidepressants to children and adolescents? 12:43:44 12:43:46 12:43:59 12:44:01 12:44:08
A A long time ago in the 1980s I wrote an article myself on the use -- this isn't the exact title, but it's something to the effect of the use of anti -- the treatment of antidepressants, and it might have said adolescents or children, or something to that effect. It might have actually been published in this very same journal. 12:44:19 12:44:24 12:44:31 12:44:33 12:44:35 12:44:40 12:44:41 12:44:43
And at the time I reviewed the literature, and what stands out in my mind -- because it's consistent with a body 12:44:46 12:44:53 12:44:56

of work that I've published over the 12:45:01
years -- was what I call to be the 12:45:03
undertreatment of depression for everybody 12:45:07
who's depressed. 12:45:08

But in this case, and I can't quote 12:45:09
you the amount, I was stunned that I had -- 12:45:11
in my study, because I -- I mentioned to you 12:45:15
all yesterday that I was the coprincipal 12:45:18
investigator on the cohort of offspring of 12:45:21
parents who had mood disorders, and we were 12:45:24
studying the offspring, some of whom were 12:45:28
children; and we looked at those who were 12:45:32
depressed and simply recorded, you know, 12:45:36
what treatments they received. 12:45:38

And I was stunned that something like 12:45:39
less than ten percent of some combination in 12:45:41
this study, of children and adolescents who 12:45:46
were depressed -- this is back in the 12:45:48
1980s -- were receiving any type of 12:45:50
treatment for their depression, let alone an 12:45:53
antidepressant. 12:45:56

And I do remember at the time 12:45:57
reviewing whatever literature there was, 12:45:59
and -- it was extremely sparse -- and being 12:46:03

stunned at how much undertreatment there 12:46:07
was. 12:46:10

In response to your question about 12:46:11
prescribing practices, you know, in general 12:46:13
I've published several articles which have 12:46:16
had wide -- have been read widespread and 12:46:19
translated into many languages on, quotes, 12:46:22
the undertreatment of depression. 12:46:26

And circa, you know, the last major 12:46:27
piece of work I did in the late 1990s, my 12:46:30
conclusion which was published, so I don't 12:46:34
know if the reviewers agreed in that case, 12:46:38
was that less than ten percent of people 12:46:41
suffering from major depression in the 12:46:43
United States and worldwide received even 12:46:45
one course of an antidepressant in an 12:46:47
adequate dose for a sufficient duration. 12:46:51

And now as part of that, because it 12:46:53
comes back to me, we looked -- we also 12:46:57
reviewed what was done in general medical 12:47:00
practice and not just psychiatry, the lion's 12:47:02
share, if not all, had to do with adults, 12:47:05
because that was in the literature. 12:47:09

But underprescription is a major 12:47:11

problem, in my judgment. 12:47:13
Q Right. 12:47:14
And since the 1980s when you were 12:47:14 discussing about it and the advent of SSRIs 12:47:19 and new therapies -- 12:47:23
A Hasn't changed. 12:47:24
I'm sorry, you didn't finish your 12:47:25 question. 12:47:28
Q And do you believe that there's an increased 12:47:28 amount of prescribing of antidepressants 12:47:30 than there was in the '80s? 12:47:34
A A lot of -- so a number of things point to 12:47:37 that; but when we did our most recent study, 12:47:42 which was an NIH consensus conference at 12:47:44 which I chaired in the late 1990s, we found 12:47:47 no -- we did not find a difference. 12:47:51
And this was published in JAMA, in 12:47:53 fact, in 19 -- I think it was published in 12:47:56 JAMA -- you could look it up. It was in the 12:47:59 late 1990s. 12:48:01
It was a lead article in JAMA on 12:48:02 the -- it was called the treatment of the 12:48:04 depression that was from a consensus 12:48:06 conference, and the conclusion then was -- 12:48:09

So the SSRIs have been available since December of 1987. So approximately ten years later, we still found that approximately ten percent of people with major depression had only received one course of adequate dose of sufficient duration. 12:48:13 12:48:17 12:48:20 12:48:23 12:48:25 12:48:28 12:48:31

Q Let me turn you to -- 12:48:32

A It's a major problem in society. 12:48:34

Q Let me turn you to page 3 of this document that's in front of you. It's the JAMA reviewers' comments. 12:48:37 12:48:40 12:48:47

Do you see No. 6? 12:48:49

Could you please read that into the record? 12:48:54 12:48:56

A "The high dose of imipramine employed in this study likely also comprised the blind." I'm not familiar with the word comprised, the definition. 12:48:57 12:48:59 12:49:04 12:49:07

Q Do you believe that might be an error? 12:49:08

A I don't know, frankly. I just don't know. 12:49:09

Q Would it make sense that maybe that sentence should be read -- should read, "This study also likely compromised the blind"? 12:49:12 12:49:14 12:49:17

A Could be. Just don't know. 12:49:20
"The authors do not address this 12:49:22
issue. However, the anticholinergic adverse 12:49:24
events cited in Table 5 are such that one 12:49:29
would expect the authors should have been 12:49:32
able to determine who was on imipramine with 12:49:33
reasonable certainty." 12:49:35
Q Do you disagree with that statement? 12:49:37
A Absolutely. 12:49:39
Q Okay. 12:49:40
A There is evidence and studies have been 12:49:40
done -- I can't tell you exactly where in 12:49:42
the literature -- that have actually made an 12:49:48
effort to have both the -- both subjects in 12:49:51
research studies as well as the 12:49:54
investigators guess what treatments that 12:49:55
they're on based on the presumptive adverse 12:49:59
events. 12:50:03
And the results have been stunning, 12:50:03
that typically people guess no better 12:50:09
than -- much better than 50 percent as to 12:50:12
whether they're on placebo or active 12:50:14
treatment or whether they can differentiate 12:50:16
treatments. 12:50:19

So there is a literature which shows 12:50:19
that despite what you would believe to be 12:50:23
sufficient enough differences in package 12:50:27
inserts that people can guess, that they're 12:50:28
not accurate in guessing what treatment 12:50:32
condition they're under. 12:50:34
Otherwise, the blind would be so 12:50:36
highly compromised, because, as you may be 12:50:38
aware, when the FDA makes a judgment as to 12:50:41
whether a treatment should be approved for 12:50:44
any disease in medicine, but here let's just 12:50:48
stick to depression, the comparisons are 12:50:51
between an active drug and placebo. 12:50:53
And since that -- so -- so this is a 12:50:55
very -- this -- 12:51:04
Q Let's look at Reviewer No. 2. Starts on 12:51:07
page 5. 12:51:17
I'd like to look at the second 12:51:25
comment, which I believe starts at the 12:51:28
beginning, top of page 6. 12:51:32
A "The strength of the study is that it is a 12:51:35
first replication of the efficacy of 12:51:37
antidepressant in treatment" -- 12:51:40
Q Top of page 6, "The study"? 12:51:41

A Oh, the second -- hold on. 12:51:47
Q I just want you to -- you can read that to 12:51:56
yourself. 12:51:58
A No, no. I had two pages stuck together, 12:51:59
so -- 12:52:01
MR. DAVIS: How is everyone holding 12:52:01
up in terms of lunch break? 12:52:02
MR. MURGATROYD: I think we've got -- 12:52:04
as soon as we finish this document, we 12:52:05
should take a break. 12:52:07
MR. COFFIN: Yes. We can do that. 12:52:08
MR. DAVIS: Sure. 12:52:10
If that's okay with Dr. Keller and 12:52:10
his counsel, it's fine with us. 12:52:12
THE WITNESS: Getting weak. Depends 12:52:15
how much time we need. 12:52:16
MR. COFFIN: No, that's -- there's 12:52:16
only a few more pages, so... 12:52:16
THE WITNESS: Either that or we just 12:52:16
go straight through without eating. 12:52:17
MR. MURGATROYD: No, no. 12:52:20
(Laughter.) 12:52:20
BY MR. COFFIN: 12:52:20
Q Okay. 12:52:20

Just read to yourself that first paragraph on the top of page 6. I'll ask you a few questions about it. 12:52:20 12:52:21 12:52:24

(Witness read document.) 12:52:32

A I read it quickly, so... 12:53:25

Q Okay. 12:53:27

Look at the sentence that starts about the middle of the paragraph. It says, "In fact"? 12:53:27 12:53:28 12:53:31

A Okay. 12:53:34

Q Can you read that, please? 12:53:35

A "In fact, it is troubling that the authors do not note a significant increase in SAEs" -- 12:53:36 12:53:39 12:53:43

Q Which means -- Which means what? Do you know what SAEs means? 12:53:46 12:53:49

A Adverse events. I'm blocking on the S. 12:53:51

Q Serious adverse events. 12:53:54

A Serious adverse events. "After paroxetine but not imipramine." 12:53:56 12:53:59

Wait. And, "In fact, it is troubling that the authors do not note a significant increase in serious -- in SAEs after paroxetine (but not imipramine) relative to 12:54:00 12:54:03 12:54:05 12:54:07

placebo (P less than .05) by Fisher's exact test." 12:54:10 12:54:17

Q Okay. 12:54:18

So this reviewer finds it obviously -- "troubling" the word he or she uses that you as the authors didn't note the significant increase in serious adverse events after paroxetine use, correct? 12:54:19 12:54:23 12:54:26 12:54:28 12:54:30

MR. DAVIS: Objection to form. 12:54:32

Q Is that how you read it? 12:54:35

A Say that again, please? 12:54:38

Q Do you read that this reviewer's concern is that you as the authors did not note the signature increase in serious adverse events that individuals in the study experienced after taking Paxil? 12:54:39 12:54:44 12:54:48 12:54:51 12:54:54

A Relative to the placebo. 12:54:57

Q Right. 12:54:58

A Yes. That's what the person said. 12:54:59

Q Okay. 12:55:00

And -- and did you find in your read of the data obtained from Study 329 that there was a significant increase in serious adverse events after individuals used Paxil? 12:55:01 12:55:06 12:55:10 12:55:12

A I'd have to go back to the article, but -- but my gestalt memory is that, as we concluded in the manuscript which was published in the Journal of the America Academy of Child and Adolescents Psychiatry, that paroxetine is generally well tolerated and effective for major depression in adolescents. So generally well tolerated.

And if I go back to the adverse events section, I don't think we were concerned based on our findings about serious adverse events.

And I would point out to you again that each reviewer is a reviewer. They're not necessarily, you know, a qualified, you know, expert anymore so than anyone else.

Indeed, one of the biggest problems journals have today is finding people to review articles.

I typically have to send an article out to 15 people before I can get three people to agree to review them.

It's very tough.

Q I understand.

