IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA, Plaintiff, vs. (1) PURDUE PHARMA L.P.; (2) PURDUE PHARMA, INC.; (3) THE PURDUE FREDERICK COMPANY; (4) TEVA PHARMACEUTICALS USA, INC.; (5) CEPHALON, INC.; (6) JOHNSON & JOHNSON; (7) JANSSEN PHARMACEUTICALS, INC.; (8) ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS; (9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.; (10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.; (11) WATSON LABORATORIES, INC.; (12) ACTAVIS LLC; and (13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC., Defendants.	Case No. CJ-2017-816 Judge Thad Balkman

DEFENDANTS' MOTION TO EXCLUDE THE TESTIMONY
OF STATE EXPERT MR. TY GRIFFITH

Pursuant to 12 O.S. § 2702 and *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993), Defendants[1] move to exclude the testimony of State expert Mr. Ty Griffith.

I. INTRODUCTION

The Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") Survey is a patient satisfaction survey required by the Centers for Medicare and Medicaid Services ("CMS") for all hospitals in the United States. The Survey was developed by CMS and the Agency for Healthcare Research and Quality. Patients who have had a hospital admission are surveyed on a list of quality issues shortly after their discharge from the hospital. In 2006, CMS added a series of pain management questions to the HCAHPS Survey.

The State's Expert Witness Disclosures ("Disclosures") state that Mr. Griffith will seek to provide an expert opinion about the "impact on hospital administration and prescribing behavior" from including pain management questions in the HCAHPS Survey. (Exhibit H to Disclosures.) Mr. Griffith seeks to opine that, "as a result" of the inclusion of the pain management questions on the HCAHPS Survey, "doctors inevitably felt pressure to prescribe more pain medication" to increase their survey scores. (*Id.*) Additionally—and despite the following not being mentioned anywhere in the Disclosures—Mr. Griffith testified at his deposition that he will also seek to provide an expert opinion on the alleged "influences" leading CMS and the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") to support the inclusion of the pain management questions in the HCAHPS Survey. (Griffith Dep. Tr., attached as **Exhibit 1**, at 202:24-203:14.)

[1] "Defendants" includes Defendants Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Watson Laboratories, Inc., Actavis LLC, Actavis Pharma, Inc., Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen, Pharmaceuticals, Inc., N/K/A Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc., N/K/A Janssen Pharmaceuticals, Inc.

Mr. Griffith has never provided an expert opinion on these topics. Nor should he be allowed to do so in this case. Mr. Griffith's lack of relevant work experience, and his stunning admission that he has failed to independently conduct any relevant research or consult any existing research or data in developing his opinions, render his testimony unqualified, unreliable, and therefore inadmissible in this case.

Although Mr. Griffith has spent the last 21 years working in the healthcare field, only 8 of those years involved a specialization in hospital administration. (Exhibit H to Disclosures.) Further, Mr. Griffith admits that the bulk of his hospital administration experience was spent in limited roles at small hospitals, with much of it confined to the years ***prior*** to the inclusion of the pain management questions on the HCAHPS Survey. Mr. Griffith simply has no knowledge about any hospitals other than the few at which he has worked, much less about the general, profession-wide practices of health care administrators and/or prescribers in Oklahoma or elsewhere in response to the HCAHPS Survey's pain management questions. Yet this is exactly the testimony the State seeks to introduce through Mr. Griffith.

Even if Mr. Griffith were to provide an expert opinion solely as to hospital administration and prescribing behavior ***at the hospitals where he has worked***—a limitation that does not exist in the Disclosures—this testimony should, nevertheless, be excluded. As Mr. Griffith himself admits, even while employed in administrative roles at these few hospitals, his "contact with physicians was limited." (Griffith Dep. Tr. at 122:09-123:11.) Nor has he ever spoken with any physician to confirm or deny whether they felt any pressure to prescribe opioids as a result of the HCAHPS' pain questions, much less whether they ever acted in response to any such pressure, even if it did exist. Shockingly, instead of seeking to supplement the deficiencies in his own base of knowledge through research, Mr. Griffith admits that he ***purposefully avoided reviewing***

available data in order to not influence the preconceived opinions he formed based on his insufficient and irrelevant work experience. Accordingly, regardless of whether Mr. Griffith seeks to provide expert testimony as to healthcare administration and prescribing behaviors at the few hospitals where he has been employed or others, his "opinions" on even those topics are likewise unqualified, unreliable, and inadmissible.