A So that the quality of the people of the reviews are mixed. 12:56:24 12:56:26
Q Okay. 12:56:27
A So if I get to the -- let me look at the adverse events. 12:56:28 12:56:31
Q Let me ask you this question: 12:56:32
A One second, please. 12:56:34
Q Well, there's no question pending. You've already answered my other question. 12:56:36 12:56:38
A Well, yes, my answer is I disagree. And as we state here, most -- most adverse events were not serious. 12:56:40 12:56:44 12:56:46
Q Most adverse events were not serious, okay. 12:56:47
Do you believe that a fivefold increase in serious adverse events over a placebo is considered a significant increase in serious adverse events over placebo? 12:56:49 12:56:50 12:56:53 12:56:58
MR. DAVIS: Object to the form. 12:57:01
A It depends on the sample size. 12:57:05
Q Well, let's take the sample size in Study 329. 12:57:07 12:57:09
There was 275, correct, total in the study? 12:57:10 12:57:17
A If you could please be more specific about 12:57:17

which adverse events you're referring to? 12:57:20

Q Well, let me ask you this: 12:57:26

Do you know what a serious adverse event is? 12:57:28 12:57:30

(Witness read document.) 12:57:33

A Yes. 12:57:35

Q Okay. 12:57:35

I'm referring to serious adverse events, and that's a term of art that's used commonly in clinical studies, correct? 12:57:38 12:57:40 12:57:42

A Yes. 12:57:45

The problem with the term of art is that it's art and not science, so that the meaning is very variable. 12:57:46 12:57:47 12:57:53

Q All right. 12:57:54

Well, let's -- 12:57:54

A That's why I asked you to get specific. 12:57:55

Q All right. 12:57:58

Well, I want your definition of a serious adverse event. Don't you use that -- 12:57:58 12:58:01 12:58:03

A I consider it to be a catch phrase category that has -- doesn't have -- that is -- that is very -- it's a very -- 12:58:05 12:58:08 12:58:15

I consider it to be a very poor descriptive category. It's a -- it's a -- you know, it's a bucket that things -- it's a bucket category, and that in order for it -- 12:58:17 12:58:21 12:58:23 12:58:26 12:58:28

In order to be meaningful, you need to look at the individual event and to see what, in fact, the event is. 12:58:29 12:58:32 12:58:34

Q Okay. 12:58:38

A You can take, for example, a digestive system here and take diarrhea, and diarrhea can be not a big deal, but diarrhea can be the entire day. It can be totally disabling as somebody, you know, with, you know, Crohn's Disease would have. 12:58:39 12:58:41 12:58:43 12:58:46 12:58:49 12:58:53

So it can totally -- it can keep you house -- diarrhea can keep you housebound, or it can just be annoying. 12:58:55 12:58:58 12:58:59

So it -- 12:59:02

Q Okay. I understand what you're saying. 12:59:03

On page 769 of the article that you published, do you see the top left paragraph says, "Serious adverse events occurred." 12:59:04 12:59:07 12:59:11

Do you see that sentence? 12:59:14

A Yes. 12:59:15

(Telephone interruption.) 12:59:17

THE WITNESS: Can we take a break for a second? 12:59:23 12:59:24

Q You need to answer that call? 12:59:25

A It's my daughter. Can I take break for a second? 12:59:27 12:59:29

MR. COFFIN: Okay. 12:59:30

Why don't we go off the record? 12:59:30

THE VIDEOGRAPHER: The time is 2:00. We're off the record. 12:59:33 12:59:36

(Luncheon recess.) 12:59:40

THE VIDEOGRAPHER: We are back on the record. The time is seven minutes after 2:00. This is Tape 3. 02:05:22 02:05:31 02:05:34

BY MR. COFFIN: 02:05:36

Q Okay, Dr. Keller, when we left for our lunch break, we were talking about serious adverse events, and I had referred you to page 769 of the article that you published. 02:05:37 02:05:41 02:05:44 02:05:47

You see there where it says -- refers to "Serious adverse events occurred in 11 patients in the paroxetine group, five in the imipramine group and two in the placebo 02:05:49 02:05:51 02:05:54 02:05:56

group."

Do you see that?

A Yes.

Q Okay.

And so when you authored this article, you clearly had a definition of serious adverse events in mind, correct?

A As I -- as I said earlier, it's a -- -- the -- it's a -- it's just a bucket. It's just a -- it's a rough category, and I don't think there is --

You know, I don't think there's a scale. I don't think there's a serious scale that enables you to make a cutoff and distinguish.

I think it's much more of an impressionistic thing. And the reason why that's I think so relevant is like when you say summarizing in grouping, like the sentence that you just read, serious adverse events, 11 patients, and if I look at it, they're spread over a wide variety of categories of different organ systems.

So that what might be a serious

02:05:59 02:06:00 02:06:01 02:06:01 02:06:02 02:06:06 02:06:08 02:06:14 02:06:17 02:06:20 02:06:26 02:06:29 02:06:30 02:06:35 02:06:37 02:06:38 02:06:39 02:06:41 02:06:44 02:06:47 02:06:51 02:06:55 02:06:58 02:07:01

event, you know, in one organ in the system 02:07:03
may not be very relevant -- 02:07:08
I don't need to answer this unless 02:07:11
it's a -- 02:07:13
(Telephone interruption.) 02:07:13
A What may not be so relevant, you know -- 02:07:14
This -- you know, how you would 02:07:17
define it would be different. I gave you an 02:07:18
example of diarrhea, and so it's -- and 02:07:20
so -- 02:07:22
Q Well, certainly it would be defined in the 02:07:23
protocol for the study that you did, 02:07:25
correct? 02:07:27
A Even that, it's -- if we -- if we got the 02:07:29
protocol, if you -- if you would get it, I 02:07:31
would be happy to read it and then go 02:07:36
through individual events with you -- 02:07:37
individual types of events, because what I'm 02:07:39
trying to say, it's so different -- 02:07:44
Q All right. 02:07:46
A In other words, a serious cardiovascular 02:07:47
adverse event, you know, would be different 02:07:50
than a serious case of diarrhea. 02:07:52
Q Okay. 02:07:56

Let me -- let me just ask you this. 02:07:56
A I'm not saying necessarily -- not just worse or better, but just so different. 02:07:59 02:08:01
Q Okay. 02:08:03
You see Exhibit 14 which has been marked in this case, and it is the -- it's actually the protocol, final protocol for Study 329. 02:08:03 02:08:05 02:08:09 02:08:11
A Okay. 02:08:15
Q If you refer to 7.5.1, do you see where that defines a serious adverse event? 02:08:15 02:08:20
A I can read it to myself or -- 02:08:27
Q Sure. 02:08:28
(Witness read document.) 02:08:29
A Yes. 02:08:46
Q Okay. 02:08:46
A See, this definition in here is so variable that it's extraordinary. That's why I think of it as a bucket that doesn't mean much until you go after the individual. 02:08:46 02:08:51 02:08:53 02:08:57
So if you take the first sentence, "A serious adverse event is any event which is fatal, life-threatening, disabling, incapacitating or results in 02:08:58 02:09:01 02:09:03 02:09:06

hospitalization."                                                    02:09:08

Okay, those sound really bad, right?                                 02:09:09

"In addition, any experience which the investigator regards as serious or which would suggest a significant hazard, contraindication, side effect or precaution with reuse of the drug may be reported as serious."    02:09:12 02:09:16 02:09:18 02:09:21 02:09:24 02:09:27

So if I said something, you know, is a, you know, a side effect, meaning, you know, meaning that I'm developing a tremor when I take the drug, that's so different than a fatality or something which is life-threatening but with something which is disabling, that the category I don't -- is not --    02:09:27 02:09:33 02:09:36 02:09:40 02:09:45 02:09:47 02:09:51 02:09:54

It's too general to be meaningful, in my opinion.    02:09:55 02:10:00

Q Well, this is --    02:10:01

A There should be -- there should be -- the distinctions should be much finer.    02:10:02 02:10:04

Q Okay.    02:10:06

And the protocol you're looking at in that exhibit is a protocol for 329, correct?    02:10:07 02:10:08

A Yes. 02:10:12
Q And that's a scientific study, correct? 02:10:12
A Yes. 02:10:16
Q Okay. 02:10:16
And so it's your goal in the 02:10:17
scientific study to have the investigators 02:10:21
all be on the same pages with regard to what 02:10:24
variables are being measured, correct? 02:10:29
A Yes. 02:10:31
Q And you want all the scientists to also 02:10:32
understand and have the same definition of a 02:10:34
serious adverse event, correct? 02:10:37
A Yes. 02:10:41
Q Okay. 02:10:43
A But the category here and the convention -- 02:10:43
and the convention that's used, in my 02:10:44
opinion, is not useful at all. 02:10:50
Q Okay. 02:10:53
A It's useful -- I don't want to be 02:10:53
misinterpreted to say it's -- it's 02:10:55
essential. It's essential to know if 02:10:58
something is fatal. It's essential to know 02:11:02
if it's life-threatening. It's essential to 02:11:04
know if it's disabling; and, yes, it's 02:11:07

essential to know whether it's a side effect 02:11:09
or precaution. 02:11:12
But those are so different that I 02:11:12
don't think it's -- I don't -- it's the 02:11:14
interpretation of it. 02:11:17
In other words, I can understand why 02:11:18
you want to pick up and grab everything that 02:11:20
looks like it might be important and dump it 02:11:22
in a pot; but when you then go to interpret 02:11:24
it and analyze it, you have to separate out 02:11:27
the individual events, as we did in the 02:11:30
manuscript on page 769, where I believe you 02:11:34
either asked me to read the first sentence 02:11:40
or you read it for me, in which you said 02:11:41
there were serious adverse events in 11 02:11:44
patients in paroxetine, five in imipramine 02:11:46
and two in placebo, and then we go on to 02:11:49
give, you know, with a number -- we describe 02:11:52
the event and give the number of patients 02:11:56
with that event. 02:11:59
That's where I believe it becomes 02:12:01
meaningful. And if you look at those, 02:12:04
you'll see how varied they are. 02:12:06
So five serious events in the 02:12:09

imipramine group consisted of a 02:12:11
maculopapular rash -- 02:12:12
Q All right. 02:12:15
I don't need you to go through each 02:12:15
and every one. 02:12:17
A I'm just trying to -- I think this is -- you 02:12:18
know, to the extent that this is such a -- 02:12:19
an important matter with regard to the issue 02:12:23
at hand and a matter with regard to 02:12:29
interpreting and understanding what you're 02:12:32
asking me, I just -- I just want -- I just 02:12:34
want to be clear. 02:12:37
Q You want to explain. I just don't want to 02:12:37
go through every specific -- 02:12:39
A All right. 02:12:40
Q We'll be here for five more days if we have 02:12:41
to go through all the specific things on 02:12:43
every question. 02:12:45
A I didn't know you could stay. 02:12:45
Q I might. I might have to. 02:12:49
(Laughter.) 02:12:50
A Cancel his flight. 02:12:51
Q Let me ask you this: 02:12:55
Were you aware -- first of all, do 02:12:56

you -- are you familiar with the term 02:12:58
"suicidality"? 02:13:00
A Yes. 02:13:01
Q Okay. 02:13:01
And were you aware that the results 02:13:02
from Study 329 found a fivefold increase in 02:13:06
suicidality in adolescents involved in the 02:13:10
study? 02:13:14
MR. DAVIS: Object to the form. 02:13:14
It's vague and ambiguous. 02:13:17
A Yes. You know, there again, maybe you can 02:13:19
tell me where I could find it in the paper. 02:13:30
Q I'm asking you if you're aware -- 02:13:32
A I don't remember the specifics. 02:13:34
Q Okay. 02:13:35
Well, have you at any time been 02:13:35
informed through literature, presentations, 02:13:37
speaking with colleagues that the results of 02:13:39
Study 329 indicated that those adolescents 02:13:42
who use Paxil are at a five-times greater 02:13:47
risk at experiencing suicidality than those 02:13:52
on placebo? 02:13:55
MR. DAVIS: Object to the form. 02:13:56
There's no foundation that that's 02:13:56

reflected in the article or the data you're talking about. 02:13:58 02:14:00

A I don't understand your question. 02:14:00

You're saying in this -- in these data? 02:14:01 02:14:03

Q No, I'm asking -- let me ask you this: 02:14:04

The question is, in the data that was obtained from Study 329, have you ever learned through publication, through presentation or through speaking with colleagues that the data indicated that there is a fivefold increase in suicidality for those adolescents who took Paxil as opposed to placebo? 02:14:06 02:14:08 02:14:11 02:14:14 02:14:16 02:14:20 02:14:24 02:14:27

MR. DAVIS: Same objection. 02:14:29

A Are you saying -- are you saying that we reported that in the paper? 02:14:30 02:14:31

Q I'm asking you have you ever heard ever that there is a fivefold increase -- this data shows -- the data from 329 shows there's a fivefold increase in suicidality in those adolescents who take Paxil compared to placebo? 02:14:33 02:14:36 02:14:39 02:14:42 02:14:45 02:14:48

MR. DAVIS: Same objection. 02:14:49

Q Have you ever heard that? 02:14:49
A I'm not aware -- I don't believe that that's reported in this paper. 02:14:50 02:14:55
Q No. 02:14:56
I'm asking you if you've ever heard it. 02:14:56 02:14:59
A No. 02:14:59
Q I'm not asking about the paper. 02:14:59
A No. 02:15:01
Q You've never heard of that? 02:15:01
A No. 02:15:02
Q Has -- 02:15:03
A I do know -- I do know that data was -- data from -- at some point it came to my attention that almost every -- or that every pharmaceutical company that had an SSRI, and eventually including the companies that had SNRIs as well, the dual reuptake inhibitors, had to turn over all of -- either had to analyze themselves or turn over their data for someone else to analyze. I don't know which of the two. 02:15:03 02:15:09 02:15:14 02:15:17 02:15:23 02:15:26 02:15:31 02:15:33 02:15:36 02:15:37
And I do know that there were extensive FDA meetings and hearings to -- in 02:15:40 02:15:41

which people were called in -- and this is 02:15:47
within the past -- I don't know when, two 02:15:51
years ago, somewhere around two to four 02:15:52
years ago, and that definite -- 02:15:55
There was enormous debate and 02:15:59
discussion about the definition of 02:16:00
suicidality. 02:16:02
And eventually -- because I saw some 02:16:05
reports from hearings. And eventually, 02:16:07
excuse me, the data was -- 02:16:09
I don't know exactly how it worked, 02:16:12
but eventually a group at Columbia 02:16:13
Presbyterian or led by people there were 02:16:16
asked to take charge of reanalyzing the data 02:16:19
from the -- from all of the SSR studies, I 02:16:22
believe. 02:16:26
I don't know the outcomes of that, 02:16:27
but I do know that the definitions that were 02:16:29
arrived at at that period varied from the 02:16:35
definitions that were reported in any number 02:16:40
of the studies that were done. 02:16:44
In other words, they tried to create 02:16:46
a consensus, you know, a consensus 02:16:48
definition. 02:16:50

So I know that there was activity in that regard, but I never -- I did not learn anything specific about this study. 02:16:51 02:16:53 02:17:00

Q Okay. 02:17:05

So you aren't aware whether -- 02:17:06

A Except, except that there's an article which was produced -- not an article. There was a draft -- 02:17:07 02:17:09 02:17:15

There was an article or a draft of an article that I -- I don't remember if I produced it. 02:17:16 02:17:18 02:17:20

MR. GREEN: You produced it. 02:17:22

A The documents that I produced that I assume you're probably going to ask about at some point that was -- that combined the results from several studies of -- that were conducted that included Paxil. 02:17:23 02:17:26 02:17:27 02:17:33 02:17:37

And I did see that article, and I do remember -- though I can't remember now, I'd have to get into it, I do remember having concerns that the way things were being reported represented a difference from what we found, because different definitions were used, and that was not made explicit in that 02:17:39 02:17:42 02:17:44 02:17:47 02:17:52 02:17:56 02:17:58

report. 02:18:00

So, you know, as we're talking now, I do have a memory of that. With regard to the specifics of what it was and what's in that article, I don't remember. 02:18:01 02:18:06 02:18:07 02:18:09

So if you were to show me that article and if that article were to show rates of suicidality, you know, differences in suicidality rates between Paxil and placebo that are different than what we reported, what I would say to you, yes, I read that material. I don't remember what the findings are so -- 02:18:11 02:18:13 02:18:17 02:18:19 02:18:25 02:18:27 02:18:31 02:18:32

MR. DAVIS: I'm sorry. 02:18:37

A Is that -- so I'm trying to be responsive by saying I do know something about it. 02:18:37 02:18:39

I don't remember the details. I don't remember the specifics. And the number fivefold doesn't -- is not something I remember at all. 02:18:41 02:18:42 02:18:45 02:18:47

Q Okay. 02:18:48

MR. DAVIS: We designate discussions about the draft manuscript as confidential pursuant to the protective order. 02:18:49 02:18:50 02:18:53

MR. COFFIN: Okay. 02:18:55
Q Let's look at this Reviewer No. 2's -- 02:18:59
continuing the same paragraph we were 02:19:02
looking at, Reviewer No. 2 of the JAMA 02:19:03
reviewers. 02:19:06
MR. GREEN: Exhibit 29. 02:19:07
A Which page, Chris? 02:19:09
Q I'm sorry, it's Exhibit -- yes, I think it's 02:19:11
29, page 6. 02:19:12
A Okay. 02:19:14
Q Do you see where it -- where it reads, 02:19:37
"However"? 02:19:39
It's in the middle of the paragraph 02:19:40
on the left side. 02:19:40
A The first -- top paragraph? 02:19:45
Q Yes, top paragraph, left side, about halfway 02:19:48
down. 02:19:50
A Okay, I see "however." 02:19:50
Q It says, "However, given the high rate of 02:19:51
primary care prescription of antidepressants 02:19:53
and the readership of JAMA, it is important 02:19:54
to emphasize the behavioral side effects in 02:20:02
the minority of patients treated with 02:20:02
paroxetine may be more serious than with 02:20:03

TCAs." 02:20:06

Do you agree with that? 02:20:08

A I don't think it's accurate, no. 02:20:13

Q Okay. 02:20:16

And do you agree that there's a high 02:20:17
rate of primary care providers who prescribe 02:20:19
antidepressants to adolescent population? 02:20:22

A I don't know if it's true with regard to 02:20:27
adolescents. 02:20:30

I do know with regard to adults, I 02:20:31
think we covered this -- 02:20:38

Q We did. 02:20:39

A -- that a high proportion of antidepressant 02:20:39
prescriptions are done by primary care 02:20:44
physicians. 02:20:47

I don't know if it's -- where -- I 02:20:50
can't tell you how the percentages compare 02:20:53
to psychiatrists, but it is -- it is a 02:20:57
meaningfully high proportion of the 02:20:59
antidepressant prescriptions in a primary 02:21:01
care setting in adults. 02:21:04

I don't know about children. And, 02:21:06
actually, we did talk about -- 02:21:07

Q Right. 02:21:09

You just don't know one way or the other how the numbers fall out for prescriptions of -- with children -- 02:21:10 02:21:11 02:21:13

A All right, yes, we did talk about it. I said I think the primary care doctors who specialize in adolescent medicine are probably much more likely to prescribe than those who are general. 02:21:15 02:21:18 02:21:20 02:21:23 02:21:25

And I do believe there's a reluctance on the part of primary care docs to treat adolescents and children with depression. 02:21:26 02:21:28 02:21:30

Q Right. 02:21:33

A But that's all. 02:21:33

Q Okay. 02:21:46

You see there's also another paragraph after the suggested revisions? 02:21:47 02:21:49

A Uh-huh, I do. 02:21:53

Q Do you see the second line there? 02:21:55

A "It is also easier to assume"? 02:21:56

Q Yes, but see the second line on that paragraph? 02:21:58 02:22:00

You could please read that? 02:22:00

A "Visits with experts in the treatment of adolescent depression"?. 02:22:02 02:22:05

Q No, "The authors." 02:22:07
A Oh. 02:22:09
"The authors do not sufficiently 02:22:09
highlight that the level of psychological 02:22:11
treatment provided in this study is much 02:22:14
more intense than that covered by almost 02:22:16
every healthcare insurance plan and far 02:22:18
exceeds the usual time spent between a 02:22:21
primary care physician and a depressed 02:22:24
patient given continuing pressure 02:22:27
from third-party payers and ongoing 02:22:30
discrimination against psychiatric patients 02:22:32
and psychiatric treatment (provided by 02:22:35
generalists or psychiatrists)." 02:22:38
Q Do you agree with that statement? 02:22:40
A No. 02:22:46
Q And that's by a different reviewer than the 02:22:46
reviewer we went through before who also 02:22:50
commented on the effect in the study being 02:22:54
related to good clinical management and not 02:23:01
the medication, correct? 02:23:04
A But the part of this -- 02:23:06
Q Is that correct? 02:23:07
A Excuse me? 02:23:08

Q Is that correct? It's a different reviewer? 02:23:09
A I don't remember. You'd have to -- I 02:23:11
mean -- 02:23:12
Q You don't remember? 02:23:14
A No. 02:23:15
Q Well, this is Reviewer No. 2. 02:23:17
A Okay. 02:23:19
Q Right? 02:23:19
A Right. 02:23:20
Q And it was Reviewer No. 1, if you flip back 02:23:20
to page 2, who also commented on the bulk of 02:23:22
the effect in the study was the result of 02:23:27
good clinical management and not medication, 02:23:29
correct? 02:23:32
A Yes, two different reviewers. 02:23:32
Now, the part of this that I think is 02:23:34
just -- for which there's absolutely no 02:23:36
evidence for the reviewer to state this is 02:23:39
the -- what you asked me to read: 02:23:42
"The level of psychological treatment 02:23:43
provided in this study is much more intense 02:23:44
than that covered by almost every healthcare 02:23:49
insurance plan and far exceeds"... 02:23:52
Now, I -- I can't imagine what the 02:23:54

factual basis is for that statement. I mean, I just can't imagine it. 02:23:59 02:24:01

I mean, I would like to see the evidence that this reviewer draws on. I'd like to see the source of data and evidence that this reviewer draws on in a scientific way to support the premise that -- that the amount of psychological treatment provided in this study is both more intense as well as -- than that covered by almost every insurance -- you know, than every insurance plan. 02:24:03 02:24:05 02:24:09 02:24:11 02:24:14 02:24:18 02:24:21 02:24:25 02:24:28 02:24:30

Because, in fact -- and I'd also like to see insurance plan records that prescribe the intensity of the psychological treatment you can give. 02:24:31 02:24:33 02:24:36 02:24:39

I mean, I am not aware -- I have never seen an insurance plan that prescribes -- that tells a primary, whatever he calls it, that tells a doctor the intensity with which they're allowed to give psychological treatment. 02:24:40 02:24:42 02:24:45 02:24:47 02:24:51 02:24:54

Q Do you understand that the point of this reviewer's comment and the other reviewer's 02:24:57 02:24:58

comment is that the therapy or clinical management that was performed in Study 329 is far different than that that you actually see in the clinical setting outside of a -- of a clinical study?