Mr. Griffith's purported "opinions" as to the supposed "influences" which led CMS and JCAHO to support the inclusion of the pain management questions in the HCAHPS Survey in 2006 are equally inadmissible. Mr. Griffith does not contest that he has no education or relevant experience regarding this topic. Indeed, he admits that he bases his "opinion" about CMS and JCAHO's actions solely on two documents he received from the State's legal counsel a mere two days prior to his deposition. Other than reviewing these two documents provided to him by the State's counsel, Mr. Griffith admits that he has conducted no research on how or why the pain management questions were added to the survey, whether the entities that added them were influenced by anyone, or whether any alleged influence came from any pharmaceutical manufacturer. Mr. Griffith is simply unqualified to provide any expert opinions on this topic as his testimony is nothing more than rank speculation fueled by the State's counsel.

Mr. Griffith's opinions are also inadmissible for the additional reason that despite various allegations that prescribers, healthcare administrators, and other independent parties acted a certain way "as a result of" or "in response to" the HCAHPS Survey's pain questions or alleged "influences," (Exhibit H to Disclosures), Mr. Griffith admits that he failed to review ***any*** available data in forming these opinions, much less with the methodology that is required for "causation" expert opinions under *Daubert*.

For each of these independent reasons, Mr. Griffith's purported expert testimony fails to satisfy the basic requirements of 12 O.S. § 2702 and *Daubert*. As a result, Mr. Griffith's expert testimony should be excluded in its entirety.

II. LEGAL STANDARD

Oklahoma evaluates the admissibility of expert testimony pursuant to the standards established by the United States Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), and its progeny. *Christian v. Gray*, 2003 OK 10, ¶ 14, 65 P.3d 591, 600. The Oklahoma statute governing expert testimony, 12 O.S § 2702, is "identical in substance" to Federal Rule 702, *id.*, 2003 OK 10, ¶ 6, 65 P.3d 591, 597, and provides that:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify in the form of an opinion or otherwise, if (1) [t]he testimony is based on sufficient facts or data; (2) [t]he testimony is the product of reliable principles and methods; and (3) [t]he witness has applied the principles and methods reliably to the facts of the case.

12 O.S. § 2702. These three requirements are commonly known as "qualification," "reliability," and "fit."

Daubert requires this Court to perform a "screening function" to ensure that Mr. Griffith's testimony is "not only relevant, but reliable." 509 U.S. at 589, 592. "[T]rial courts act as 'gatekeepers' to ensure that speculative, unreliable expert testimony does not reach the jury." *Kilpatrick v. Breg, Inc.*, 613 F.3d 1329, 1335 (11th Cir. 2010) (quoting *Daubert*, 509 U.S. at 597 n.13). The purpose of the reliability analysis is to "make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Kumho*, 526 U.S. at 152. In order to survive this requirement, the "proposed testimony must be supported by appropriate validation—*i.e.*, 'good grounds,' based on what is known." *Daubert*, 509 U.S. at

590. Thus, an expert's opinion must "rest on a reliable foundation." *Id.* at 597. The State, as the party offering the expert testimony, has the burden of proving admissibility by a preponderance of the evidence. *Id.* at 592.

Under these standards, all of Mr. Griffith's proffered testimony is inadmissible and must be excluded.

III. ARGUMENT

A. Regardless Of Whether Mr. Griffith Seeks To Provide Expert Testimony As To Health Care Administration And Prescribing Behaviors At His Own Hospital Or Others, These Opinions Should All Be Excluded

An expert may be qualified to testify "by knowledge, skill, experience, training, or education." *Gray*, 2003 OK 10, 65 P.3d 591, 597. Here, Mr. Griffith concedes that he is testifying based solely on his work experience.[2] However, Mr. Griffith's limited work experience at 4 hospitals does not equip him to opine as to the practices at all or even a majority of the hospitals in the State of Oklahoma, much less as to the general, profession-wide practices of all health care administrators and prescribing physicians. Further, even if Mr. Griffith were to opine solely as to the practices of health care administration and prescribing physicians at the few hospitals where he has held administrative positions, he admits that the quantity of work experience relevant to the opinions he seeks to offer is "limited." (Griffith Dep. Tr. at 104:14-105:15.) Rather than attempting to address this deficiency, Mr. Griffith also admits that he purposefully avoided reviewing available data so as to not influence the preconceived opinions he formed based on his insufficient work experience and speculation. Accordingly, regardless of whether Mr. Griffith

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[2] (Griffith Dep. Tr. at 110:15-23) ("**Q:** All right. Is there anything other than your work experience in healthcare that you believe qualifies you to provide the expert opinions you're planning to offer in this case? . . . **A:** No, ma'am.")

seeks to provide expert testimony as to healthcare administration and prescribing behaviors at his own hospital or others, his opinions are unqualified, unreliable, and inadmissible.