A I read -- I -- the statement that you made appears to be accurate that that's their point.

Q But you disagree with this?

A But when you ask me if I agree, I am telling you that I disagree, and I'm giving you my reason. And I would challenge you or anyone else to show me the data that supports this statement.

I just -- I just -- to me, I would be stunned if anybody could produce any data that -- in an insurance plan which says -- which prescribes the level of intensity of treatment that a primary care physician is allowed to give.

Q Yes.

But the point -- the point is --

A This is just plain wrong.

Q Well, that's your opinion; but there's two

reviewers who are basically -- 02:25:59
A Well, no, no, no, it's not -- 02:26:01
Q There are two reviewers who are making the same point about -- about data that was published by you and other authors showing that -- their point is that the clinical trial setting cannot be carried over into clinical practice. 02:26:02 02:26:04 02:26:07 02:26:09 02:26:11 02:26:14
A But that's not what they'd they said, Chris, and we should live in a world of evidence; and I assume that the jury in this case want -- would want to see the evidence. 02:26:15 02:26:18 02:26:19 02:26:22
Q Absolutely. And they will. 02:26:24
A And I would encourage you to present the evidence by showing a healthcare insurance plan -- and I would appreciate it if you send me a copy of a healthcare insurance plan that says what the level of intensity is of psychological treatment that primary care doctors should use. 02:26:26 02:26:30 02:26:34 02:26:35 02:26:38 02:26:41 02:26:44
I've never seen it. 02:26:45
Q But you're -- that's -- that's not the point of what either reviewer is saying. 02:26:46 02:26:48
A That is the point. 02:26:49

Q No. 02:26:50
A That is exactly the point. 02:26:51
Q The point -- 02:26:52
A I'm quoting. Chris, I'm giving a quote. 02:26:52
Q I hear what you're saying. I hear what you're saying. 02:26:55 02:26:57
A Well, if a quote isn't the point -- 02:26:58
Q Let me ask you this -- 02:26:59
A -- then was it was maladroitly stated and it wasn't -- it was -- it's wrong. It's just wrong. 02:26:59 02:27:04 02:27:06
Q You didn't agree with the point that either reviewer made about the use of case management therapy actually being different than that that is in the primary care setting; is that correct? 02:27:08 02:27:10 02:27:13 02:27:17 02:27:19
A What I said earlier is a matter of record. 02:27:20
Q You didn't agree with that? 02:27:22
A I don't -- I'm not going to go back and give a generalization. I'm dealing with a specific point -- 02:27:23 02:27:25 02:27:28
Q I'm asking you a question. 02:27:28
A What's the question? 02:27:29
Q The deposition is I ask you the question and 02:27:30

you provide a response. 02:27:32
A Oh, I didn't realize that. 02:27:33
Q So all I'm asking is, you disagree with the two reviewers who stated that the therapy -- the clinical management therapy that was provided for in Study 329 is different than or not the same as what would be applied in clinical -- in clinical practice. 02:27:34 02:27:36 02:27:40 02:27:44 02:27:49 02:27:53
You disagree with that, correct? 02:27:55
A I don't think you are accurately characterizing what each of the two reviewers said; so that if you were to go back, Chris, and -- to each of the two reviewers that you want to ask me about and read me the sentence or the line or the paragraph that you believe is germane to the point you're asking me about, then I can answer your question. 02:27:57 02:28:00 02:28:04 02:28:06 02:28:11 02:28:16 02:28:18 02:28:20 02:28:23
But I don't believe you're accurately characterizing what's written. 02:28:24 02:28:25
Q Okay. 02:28:27
A I think it's just wrong. 02:28:27
Q I hear what you're saying. We'll let the jury decide when they get to review it and 02:28:28 02:28:31

they get to hear testimony. All right. 02:28:33

MR. COFFIN: In the interest of time, 02:28:34
of which we have very little, Mr. Murgatroyd 02:28:36
is going to take over questioning. 02:28:40

I need to catch a flight, but we'll 02:28:42
obviously reserve our right, as we've 02:28:44
discussed earlier, to come back and talk to 02:28:46
you about this same subject material at a 02:28:48
later date. 02:28:52

So let's go off the record, and 02:28:53
Mr. Murgatroyd will take over. 02:28:54

THE VIDEOGRAPHER: Okay. The time is 02:28:56
2:30. We are off the record. 02:28:57

(Recess.) 02:28:59

THE VIDEOGRAPHER: Stand by. We're 02:31:47
back on the record. The time is 2:33. 02:31:48

CONTINUED EXAMINATION 02:31:49

BY MR. MURGATROYD: 02:31:51

Q Okay. 02:31:52

Doctor, before I go into some 02:31:52
questions that I've laid out, I want to pick 02:31:54
up on the question Mr. Coffin asked you 02:31:56
about the fivefold increase of the Paxil 02:31:59
kids experiencing suicidality over the 02:32:01

placebo kids. 02:32:05
Do you recall those questions? 02:32:06
A I do. 02:32:07
Q And you said that you weren't -- you weren't particularly aware of that except for with regard to a manuscript that was sent to you in confidence by GSK? 02:32:07 02:32:08 02:32:10 02:32:12
A Correct. 02:32:14
Q That actually is not correct, though. 02:32:15
I mean, you actually -- this was an issue that had been presented to you by a number of different reporters that you personally responded to; is that correct? 02:32:16 02:32:18 02:32:20 02:32:22
MR. DAVIS: Object to the form. 02:32:24
A I don't remember. 02:32:25
Q Well -- 02:32:26
A If -- let me -- I'm saying I don't remember if, in fact, there is -- 02:32:27 02:32:28
When you say "reporters," if it's in the materials that I produced, then -- 02:32:37 02:32:38
Q It is, indeed. Let's take a look at it. 02:32:42
A I'm happy to go over it. 02:32:44
(Exhibit No. 31 marked for identification.) 02:32:45 02:32:45

BY MR. MURGATROYD: 02:32:45
Q Great. I'm handing you Exhibit 31. 02:32:46
Take your time, look at that; and 02:32:49
then after you've read it, we'll identify it 02:32:51
for the record. 02:32:54
(Witness read document.) 02:32:55
MR. DAVIS: I'd like to look at that, 02:32:58
too, before you question him. It won't take 02:32:59
very long for me to look at it. 02:33:02
I would also designate the portion of 02:33:03
the transcript dealing with the draft 02:33:06
manuscript that he just referenced as 02:33:07
confidential pursuant to the protective 02:33:10
order. 02:33:12
MR. MURGATROYD: Okay by me. 02:33:15
MR. GREEN: I'll add that to the list 02:33:17
of things I won't talk about. 02:33:18
A I'm a little confused by the different 02:34:57
emails buried in here. This is all one -- 02:34:59
Q I got it from you, so -- 02:35:03
A No, no, no. 02:35:04
I'm trying to reorient myself. I 02:35:04
assume this is all one string? 02:35:06
Q I'm giving it to you the way it was produced 02:35:09

to me by your lawyer. 02:35:11
A I know. 02:35:13
Q Normally that's the case. 02:35:14
A Normally. I'm trying to line up the dates. 02:35:18
(Witness read document.) 02:35:32
A Okay. 02:36:33
Q Have you had a chance to review that document? 02:36:34 02:36:36
A Yes. 02:36:37
Q Does that refresh your recollection that, in fact, you were familiar with the fivefold increase of Paxil patients over placebo patients in their study? 02:36:37 02:36:38 02:36:40 02:36:42
MR. DAVIS: May I review it, pursuant to my request? 02:36:44 02:36:45
Thanks, Doctor, before you answer that... 02:36:47 02:36:49
(Counsel read document.) 02:36:50
A Do you have one of those in bigger print? 02:37:04
Q It's all I've got. It's only what you gave me. 02:37:07 02:37:10
MR. GREEN: Blame me. 02:37:10
Q Doctor, do you recall the question that was pending? 02:38:18 02:38:19

A One second. 02:38:23

(Witness read document.) 02:38:27

A I would appreciate it if you repeat it. 02:38:37

MR. MURGATROYD: I'll have the court reporter read it back to you. 02:38:40 02:38:40

(Record read as requested.) 02:38:41

A Well, at the time -- no. 02:39:05

At the time Mr. -- Chris asked me the question, I didn't recall this. So now that I'm reading it, I -- I know that this is me and I wrote it and I know I interacted with it. 02:39:12 02:39:17 02:39:21 02:39:29 02:39:33

I mean, this is obviously something that I was -- read carefully and -- 02:39:33 02:39:35

My understanding of what's written here is that it was in the context of I guess this report is -- questions, which is sometime in 2005, that the issue of rates of suicidality was examined. 02:39:53 02:39:55 02:40:03 02:40:09 02:40:12

It's -- from reading this, I believe my initial response was that the rate of 6.5 to 1 had to do with emotional lability, which was in the table. 02:40:16 02:40:18 02:40:24 02:40:29

What I believe to be the case, 02:40:32

because I've cross-referenced the article since we -- we give examples of emotional lability. 02:40:33 02:40:35 02:40:39

What I believe is the case is that sometime -- at some point during the period of time when there's various bodies, external bodies, FDA and others, were looking at this data, and I don't know the process, but I believe GSK or someone else went -- went -- reviewed the data and in this instance examined -- from my understanding, examined the narrative reports that were written down and then had those reviewed by -- by, you know, some consensus group of individuals to define what was considered suicidality. 02:40:41 02:40:43 02:40:45 02:40:49 02:40:52 02:40:59 02:41:02 02:41:07 02:41:15 02:41:17 02:41:19 02:41:26 02:41:32

So I don't -- I'm not sure that I fully understand your question, Skip; but what I think is going on here is that this issue and discussion of it occurred around -- around these dates. 02:41:33 02:41:36 02:41:39 02:41:41 02:41:45

Q Okay. Well, let's authenticate the document first. 02:41:47 02:41:49

I think you agree that that is a 02:41:50

document that you produced in this litigation? 02:41:51 02:41:53
A Yes. 02:41:53
Q Okay. 02:41:54
And you wrote that document? 02:41:54
A It's an email that I wrote. 02:41:57
Q Okay. 02:41:59
And you received that in the ordinary course of your business? 02:42:00 02:42:01
A Yes. 02:42:03
Q Or wrote that? 02:42:03
A Yes. 02:42:05
Q Okay. 02:42:05
And does it discuss a fivefold increase in suicidality in paroxetine patients over kids who took placebo? 02:42:05 02:42:08 02:42:10
MR. DAVIS: Object to the form. 02:42:14
(Witness read document.) 02:42:17
A What -- I'm sorry, repeat the question. 02:42:36
MR. MURGATROYD: Can you read the question back, please? 02:42:40 02:42:40
(Record read as requested.) 02:42:41
A Yes, it discusses it. 02:42:53
Q Okay. 02:42:54

Now, you agree that your study, 329, did show a fivefold increase of suicidality of kids taking Paxil over placebo? 02:42:55 02:43:01 02:43:04

That's not in dispute, is it? 02:43:08

MR. DAVIS: Object to the form. 02:43:10

A What I believe to be the case is that -- I'm having trouble fighting through the language here. 02:43:11 02:43:17 02:43:18

What I believe to be the case is that what -- what we found and reported was a fivefold increase in emotional lability. 02:43:18 02:43:25 02:43:31

And within the category of emotional lability, it included suicidal ideation, suicide attempts. I believe it included worsening of depression. I believe it included changes of mood. And that was the information that we had at that time. 02:43:36 02:43:40 02:43:44 02:43:47 02:43:48 02:43:50

So I -- unless I'm really missing something here... 02:43:58 02:44:00

Q I'm asking as of you sit here today, not as of that time. 02:44:03 02:44:05

Do you agree that now that the data is available, that Study 329 showed at least a fivefold increase of suicidality in kids 02:44:06 02:44:09 02:44:14

taking Paxil over those kids who were taking placebo? 02:44:17 02:44:20

MR. DAVIS: Object to the form. 02:44:21

A I -- I -- it's my understanding that based on the redefinition of suicidality through this process that occurred sometime -- sometime around two to three years ago, that -- and reanalysis of this data somewhere around this time, that using those definitions and that reanalysis, that the rates of suicidality on paroxetine compared to placebo are in the fivefold range. 02:44:47 02:44:57 02:45:04 02:45:06 02:45:09 02:45:14 02:45:18 02:45:20 02:45:25

Q Okay. 02:45:31

And when you were doing the clinical trial, during the course of the clinical trial, you -- your site -- you had a site, correct? 02:45:32 02:45:34 02:45:36 02:45:39

A Yes. 02:45:40

Q Okay. 02:45:40

And you were were responsible for that site, correct? 02:45:41 02:45:43

A Yes. 02:45:44

Q And you had suicidality events occur among the kids at your site, right? 02:45:44 02:45:47

MR. DAVIS: Object to the form. 02:45:50
A I don't recall what was specific to our site. I believe in the end run, there were 15 sites in the study. 02:45:52 02:45:57 02:46:00
Q Right. 02:46:02
I'm asking about your site. 02:46:03
A And I -- 02:46:04
Q Do you recall the suicide events that occurred in your site? 02:46:05 02:46:07
MR. DAVIS: Object to the form. 02:46:08
A I do not recall it. If there were any suicide events at our site, we would have filled out incident reports and submitted those to the institutional review boards that, you know, had -- what's the word, you know, had governed the study. 02:46:09 02:46:12 02:46:14 02:46:17 02:46:20 02:46:26
And we had at least three institutional review boards that got -- that got each event. 02:46:28 02:46:30 02:46:33
So we would have to go back through the study records from the site at Brown, which was also conducted at two other hospitals, Butler and Rhode Island -- and Lifespan Hospitals, and see which ones. 02:46:34 02:46:36 02:46:40 02:46:43 02:46:45

I don't remember what -- 02:46:47
Q Okay. 02:46:50
A What happened at our site. 02:46:51
Q Okay. 02:46:52
A I'm not saying there werent. 02:46:52
Q Okay. That's all. 02:46:54
A But I'm sure if there are, we reported -- we did a full-blown incident report. 02:46:55 02:46:58
Q That's fine. 02:47:00
And we'll get into that at our next session, because I will show you documents that show there were such incidents at your site. 02:47:00 02:47:03 02:47:05 02:47:07
But my question is, when you reported those suicide events, did you code them personally as emotional lability? 02:47:07 02:47:09 02:47:11
Is that something you were told to do? 02:47:15 02:47:16
A No, I didn't -- I did not do any coding. 02:47:16
(Exhibit No. 32 marked for identification.) 02:47:18 02:47:18
BY MR. MURGATROYD: 02:47:18
Q Okay. 02:47:18
Now, let me show you what I've marked 02:47:19

as Exhibit 32. 02:47:21

MR. DAVIS: Can I see that before you hand it to -- 02:47:22 02:47:23

May I see that, Doctor, before you look at it? Thanks. 02:47:24 02:47:27

(Counsel read document.) 02:47:29

MR. DAVIS: This document has already been dedesignated as not being subject to the protective order, but it still bears the legend on it. 02:47:33 02:47:34 02:47:36 02:47:39

MR. MURGATROYD: You've got to send me a new one. 02:47:42 02:47:43

MR. DAVIS: I think I did. 02:47:43

MR. MURGATROYD: Did you? My -- my fault. 02:47:45 02:47:47

(Witness read document.) 02:47:47

A I've read it quickly to get the gist. 02:48:08

Q That's fine. 02:48:10

You see that it is an email from the FDA to GSK. 02:48:11 02:48:12

Do you recognize that as being so? 02:48:14

A I'm just trying to find the "from" and "to." From David Paul? 02:48:21 02:48:24

Q Yes. 02:48:25

You see where it says cedr.fda.gov at 02:48:25
the top? 02:48:32
Right here, right here. 02:48:36
A Oh, David Paul -- 02:48:38
Q Right. 02:48:40
A -- at cderf [sic] -- yes, yes, yes, yes, 02:48:40
yes. 02:48:42
Q Okay. 02:48:43
And it's addressed to Jim Murray, 02:48:43
correct, at GSK? 02:48:45
A Yes. 02:48:46
Q Okay. 02:48:46
And you see that it references Paxil 02:48:47
329 at the bottom? 02:48:48
A Yes. 02:48:51
Q And it has in quotes "possibly 02:48:52
suicide-related." 02:48:56
Do you see that? 02:48:58
A Yes. 02:48:58
Q And do you see that it has a risk ratio? 02:48:59
A Yes. 02:49:01
Q And what is that risk ratio? 02:49:01
A 5.9. 02:49:03
Q So that's actually a six -- almost sixfold 02:49:04

increase of suicidality in kids taking Paxil over placebo? 02:49:07 02:49:11
A Well, no, but -- 02:49:12
Skip, with -- what this says is possibly -- possibly suicide-related. It doesn't say suicide event. 02:49:14 02:49:18 02:49:21
Q Okay. 02:49:23
It says possible suicide-related? 02:49:23
A It says possible. There's a big difference between possible and suicide. 02:49:26 02:49:27
Q Okay. 02:49:29
And it's an increased rate now. Now we're seeing a sixfold rate instead of a fivefold rate? 02:49:29 02:49:31 02:49:33
A But -- no, Skip, please. It says possible. Possible isn't a suicide attempt. It is possibly suicide-related. 02:49:35 02:49:39 02:49:43
So there's a big difference. To qualify "possibly" is enormous. It's an adjective which qualifies it, so it doesn't say "suicide-related." It says "possibly." 02:49:45 02:49:50 02:49:52 02:49:55
Q Okay. 02:49:57
And it's a sixfold increase? 02:49:58
A It says it's possibly -- it -- 02:49:59

Q It's sixfold -- 02:50:01

02:50:01

A There's a -- there's a 5.9 risk ratio or, 02:50:02
you know, approximately a sixfold increase. 02:50:06

Q Of paroxetine kids over placebo kids taking 02:50:09
drugs, right? 02:50:13

MR. DAVIS: Objection to form. 02:50:14
Mischaracterizes the document. 02:50:15

A Not -- who -- with possible suicide-related 02:50:17
events. 02:50:20

Q Okay. 02:50:21
So a child taking Paxil had a 02:50:22
six-time increased risk of experiencing a 02:50:28
possible suicide-related event as opposed to 02:50:30
a child taking placebo, correct? 02:50:35

MR. DAVIS: Objection. 02:50:37
Mischaracterizes the study in terms 02:50:37
of the participants. 02:50:39

Q Is that correct, Doctor? 02:50:40

A I'm sorry, just say it once more and I'll 02:50:43
let you know. 02:50:45

MR. MURGATROYD: We'll have it read 02:50:46
back to you. 02:50:47

(Record read as requested.) 02:50:47

A Yes. 02:51:12

Q Okay. 02:51:12

Now, let's drop down to suicide 02:51:13
attempts. 02:51:16

Do you see that right below that? 02:51:16

A Yes. 02:51:17

Q And how many suicide attempts were on the 02:51:18
drug? 02:51:21

MR. DAVIS: Object to the form of the 02:51:21
question. 02:51:22

Mischaracterizes the document. 02:51:22

MR. GREEN: You can answer. 02:51:27

THE WITNESS: What? 02:51:29

MR. GREEN: You can answer. 02:51:29

A This says 5.4 percent. 02:51:30

Q Okay. 02:51:32

So that's -- so 5.4 percent of the 02:51:33
kids who were in your study, 329, tried to 02:51:35
kill themselves, correct? 02:51:38

MR. DAVIS: Object to the form. 02:51:40

Mischaracterizes the document and the 02:51:40
data. 02:51:42

A I don't think that's correct. 02:51:42

Q Do you think the FDA has wrong numbers here? 02:51:46

A No. I think the way you stated it is -- is not precise enough. 02:51:48 02:51:53

Suicide attempts are then typically rated in terms of what's considered to be the intent of the attempt. So there are suicide attempts. 02:51:56 02:52:01 02:52:04 02:52:09

There are people that char -- some attempts are characterized as something and it's not thought to be an effort to kill oneself. 02:52:11 02:52:13 02:52:15 02:52:20

It's often perceived to be, you know, something between a -- they use the word gesture, which I don't particularly like, but itself-harm, self-harm. 02:52:21 02:52:25 02:52:32 02:52:35

And, in fact, I do know -- I -- I did read a quote from Tom Laughren of the FDA in which he made the statement that he thought that -- because it struck all of us, that -- that cutting one's wrist, you know, wrist slashing with a little bit of blood, he didn't see that as necessarily a suicide attempt. 02:52:38 02:52:41 02:52:46 02:52:48 02:52:52 02:52:55 02:52:58 02:53:01

Q Right. 02:53:02

A It was an attempt at self-harm. 02:53:03

So when you said -- when you -- what I'm objecting to, Skip, because this is such a serious matter, I mean, I know people, I know parents whose children have killed themselves, so I take this very seriously. 02:53:05 02:53:06 02:53:08 02:53:11 02:53:14

That the children were trying to kill themselves, I think that's an improper way to state it. 02:53:16 02:53:18 02:53:21

I think to go with the suicide attempt is different; and in many of these cases, I believe it was an attempt at self-harm or a gesture but definitely not an attempt to kill oneself. 02:53:23 02:53:26 02:53:29 02:53:32 02:53:37

Q Well, there were kids in Study 329 who did try to kill themselves, weren't there? 02:53:39 02:53:43

MR. DAVIS: Object to the form. 02:53:45

A I don't know that that's true. 02:53:46

Indeed, there have been no suicides reported on any of the -- by adolescents in any of the suicide databases, no actual suicides. 02:53:47 02:53:54 02:53:57 02:54:00