Although the State seeks to introduce profession-wide testimony from Mr. Griffith about "healthcare administrators" and "prescribing behavior," *see* (Exhibit H to Disclosures), Mr. Griffith's testimony makes clear that his work experience simply does not qualify him to make such broad assertions. Indeed, at various times during his deposition, Mr. Griffith admitted that his work experience at his prior hospitals did not expose him to the data or practices of any other Oklahoma hospital:

- **Q:** ". . . [H]ave you ever talked to any other hospital administrator at another hospital in the State of Oklahoma about the -- about whether or not their chronic pain diagnosis have gone up since the late 1990s?
  A: No." (Griffith Dep. Tr. at 240:23-241:2.)

- **Q:** "Okay. Have you ever looked at data from any of those other hospitals in the State of Oklahoma, regarding the level of opioid medications that are being prescribed and administered in those hospitals from 1990 to today?
  MR. HALL: Object to the form.
  A: I have not, because they don't influence my personal experience in the places that I was, and I haven't reviewed more data --" (Griffith Dep. Tr. at 250:12-19.)

- **Q:** ". . . At any point in time during your professional or academic career, have you communicated with or gathered data from any other hospital or a hospital administrator in the State of Oklahoma, about how the inclusion of the pain management dimension in the HCAHP survey has impact -- impacted how they operate their hospital?
  A: No." (Griffith Dep. Tr. at 275:12-18.)

- **Q**: "Have you communicated or gathered data from any other hospital or hospital administrator in the State of Oklahoma at any time during your professional or academic career about the impact of including the pain management dimension on the HCAHPS survey as it relates to the prescribing behaviors at their hospitals?
  MR. HALL: Object to the form.
  A: Not to any other administrators, no.
  Q: Okay. At any other hospitals?
  A: I mean, in our own hospital --" (Griffith Dep. Tr. at 278:6-18.)

- **Q:** "And you don't know if pain management was a key driver within the other hospitals in the State of Oklahoma that you did not work at --"
  MR. HALL: Same objection --
  Q: -- do you
  MR. HALL: -- asked and answered
  Q: No it hasn't been answered. Can you answer that?
  A: I've -- I -- I've never seen another hospital's individualized report." (Griffith Dep. Tr. at 307:20-308:04.)

Not only does Mr. Griffith admit that he has no knowledge as to the practices of healthcare administrators and prescribing physicians at any hospital other than the 4 at which he has worked, but in fact he openly admits that he purposely chose ***not*** to conduct any research into these topics in order to avoid influencing his preconceived opinions:

- **Q:** ". . . And you've not pulled any data for the purpose of formulating your expert opinion in this case to determine how much those diagnosis codes have increased, have you?
  MR. HALL: Object to the form.
  A: No -- my expert opinion was my expert opinion from the beginning. I have not pulled any other data to influence my expert opinion." (Griffith Dep. Tr. at 236:11-19.)

- **Q:** "At any point in time -- and I'm not just limiting this to since you became an expert in this case. Have you, at any point in time, reviewed or analyzed data as it relates to the hospitals in the State of Oklahoma and whether or not the increase -- whether or not there has been an increase in diagnosis for chronic pain since the late 1990s?
  A: I have not reviewed any data, outside my own review of -- during my career of understanding those codes to influence my expert -- expert testimony." (Griffith Dep. Tr. at 239:20-240:05.)

- **Q:** "Okay. Have you ever looked at data from any of those other hospitals in the State of Oklahoma, regarding the level of opioid medications that are being prescribed and administered in those hospitals from 1990 to today?
  MR. HALL: Object to the form.
  A: I have not because they don't influence my personal experience in the places that I was and I haven't reviewed more data --
  Q: Right.
  A: -- that might -- that would -- that would in some way -- you would – did that influence your opinion? -- I have not gone out and reviewed data purposefully because it's -- these are my opinions." (Griffith Dep. Tr. at 250:12-19.)