Therefore -- 02:54:02

Q Wait, let me stop you right there. 02:54:03

Are you talking about in clinical 02:54:05

trials or in -- 02:54:06
A Clinical trials. 02:54:07
Q Because there are suicide deaths by lots of 02:54:08
kids who are given antidepressants and then 02:54:11
not monitored and left alone that are 02:54:14
registered in the FDA database, correct? 02:54:16
MR. DAVIS: Object to the form. 02:54:18
There's no data to support that. 02:54:20
A Yes, I don't -- I don't -- I'm not aware of 02:54:22
any data to support that. 02:54:24
Q But -- 02:54:26
A But I can say -- 02:54:26
Q Well, let me just explore that for a second. 02:54:27
You're not -- you have -- 02:54:31
GSK has not shown you the documents 02:54:32
that show the number of kids who kill 02:54:33
themselves on Paxil? 02:54:34
A That is correct. 02:54:37
MR. DAVIS: Excuse me. Let me going 02:54:38
to object to the form. 02:54:38
Let's stop with the grandstanding. 02:54:40
If you've got a serious, legitimate 02:54:42
question, ask the witness; but don't make up 02:54:44
data, don't make up facts, don't make up 02:54:45

what you call as evidence. 02:54:48

Ask him a serious, legitimate question. 02:54:49 02:54:52

MR. MURGATROYD: You can object and that's fine. 02:54:52 02:54:53

I asked him a question that I think is very important, because GSK knows that kids were killing themselves on Paxil -- 02:54:54 02:54:55 02:54:56

MR. DAVIS: You have got -- 02:54:59

MR. MURGATROYD: -- and they have documented them, and I will show him the documents. 02:54:59 02:54:59 02:55:01

MR. DAVIS: You have got no data -- 02:55:01

MR. MURGATROYD: I want to know whether or not -- 02:55:03 02:55:03

MR. DAVIS: You have no data to support that statement. 02:55:03 02:55:04

MR. MURGATROYD: Well, that's incorrect. You can lay your objection, and that's it. 02:55:05 02:55:05 02:55:07

MR. DAVIS: No, no. 02:55:08

BY MR. MURGATROYD: 02:55:08

Q My question to you, Doctor, has GSK ever showed you the data, the FDA data that shows 02:55:09 02:55:11

that kids were killing themselves on Paxil 02:55:14
prior to the date of that email? 02:55:16
MR. DAVIS: Same objection. 02:55:19
No foundation for that question. 02:55:19
A I'm not sure whether the -- whether the yes 02:55:23
and nos -- I don't know if there's a 02:55:25
double-negative in your question, so if you 02:55:27
just -- 02:55:29
Q I want to know whether or not -- 02:55:30
A Yes. 02:55:31
Q -- GSK has shared with you the data from the 02:55:33
FDA database that showed kids were killing 02:55:35
themselves on Paxil. 02:55:38
MR. DAVIS: Objection. 02:55:40
Q That's the only question. 02:55:41
MR. DAVIS: Object to the form. 02:55:42
A The answer is that GSK has never showed me 02:55:42
any database that showed that kids were 02:55:49
killing themselves, nor am I aware from any 02:55:54
source that such a database exists. 02:55:58
Q Well, that would be -- 02:56:01
A I have no knowledge of that. 02:56:02
Q Well, that would be very important to you, 02:56:03
wouldn't it, for you to know that kids were 02:56:04

actually killing themselves on Paxil? 02:56:06

Wouldn't that be important to you? 02:56:07

MR. DAVIS: Object to the form. 02:56:08

It's argumentative. 02:56:09

A If it were an established scientific fact that kids -- but I believe we're talking about adolescents here in terms of 329; but if it were an established fact that kids or specifically adolescents were killing themselves, that would be something that would be -- that I would want to know about. 02:56:14 02:56:20 02:56:26 02:56:31 02:56:34 02:56:36 02:56:39

Q Okay. That's good. 02:56:44

A I don't know that that's true. 02:56:45

Q I will gladly show you the documents at the next session. 02:56:47 02:56:49

Now, going back to -- 02:56:50

MR. DAVIS: Move to strike comments -- 02:56:52 02:56:53

Q -- Exhibit 31. 02:56:54

MR. DAVIS: Comments of counsel. 02:56:56

Q Well, let me ask you this: 02:57:01

I showed you a document yesterday where GSK acknowledges that there was a definite risk of suicidality in kids, 02:57:02 02:57:03 02:57:04

correct? 02:57:07

MR. DAVIS: Objection. 02:57:08

MR. GREEN: You were going to show it 02:57:09
to him, but you never did. 02:57:10

Q Oh, you never -- you never had a chance to 02:57:11
read it? 02:57:12

MR. GREEN: No. 02:57:13

Q Okay. Let's look at Exhibit 24. 02:57:13

MR. MURGATROYD: Jim, can you dig 02:57:16
that out for me, please? 02:57:17

MR. GREEN: That's the one we signed 02:57:19
the notice about, but then you didn't -- 02:57:20

MR. MURGATROYD: Yes, correct. 02:57:22

A Are we off the record? 02:57:24

Q No. We're going to stay on the record. 02:57:25
We need to move things along, or 02:57:28
we're going to run out of daylight. 02:57:30

THE WITNESS: I think it's cortical 02:57:31
function that's a higher, more immediate 02:57:31
risk than daylight. 02:57:31

MR. GREEN: It wasn't 23 -- 02:57:43

MR. MURGATROYD: It was 24 at the 02:57:45
bottom. 02:57:47

MR. GREEN: Here it is. You want to 02:57:55

see it? 02:57:56

MR. DAVIS: Thank you. 02:57:58

(Counsel read document.) 02:58:31

MR. DAVIS: GSK designates discussions concerning these documents as confidential. 02:58:38 02:58:39 02:58:40

There's also been no foundation laid whatsoever that this witness has any knowledge of the document, has any familiarity with what issues are being discussed, the context of the discussions, or what data is being discussed and analyzed in the document. 02:58:41 02:58:43 02:58:44 02:58:47 02:58:48 02:58:50 02:58:56

MR. GREEN: And you'd like him to read it? 02:58:57 02:58:58

MR. MURGATROYD: Yes, please. 02:58:59

BY MR. MURGATROYD: 02:58:59

Q And, actually, I'm only -- the only question I'm going to ask you about is the first three bullet points. 02:58:59 02:59:01 02:59:03

If you want to read the whole document, please do; but those -- that's where we're going to be centering our discussions at this time. 02:59:04 02:59:05 02:59:06 02:59:11

A This was sent on? 02:59:13

THE WITNESS: Who is this from? 02:59:26

MR. GREEN: It's from -- it's from someone at GSK. 02:59:28 02:59:30

THE WITNESS: It's to. 02:59:35

MR. GREEN: To someone at GSK from someone at GSK. 02:59:37 02:59:38

THE WITNESS: No, no, these are the ccc's. I can't see who it's from. 02:59:40 02:59:41

Q That's fine. It's an internal GSK email. 02:59:43

A Okay. 02:59:46

Q Okay. That's fine. 02:59:47

A I just didn't know whether it was from the FDA to -- 02:59:47 02:59:50

Q No, it wasn't. No, internal. 02:59:51

A Mm-hmm. 02:59:52

(Witness read document.) 02:59:53

A QP. What's the QP? 03:00:58

Q Don't know. 03:01:04

A Okay. So I've -- 03:01:05

Q All right. 03:01:06

A I've gone through it. 03:01:07

Q Have you had a chance to review it? 03:01:08

A Yes, sir. 03:01:09

Q Okay. 03:01:09
Is there a statement in there about a 03:01:09
definite risk of suicidality? 03:01:12
A Yes. 03:01:17
Q Okay. 03:01:18
Can you read it into the record, 03:01:18
please? 03:01:19
A "In adolescents treated with paroxetine, 03:01:20
there is a definite risk of increased 03:01:23
suicidality." 03:01:26
Q Okay. 03:01:27
Now, has GSK shared that information 03:01:28
with you today before you saw this document? 03:01:33
MR. DAVIS: Object to the form. 03:01:36
A No. 03:01:37
Q Okay. 03:01:37
Can you read next bullet point, 03:01:37
please? 03:01:38
A "We have little or no evidence of efficacy 03:01:38
in major depressive illness in this age 03:01:40
group." 03:01:43
Q Okay. 03:01:45
Has GSK shared that information with 03:01:45
you prior to you reading this document day? 03:01:48

MR. DAVIS: Object to the form. 03:01:49
A No. 03:01:50
Q Okay. 03:01:50
Now, do you contend that the results 03:01:53 of Study 329 as written up in your article 03:01:59 demonstrate efficacy in pediatric 03:02:04 depression? 03:02:08
Efficacy of paroxetine in treating 03:02:13 pediatric depression, to be exact. 03:02:14
A Yes. I believe as stated in the conclusion, 03:02:20 that paroxetine -- that -- let me put it 03:02:24 this way: 03:02:27
That this study, this -- the only 03:02:28 thing I'm counting upon is this experiment. 03:02:33
Q Mm-hmm. 03:02:35
A That this study showed evidence that 03:02:36 paroxetine is effective for major depression 03:02:40 in adolescents. 03:02:44
And as a way -- a partial support for 03:02:46 that would -- I believe that this is 03:02:49 supported more broadly, that in some of the 03:02:52 FDA materials that I did look at -- and I 03:02:57 only saw parts of it -- there was a special 03:03:03 notation made in one of the tables that 03:03:05

pointed out specifically that on several of the depression improvement outcome variables, Study 329 -- I don't know if they called it 329, but they were referring to this study -- did show evidence of efficacy. 03:03:10 03:03:14 03:03:16 03:03:21 03:03:23

So in that -- in the whole sea of studies that were reviewed and so on and so forth, specific mention was made in the table about this study showing evidence. 03:03:25 03:03:28 03:03:30 03:03:33

And the same, I believe -- I don't know whether it was someone that the FDA asked to review the materials or whether it was a member of the FDA, but I know I've read that. 03:03:37 03:03:39 03:03:42 03:03:48 03:03:51

Q Right. 03:03:52

And that was the table that stated that 329 was a negative or failed study? 03:03:52 03:03:54

Do you remember that part of the table? 03:03:57 03:03:58

MR. DAVIS: Objection. 03:03:58

A No. 03:03:59

Q Well, let me show it to you. 03:03:59

I believe what you're referring to is Thomas Laughren's memo. And I'm going to 03:04:16 03:04:17

mark as it Exhibit 33. 03:04:23

(Exhibit No. 33 marked for identification.) 03:04:27

BY MR. MURGATROYD: 03:04:27

Q And there is a table -- 03:04:28

A Can I ask my counsel a question? 03:04:29

Q Sure, you can. You can go out -- you can go off the record. 03:04:31 03:04:33

THE VIDEOGRAPHER: Don't forget your microphone. It's four minutes after 3:00. We're off the record. 03:04:34 03:04:35 03:04:40

(Recess.) 03:04:41

THE VIDEOGRAPHER: We are back on the record. The time is 12 minutes after 3:00. 03:10:16 03:10:17

BY MR. MURGATROYD: 03:10:20

Q Before we took the break, Doctor, you said you had reviewed or seen an FDA document that had a table that referenced the -- some efficacy coming out of 329; is that correct? 03:10:20 03:10:22 03:10:25 03:10:29

A Referening what? 03:10:32

Q Some efficacy coming out of 329? 03:10:33

A Yes, yes. 03:10:35

Q And I've presented you with an exhibit which we've marked as Exhibit 33, correct? 03:10:36 03:10:38

A Yes. 03:10:41
Q Okay. 03:10:42
And I've shown you a table that's attached -- that's part of that exhibit, correct? 03:10:42 03:10:44 03:10:45
A Yes. 03:10:46
Q And is that the table you were referring to? 03:10:46
A There's something in addition to this that I am pretty sure we produced. There's something in addition to this, and I believe it was -- 03:10:51 03:10:56 03:10:59 03:11:01
I don't see the name on here. Either someone named Mosbach or -- there were two people, Mosbach and someone else. 03:11:02 03:11:04 03:11:08
Q Mosholder. 03:11:11
A Something like that. 03:11:13
Q Yes. Okay. 03:11:14
A And another one, there was another individual. 03:11:14 03:11:16
So in addition to this material, which I think I've seen before -- 03:11:16 03:11:20
Q Okay. 03:11:22
A -- and I may even have produced this, I believe there's something else. 03:11:22 03:11:24

Q Yes, I think we'll get to that in a minute. 03:11:26
Let's go to that table in the back. 03:11:27
A Okay. 03:11:29
Q Do you see the table in the back? 03:11:31
MR. DAVIS: Can I go off the record 03:11:34
and take this for a second? 03:11:35
THE VIDEOGRAPHER: The time is 3:13. 03:11:37
We're off the record. 03:11:38
(Exhibit No. 34 marked for 03:12:23
identification.) 03:12:23
THE VIDEOGRAPHER: We're back on the 03:12:32
record. The time is 3:14. 03:12:32
BY MR. MURGATROYD: 03:12:34
Q Okay. 03:12:35
And, Doctor, we were talking about 03:12:35
the chart that's attached or part of that 03:12:36
Exhibit 33, correct? 03:12:38
A Yes. 03:12:41
Q And does it reference Study 329? 03:12:41
A Yes. 03:12:43
Q And does it say that it was a negative 03:12:44
study? 03:12:46
A It says that it was -- it says the summary 03:12:47
is outcome negative, and the footnote is 03:12:51

Keller, et al. 2001; positive on most secondary endpoints. 03:12:56 03:12:59

Q Okay. 03:13:01

So the -- 03:13:01

A And the description in here says one paper describes one of the Paxil studies as a positive on those secondary endpoints while acknowledging that it failed on the primary endpoint. 03:13:02 03:13:04 03:13:06 03:13:09 03:13:11

Q Okay. 03:13:12

A So I guess -- 03:13:13

Q And it's listed as a negative study, correct? 03:13:14 03:13:16

MR. DAVIS: Object to the form. 03:13:17

A The interpretation in here is that it's a negative study. 03:13:18 03:13:20

Q And that's consistent -- that's consistent with the Mosholder statement that you were talking about earlier, that you saw another document by a man by the name of Mosholder from the FDA? 03:13:22 03:13:24 03:13:26 03:13:28 03:13:31

Do you recall that? 03:13:32

A You'd have to show me. 03:13:33

Q All right. 03:13:34

I'm going to show you what I've marked as Exhibit 34, which is clinical review by a reviewer by the name of Andrew D. Mosholder, MD, MPH, dated 10/7/02. 03:13:36 03:13:36 03:13:40 03:13:42

And I will show you that he analyzed -- you can take a look through the document. I think you're familiar with it, the efficacy -- 03:13:49 03:13:54 03:13:56 03:13:57

A Yes. I have to see it again -- 03:13:58

Q Okay. Great. We'll let you take a look at that. 03:13:59 03:14:02

(Witness read document.) 03:14:03

MR. DAVIS: Can we go off the record again? 03:14:20 03:14:21

THE VIDEOGRAPHER: The time is 3:16. We're off the record. 03:14:22 03:14:24

(Recess.) 03:14:37

THE VIDEOGRAPHER: We're back on the record. The time is 3:17. 03:15:20 03:15:21

A Okay. 03:15:37

Q Okay. 03:15:38

And is that the document you were referring to a few minutes ago? 03:15:38 03:15:39

A I think so. 03:15:41

Q Okay. 03:15:41
And it is by Andrew Mosholder, you see that on the front cover? 03:15:42 03:15:45
A Yes. 03:15:46
Q And it does talk about three Paxil studies, and they refer to the treatment of MDD or Major Depressive Disorder. 03:15:47 03:15:49 03:15:52
Do you see that? 03:15:54
A Yes. 03:15:55
Q Okay. 03:15:55
And the three are 377, 701 and then your study, 329; is that correct? 03:15:56 03:16:01
A Yes. 03:16:04
Q Okay. 03:16:04
And with regard with 329, does Mr. Mosholder refer to it as a failed study? 03:16:04 03:16:08
MR. DAVIS: Object to the form. 03:16:12
A What he says is interesting. He says, "On balance, this trial should be considered as a failed trial." 03:16:17 03:16:20 03:16:24
Q Okay. 03:16:26
And why is -- 03:16:26
A And that neither -- 03:16:27
Q Okay. Go ahead. 03:16:29

A -- active treatment group shows superiority over placebo by a statistically significant margin. 03:16:30 03:16:33 03:16:35

So he's saying that on balance, he does -- he did enumerate at least four outcome measures which were positive. 03:16:38 03:16:40 03:16:46

Q But concluded that the trial was a failed study, right? 03:16:51 03:16:52

MR. DAVIS: Object to the form. 03:16:53

Q That's his words? 03:16:56

A Failed trial. 03:16:57

Q Okay. 03:16:57

And are you aware that GSK has disavowed your assertion that Study 329 showed efficacy of paroxetine in treating kids for depression? 03:16:58 03:17:03 03:17:07 03:17:09

MR. DAVIS: Objection to the form. 03:17:09

Mischaracterizes the testimony. 03:17:11

A No. 03:17:16

Q Let's take a look at a whole slew of documents. 03:17:16 03:17:18

MR. DAVIS: Move to strike counsel's colloquy. 03:17:18 03:17:20

MR. MURGATROYD: We're at 35? 03:17:20

THE WITNESS: Well, actually, in terms of -- if I can elaborate in my response to your question, just because I -- 03:17:22 03:17:23 03:17:26

Though I don't remember the details, and I assume that we're going to go through the article, as I said to you earlier, because when I jumped and said no, there is this manu -- draft of the manuscript that GSK did send me that was produced which both aggregated the results three studies as well as had a reanalysis of the data in Study 329, and I don't remember the details of that, of what was in there right now. 03:17:33 03:17:33 03:17:37 03:17:41 03:17:45 03:17:50 03:17:55 03:17:57 03:18:01 03:18:05

When I look at it, I'm sure it will refresh me, but I do remember disagreeing strongly with the way the manuscript was constructed and the conclusions reached by the authors of the manuscript at GSK. 03:18:09 03:18:10 03:18:13 03:18:17 03:18:20

BY MR. MURGATROYD: 03:18:22

Q Okay. 03:18:22

A And there was quite a bit of exchange about that, so... 03:18:23 03:18:25

Q Yes, we'll get into that. 03:18:26

A So -- no, so what I'm saying, Skip, I'm 03:18:28

trying to make sure I don't misrepresent. 03:18:29
When I quickly answered no, it's 03:18:32
possible that what I was disagreeing with 03:18:35
was the -- the conclusion that they reached 03:18:39
through the process I described, which was 03:18:41
different than -- which I thought was not 03:18:43
accurate. 03:18:45
Q That's all right. 03:18:47
Well, let's take a look at the 03:18:47
conclusion they arrived at just by looking 03:18:49
at your study with the next document that 03:18:51
I'll show you, which is -- I've marked as 03:18:53
Exhibit 35. 03:18:55
(Exhibit No. 35 marked for 03:18:56
identification.) 03:18:56
(Witness read document.) 03:18:57
MR. DAVIS: And I'd like to see that 03:19:10
before the witness is questioned about the 03:19:11
document. 03:19:12
(Witness read document.) 03:19:12
A Okay, I've read that. 03:19:27
Q Okay. 03:19:28
MR. DAVIS: May I see that, please? 03:19:29
MR. MURGATROYD: Let's show it to 03:19:30

Mr. Davis. 03:19:31

(Counsel read document.) 03:19:32

MR. DAVIS: Okay. 03:19:39

MR. MURGATROYD: Okay. 03:19:40

Can I have that for a second? 03:19:42

MR. DAVIS: Okay. 03:19:43

BY MR. MURGATROYD: 03:19:45

Q And, Doctor, you see that that is an email, 03:19:50
correct? 03:19:54

A Yes. 03:19:56

Q Okay. 03:19:56

It's not addressed to you, though, is 03:19:57
it? 03:19:58

A No. 03:19:58

Q Okay. 03:19:59

And it's talking about Study 329; is 03:19:59
that correct? 03:20:02

Do you see that in the referenced 03:20:03
section of the email? 03:20:04

A Yes. 03:20:05

Q Okay. 03:20:06

And what -- do you see the sentence 03:20:06
that begins with the word "essentially" in 03:20:08
the first big paragraph? 03:20:10

A Yes. 03:20:13

Q Can you read that into the record, please? 03:20:14

A "Essentially the study did not really show 03:20:16 Paxil was effective in treating adolescent 03:20:19 depression, which is not something we want 03:20:21 to publicize. However, we should prepare a 03:20:24 Q&A and key messages in case reporters do 03:20:27 cover this study. The proofs would come in 03:20:31 handy." 03:20:34

Q Now, would you agree, sir, that that 03:20:37 statement is inconsistent with your 03:20:40 conclusion in your article that paroxetine 03:20:43 or Paxil is efficacious for kids who have 03:20:45 depression? 03:20:50

MR. DAVIS: Objection. 03:20:50

No foundation as to the circumstances 03:20:50 surrounding the document that the witness is 03:20:52 being presented with. 03:20:54

MR. GREEN: You can answer it. 03:20:56

A Yes, again, Skip, I'm not trying to be -- 03:20:57 well, I am trying to be precise. I'm not 03:21:00 trying to be picky unnecessarily. 03:21:03

You said kids and -- 03:21:05

Q Children and adolescents. 03:21:07

A No, I would say adolescents. 03:21:10
Q Okay. Fine. 03:21:12
A That -- so if you -- if you wouldn't mind 03:21:13
restating your question to me. 03:21:16
Q Well, I just want to know whether or not the 03:21:19
statement that you just read into the record 03:21:21
is inconsistent with the conclusion that you 03:21:23
drew or you state in your article. 03:21:26
MR. DAVIS: Same objections. 03:21:30
A It's -- it's inconsistent to an extent, but 03:21:42
not completely. It's a matter of emphasis, 03:21:45
because the sentence, as I read it, says, 03:21:48
"Essentially, the study did not really show 03:21:51
Paxil was effective." 03:21:58
And I think that we concluded, as was 03:22:01
characterized by Laughren or someone else, 03:22:06
that though our study wasn't positive on the 03:22:08
primary outcome measures, it was positive on 03:22:12
four other outcome measures. 03:22:17
So I don't think this is a -- you 03:22:19
know, I think it's a partial -- you know, 03:22:21
it's a disagreement in -- in emphasis. 03:22:27
But I -- and I don't really -- I 03:22:34
don't know specifically what was meant by 03:22:36

the phrase "did not really show." 03:22:38
Q Okay. 03:22:41
A But that may well have been the part which was in agreement that we had for statistically significant differences. 03:22:41 03:22:44 03:22:48
Q All right. Well, let's take a look at the next document. 03:22:50 03:22:52
(Exhibit No. 36 marked for identification.) 03:22:53 03:22:53
BY MR. MURGATROYD: 03:22:53
Q I think it's a little clearer, and I'll mark this Exhibit 36. 03:22:53 03:22:56
It's a GSK sales connection memo that has attached to it use of Paxil CR or Paxil in pediatric patients. 03:22:57 03:22:59 03:23:02
And I've put a red sticky -- you're free to read the document. I've put a red sticky by the part that I'm going to question you about. 03:23:04 03:23:07 03:23:10 03:23:13
MR. MURGATROYD: Todd, you need -- I think you stuck a confidential stamp on that as well as almost every other document you've produced in this case, and I want to know if you're willing to remove that from 03:23:15 03:23:16 03:23:17 03:23:21 03:23:23

under seal, as well as the previous document. 03:23:24 03:23:26

Actually, this one isn't under seal. 03:23:27

MR. DAVIS: Well, if you're going question him about the attachment -- 03:23:30 03:23:31