As Mr. Griffith himself concedes, he is simply not equipped to provide an expert opinion on behaviors at hospitals other than the 4 at which he worked. *See* (Griffith Dep. Tr. at 110:15-23.) Accordingly, any opinions Mr. Griffith might seek to offer regarding behaviors generally at Oklahoma hospitals should be excluded. *See Arias v. DynCorp*, 928 F. Supp. 2d 10, 17 (D.D.C. 2013) (finding expert was not qualified, notwithstanding expert's "impressive credentials," because "plaintiffs [did] not demonstrate[ ] how [expert's] academic and professional experiences ma[d]e him qualified to testify" about the particular factual questions at issue).

Yet even if Mr. Griffith sought to provide an expert opinion solely as to hospital administration and prescribing behavior ***at his prior hospitals***—a limitation that does not exist in the Disclosures—this testimony should be excluded too. Although Mr. Griffith has spent 21 years in healthcare, only 8 of those years involved a specialization in hospital administration. (Exhibit H to Disclosures.) And even during the short time he worked in hospital administration, Mr. Griffith admits that the bulk of his work experience was spent in limited roles at small hospitals, with much of it confined to the years ***prior*** to the implementation of the pain management questions in HCAHPS Survey. (Griffith Dep. Tr. at 121:4-8, 122:9-123:11.) Indeed, although Mr. Griffith seeks to opine that "doctors inevitably felt pressure to prescribe more pain medication" to increase their scores in the HCAHPS Survey, (Exhibit H to Disclosures), he himself admits that at his prior hospital his "contact with physicians was limited." (Griffith Dep. Tr. at 121:4-8.) Further, even as Mr. Griffith's contacts with physicians increased due to changing roles in his employment, this is of no moment because Mr. Griffith ***never*** asked a single physician if they felt increased pressure to prescribe pain medications as a result of the HCAHPS pain questions, much less if they ever acted on any said pressure. (Griffith Dep. Tr. at 282:18-295:1.)

Mr. Griffith's inadequate work experience and failure to speak to any physician regarding the supposed "pressure" to prescribe opioids as a result of the HCAHPS pain questions is compounded by the fact that despite the availability of data at his prior hospitals that might allow him and Defendants to confirm or deny his purported expert conclusions, he failed to seek out and review any such data:

- **Q:** "All right. So -- and, again, you worked at hospitals and healthcare facilities of different sizes -- those four that we mentioned are different sizes in terms of number of beds and number of average census per day --
  A: Yes, ma'am.
  Q: -- correct? So as we sit here today you're unable to provide me with any data or statistics in the percentage increase in the ICD9 diagnosis for the hospitals you've worked at from let's say 2000 to the present?
  MR. HALL: Same objection.
  A: It's been my experience that those – those diagnoses have gone up.
  Q: Right, I understand that. I'm asking you can you tell me how much they've gone up can you?
  A: I have not.
  Q: And you've not gone back and looked at any data since you were retained as an expert witness in this case to try to determine how much the ICD9 diagnosis have gone up at the hospitals in which you've worked?
  A: Correct." (Griffith Dep. Tr. at 229:2-230:23.)

- **Q:** "Can you provide us . . . with any statistics or data regarding how, if at all the prescribing behavior by physicians as it relates to opioids has been impacted at either of the three hospitals you've worked at in Oklahoma since the implementation of the HCAHP survey?
  A: I can only provide my opinions that were based upon my -- my experiences at those hospitals.
  Q: Objection nonresponsive [] I'm asking can you provide us any statistics or data upon which those opinions?
  A: I'm not.
  Q: Are purportedly based?
  A: I'm sorry.
  Q: Can you provide me any data or starts particulars upon which your stated opinion is based as it relates to the impact of the implementation pain management dimension on the HCAHP survey on prescribing behavior at the facilities where you have worked since entering hospital administration?
  MR. HALL: Object to the form.
  A: I'm not a statistician so I cannot provide you with those numbers.
  Q: And you don't have to be a statistician to provide me with those numbers?
  A: Correct.

MR. HALL: Object to the form.
Q: So can you provide me with any data?
A: My tell is based on my experience, I cannot bring you data of the numbers for numbers to give to you at this time.
Q: But that data is out there, if you wanted to or had wanted to you could have pulled data from let's just say the facility that you're working at right now you could pull data couldn't you about how the chronic pain diagnosis has changed if at all in the past 20 years couldn't you?
MR. HALL: Object to the form.
A: I'm not sure I could do that with the private -- private sayings rules and state rules I'm not sure I could do it may be possible I just don't know if it's possible.
Q: And you haven't looked into whether or not that's possible believe?
MR. HALL: Object to the form.
A: I did not because my opinions were based upon my experience up to that point. I didn't want to pull data to -- to influence those opinions. I -- I wanted -- I would come to testify about my opinions and my experiences and I didn't want data be -- to be pulled in to – to influence my opinion. My opinion was my opinion based upon my experience.
Q: So even if the -- if -- even if the data might have not supported your opinion I just chose to – you chose not to want to look at the data because you didn't want it to influence your opinion?
MR. HALL: Object to the form.
A: I didn't want to be accused of influencing my opinion by the data.
Q: Got it." (Griffith Dep. Tr. at 272:22-274:24.)

- **Q:** "Have you done any research on that or compiled any data or reviewed any data, for purposes of making the statement in your expert report, to support that statement?
  A: No I have not.
  Q: Are you aware of any data that has been published or is publicly available that would support your statement here that the three most indicative dimensions on a hospital's performance are those three that you've listed: Physician communication, nurse communication and pain management?
  A: I --
  MR. HALL: Object to the form.
  A: I listed those under my personal experience. I have not look – reviewed data to inform that opinion." (Griffith Dep. Tr. at 297:21-298-5.)

- **Q:** "So during the 18 or so years that you ever been in hospital administration, how many times have you seen a physician write more prescriptions or a prescription or more prescriptions in order to improve a pain management score?
  A: Again --
  MR. HALL: Same objection.
  A: -- I'm not –
  Q: Is it –
  A: I'm not going to put a number on it. Sorry.

Q: Okay. And that – and have you kept data on that, such that you could put a number on it?
MR. HALL: Same objection.
A: No I have not.
Q: Have you looked at data on that?
A: I, purposely, did not review data before my expert testimony, so it would not so seem that it was influencing my opinions of an -- as an expert." (Griffith Dep. Tr. at 345:3-21.)

- **Q:** So you were just asked some questions about your observations about sales reps/ Do you -- do you recall that?
A: Yes.
Q: And did you -- is it your testimony that you observed an increase in the number of sales reps who visited doctors?
A: Yes.
Q: And that observation is based on your experience; it's not based on any data is it?
MR. HALL: Object to the form.
A: All of my observations are based upon my observations. My opinions are based upon my observations.
Q: But that's -- but your opinion is not based on any data that monitors or tracks the number of visits by sales reps is it?
A: I have no counter of sales reps, no.
Q: Sorry just so I understand -- your answer you said you have no count of --
A: No counter. You know, like a -- balls and strikes, you know, there's no counter of how many sales reps I saw, no.
Q: And there was no report you consulted?
MR. HALL: Object to the form.
A: No.
(Griffith Dep. Tr. at 356:23-357:22.)

Accordingly, regardless of whether Mr. Griffith seeks to provide expert testimony as to health care administration and prescribing behaviors at his own hospital or others, the fact is that Mr. Griffith lacks sufficient relevant work experience on either topic and has failed to review ***any*** data in preparing his opinions. Numerous courts have held in less egregious cases that failure to review substantial available data renders expert testimony inadmissible under *Daubert*.[3] This Court should hold the same here.

[3] *See Bowling v. Hasbro, Inc.*, No. CIV.A. 05-229S, 2008 WL 717741, at *4 (D.R.I. Mar. 17, 2008) (holding expert testimony inadmissible where "analysis lacks sufficient reference to facts,

B. Mr. Griffith's Opinions As To The Supposed "Influences" Behind CMS And JCAHO's Support For Including Pain Management Questions In The HCAHPS Survey Are Unqualified, Unreliable, And Should Be Excluded

Mr. Griffith's opinions as to the supposed "influences" behind CMS and JCAHO's support for including pain management questions in the HCAHPS Survey are equally inadmissible.

Mr. Griffith does not claim that he has any relevant education or experience in the workings of CMS or JCAHO. Nor does he provide any other reliable basis for his opinions about them. Indeed, he admits that the only basis for his opinions as to CMS and JCAHO are two documents he received from counsel two days prior to his deposition. He admits that other than reviewing the two documents forwarded by counsel, he has no knowledge and conducted no research on how the pain management questions were added, whether the entities that added them were influenced by anyone, or whether said influence came from a pharmaceutical manufacturer:

> **Q:** Okay. So prior to looking at one of the documents that was provided to you two days ago --
> **A:** Correct.
> **Q:** -- by counsel for the State of Oklahoma, you had no knowledge or information about why the Joint Commission or any of these other bodies had started looking at pain back in the 1990s –
> **MR. HALL:** Objection to the form
> **Q:** -- is that correct?
> **A:** Correct." (Griffith Dep. Tr. at 134:7-16.)