MR. MURGATROYD: Yes. 03:23:33

MR. DAVIS: That the attachment is a medical information letter that gets sent to healthcare providers upon an unsolicited request, then that would not be subject to the protective order. 03:23:33 03:23:34 03:23:37 03:23:39 03:23:41

MR. MURGATROYD: Okay. 03:23:43

How about the whole document? 03:23:43

MR. DAVIS: Certainly can -- yes, we'll dedesignate that. That's fine. 03:23:54 03:23:57

BY MR. MURGATROYD: 03:23:59

Q All right. Doctor, if you would, take a look at that exhibit. 03:24:00 03:24:02

The red tagged -- feel free to look at the whole document, but I'm talking about the paragraph that has the red sticky on it. 03:24:03 03:24:05 03:24:08

(Witness read document.) 03:24:25

A Okay. 03:24:47

Q Have you had a chance to review that? 03:24:48

A Yes. 03:24:49

Q Okay. 03:24:50

Can I see that for a second, please? 03:24:50

Can you read into the record, please, 03:24:59
the third bullet point that starts with the 03:25:00
word "from"? 03:25:02

A "From an efficacy standpoint, trials in 03:25:03
pediatric patients have shown Paxil to be 03:25:05
statistically superior to placebo in the 03:25:07
treatment of OCD and social anxiety 03:25:09
disorder. The studies did not show a 03:25:13
benefit for the treatment of MDD in children 03:25:15
or adolescents under the -- under 18 years 03:25:20
of age. Conclusions regarding efficacy and 03:25:22
safety of Paxil and Paxil CR in children and 03:25:25
adolescents for the treatment of panic 03:25:29
disorders, GAD and PTSD await further 03:25:31
study." 03:25:35

Q Okay. 03:25:36

We're just talking about Major 03:25:36
Depressive Disorder, correct? 03:25:38

And what does it say again regarding 03:25:39
just Major Depressive Disorder? 03:25:41

A The studies did not show a benefit for the 03:25:42

treatment of Major -- of MDD in children or adolescents under 18 years of age. 03:25:45 03:25:48

Q And would you agree, Doctor, that that statement is inconsistent with your conclusion in your article? 03:25:51 03:25:52 03:25:54

A Yes. 03:25:55

Q Okay. 03:25:56

Let me show you the next document. 03:25:57

(Exhibit No. 37 marked for identification.) 03:25:59 03:25:59

MR. DAVIS: Can I see that? 03:25:59

MR. MURGATROYD: 37 or 38? 03:26:09

Todd, what's the number on the front of that? 03:26:12 03:26:14

MR. DAVIS: 37 -- excuse me, 36. 03:26:15

MR. MURGATROYD: 36? 03:26:19

MR. DAVIS: Yes, you're up to 37. 03:26:20

May I look at that, please, before you show it to the witness? 03:26:21 03:26:23

MR. MURGATROYD: Yes. 03:26:25

(Counsel read document.) 03:26:26

MR. DAVIS: Okay. 03:26:37

(Witness read document.) 03:27:34

A Okay. 03:27:48

BY MR. MURGATROYD: 03:27:48
Q Have you had a chance to review that 03:27:48
document? 03:27:50
A Yes. 03:27:50
Q And can you identify for the record what 03:27:50
that document is? 03:27:52
It's a Dear Healthcare Provider 03:28:02
document? 03:28:04
A Yes, yes. 03:28:04
Q Okay. 03:28:05
And is it from -- look like -- does 03:28:05
it appear to be sent out from GSK? 03:28:06
A Yes. 03:28:08
Q Okay. 03:28:08
And can I see it for a second, 03:28:09
please? 03:28:11
MR. MURGATROYD: So the record's 03:28:15
clear, it's dated June 2003, which is in the 03:28:16
bottom right-hand corner. 03:28:18
Q And, Doctor, can you read the paragraph into 03:28:20
the record that starts with "A recently"? 03:28:23
A "A recently completed program of clinical 03:28:28
trials in children and adolescents under 18 03:28:32
years of age failed to demonstrate efficacy 03:28:33

in Major Depressive Disorder and there was a
doubling of the rate of reporting of adverse
events in the paroxetine group compared with
the placebo, including: Concluding
decreased appetite, tremor, sweating,
hyperkinesia, hostility, agitation,
emotional lability (including crying, mood
fluctuations, self-harm, suicidal thoughts
and attempted suicide)."

Q Now, would you agree, Doctor, that that
statement is inconsistent with the
conclusion that you drew or you stated in
your article in 329?

MR. DAVIS: Object to the form.

A Well, this Exhibit 37 does not specifically
refer to Study 329. It refers to a program
of completed clinical trials, so this does
not specifically contradict 329.

Q Well, 329 says the drug is safe and
effective, right?

I mean, your -- your article
basically says that Paxil was safe and
effective for kids, right?

A It says it's well-tolerated, and I -- I

don't think this agrees -- disagrees about 03:30:01
its being well tolerated, and -- 03:30:05
Q Does it disagree about it being effective? 03:30:08
A What I'm saying is that this says that the 03:30:10
recent -- the completed program of 03:30:12
studies -- 03:30:15
Q Right. 03:30:16
A -- whatever the word is, failed to 03:30:18
demonstrate. 03:30:21
Q Okay. 03:30:22
A I'm making a distinction between that. And 03:30:23
it doesn't comment specifically on this. 03:30:25
Q Okay. 03:30:27
Will you agree that 329 is included 03:30:27
in that program; will you not? 03:30:29
A Yes. 03:30:31
Q Okay. 03:30:31
Now -- 03:30:31
MR. DAVIS: Just to give you a 03:30:36
heads-up, it's almost 3:45. 03:30:36
MR. MURGATROYD: Okay. Thank you. 03:30:39
BY MR. MURGATROYD: 03:30:42
Q Doctor, would you consider a drug that 03:30:43
causes -- that has a sixfold increase of 03:30:45

possible suicide events of kids or children 03:30:47
and adolescents who take Paxil over those 03:30:53
who take placebo to be a safe drug? 03:30:54

MR. DAVIS: Object to the form. 03:30:59

A I think the issue is one of tolerability and 03:31:21
degree and safety to an extent. 03:31:31
The concern I have about this whole 03:31:48
issue is that the distinction's been blurred 03:31:49
between possible suicide events, some of 03:31:57
which were rather minor efforts of -- of 03:32:04
self-mutilation or self-harm and between a 03:32:13
child -- an adolescent or a child; but I'm 03:32:17
more talking about the adolescents 03:32:23
attempting to kill themselves. 03:32:26
Now, killing oneself certainly -- and 03:32:28
an effort to kill oneself, to the extent 03:32:32
that that's the case, I would certainly 03:32:35
think that any medication that did that is 03:32:37
not safe. 03:32:42

Q Okay. 03:32:43

A But I'm just -- I'm just wanting to be 03:32:43
careful. 03:32:46

Q I understand. 03:32:47

A Because of the -- how important the issue 03:32:48

is. 03:32:50

Q I agree, and I appreciate your candor. 03:32:50

A To not, you know, blur the -- to not lump everything. 03:32:52 03:32:55

Q Okay. That's fine. 03:32:56

Now, we have a lot more documents. I think we've agreed to one more day. I think Mr. Davis needs to leave to catch his plane. 03:33:02 03:33:04 03:33:06

I think you asked to stop at this time. Is that correct, Todd? 03:33:08 03:33:10

MR. DAVIS: We all agreed that we were going to stop at 4:00, and I've just asked for an additional -- or 3:45, I guess, is when we talked about stopping. 03:33:12 03:33:13 03:33:15 03:33:18

I just asked for an additional couple of minutes so I could get on a plane. 03:33:19 03:33:21

MR. MURGATROYD: Okay. 03:33:24

I'm obviously not going to requite you a couple of minutes, so we will stop for now. 03:33:24 03:33:27 03:33:29

THE WITNESS: Okay. 03:33:30

BY MR. MURGATROYD: 03:33:30

Q And we'll pick this up at a date that's convenient to you. 03:33:30 03:33:32

A Okay. 03:33:32
Q And if it's okay with you, we'd like to communicate with your counsel, Mr. Green -- 03:33:32 03:33:34
A Sure. 03:33:36
Q -- to get an appropriate date and time. 03:33:36
A Yes. 03:33:38
MR. MURGATROYD: Okay? 03:33:38
MR. GREEN: Mm-hmm. 03:33:38
MR. MURGATROYD: Thank you. 03:33:40
MR. DAVIS: I reserve the right to -- well, I think until the deposition is complete, I think it's appropriate that -- that the deposition not be utilized until the questioning that I have is done, and that's what's -- what the next session is designed to do. 03:33:40 03:33:44 03:33:46 03:33:48 03:33:52 03:33:54 03:33:56
MR. MURGATROYD: Okay. 03:34:00
THE WITNESS: I have a question. Am I -- am I free to go when you guys discuss this? 03:34:00 03:34:01 03:34:03
MR. MURGATROYD: Yes, you're done. 03:34:03
THE VIDEOGRAPHER: The time is 3:35. We're off the record. 03:34:04 03:34:06
(Discussion off the record.) 03:34:20

MR. MURGATROYD: By stipulation of 03:34:42
counsel, provided Mr. Davis agrees, that 03:34:45
under California law, you're supposed to 03:34:48
maintain the original, but we're going to 03:34:49
relieve you of that duty, and you're going 03:34:51
to send the original to me at Baum Hedlund. 03:34:54

You're going to send a copy to 03:34:59
Mr. Green at our expense, who will forward 03:35:01
it to Mr. -- Dr. Keller for his review and 03:35:04
signature and with a note that any changes 03:35:08
need to be forwarded on to me. Okay? 03:35:13

Todd, you agree to that? 03:35:17

MR. DAVIS: I agree. 03:35:18

MR. MURGATROYD: Thank you very much. 03:35:18

(Proceedings adjourned at 3:35 p.m.) 03:35:19

# I N D E X

WITNESS:

MARTIN B. KELLER, M.D.



# E X H I B I T S

C E R T I F I C A T E

I, Jill K. Ruggieri, Registered Merit Reporter and Certified Realtime Reporter, do certify that the deposition of MARTIN B. KELLER, M.D., in the above-captioned matters, on September 7, 2006, was stenographically recorded by me, having been duly sworn by me, a Commissioner of Deeds for the State of Rhode Island and Providence Plantations; that the transcript produced by me is a true record and accurate record of the proceedings to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to the above action; and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

_____________________

Jill K. Ruggieri, RMR/CRR

My commission expires: April 7, 2007