- **Q:** "Do you know any things that caused the Joint Commission to start telling hospitals to start focusing on pain?
  MR. HALL: Objection.
  A: My understanding, reading the AIG report -- or the Office -- the General --

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data, or any relevant information at all" and instead, "begins and ends with [expert's] reliance on and reference to his own expertise."); *LeClercq v. The Lockformer Company,* No. 00-C-7164, 2005 WL 1162979, at 4 (N.D. Ill. Apr. 28, 2005) (granting motion to exclude expert testimony where "disregard of relevant data undermine[d] the reliability of [the expert's] entire opinion."); *IP Innovation L.L.C. v. Red Hat, Inc.*, 705 F. Supp. 2d 687, 690 (E.D. Tex. 2010) (granting motion to exclude expert testimony where expert failed to consider available "factual data necessary for a reliable assessment.").

Q: The GAO?
A: -- the GAO report that -- that there was influences from companies to make sure that that became a focus of care.
Q: So your statement that -- everything you just said.
Q: -- is based on what you read in the General Accounting Office report two days ago?
A: Yes." (Griffith Dep. Tr. at 202:24-203:14.)

- **Q:** "Okay. Prior to reading the General Accounting Office report that was given to you by the lawyers for the State two days ago, did you have any information at all Mr. Griffith as to what led the Joint Commission to star requiring hospitals to focus on pain sometime in the mid 1990s?
MR. HALL: Object to the form.
A: My experience in healthcare was that we focused on pain from the beginning of my career.
Q: I appreciate --
A: Tho –
Q: -- that
A: Those things led to things that perhaps were not as – were not good. When it started and how it started, I -- I'm -- I was not privy to that knowledge before given -- being given that report.
(Griffith Dep. Tr. at 203:16-204:7.)

- **Q:** "-- very simply: Before getting a copy of a document that was provided to you, by the lawyers for the State of Oklahoma, two days ago --
A: Sure
Q: -- did you have any knowledge or information about what caused the Joint Commission, back in the mid 1990s to start asking hospitals to focus on pain?
MR. HALL: Same objection asked and answered.
A: I knew we focused on it.
Q: Right.
A: Whether I knew why, I -- I -- it -- it was not my -- it was... it was not our place to ask why it was only our place to do and die.
Q: Okay.
A: We knew that it was a big deal.
Q: I get that, Mr. Griffith --
A: And so if you --
Q: -- and you've said that --
A: -- ask me do I -- did I know how it got there no." (Griffith Dep. Tr. at 207:10:-208-4.)

To Defendants' knowledge, no court has ever held that an individual with no relevant education or experience may provide an expert opinion solely based on the review of two documents provided by counsel. This Court should not be the first.

Nevertheless, the two documents in this case are not a reliable basis for Mr. Griffith's speculation about why the questions regarding pain were initially included in the HCAHPS Survey. The first of these documents briefly discusses the pain management questions and the HCAHPS Survey, but does not discuss how or why the pain management questions were added to the survey, much less attribute their inclusion to the influence of any pharmaceutical manufacturer.[4] The second does not even discuss the pain management questions or the HCAHPS Survey at all.[5] They simply cannot, as Mr. Griffith alleges, serves as the basis for his opinion as to why the pain management questions were included in the HCAHPS Survey, much less as the basis for a reliable expert opinion as required under *Daubert*.

C. All Of Mr. Griffith's Opinions Related To Causation Should Be Excluded Because They Are Nothing More Than *Ipse Dixit*

Mr. Griffith seeks to opine that prescribers, healthcare administrators, and other independent parties acted a certain way "as a result of" or "in response to" the HCAHPS survey's pain questions or alleged influences. (Exhibit H to Disclosures.) Those opinions are especially unreliable.

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[4] The President's Commission on Combating Drug Addiction and The Opioid Crisis, Final Report (2017), *accessible at* https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

[5] U.S. Government Accountability Office, Report to Congressional Requesters, PRESCRIPTION DRUGS: OXYCONTIN ABUSE AND DIVERSION AND EFFORTS TO ADDRESS THE PROBLEM (Dec. 2003), *accessible at* https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-04-110/pdf/GAOREPORTS-GAO-04-110.pdf

Where, as here, "an expert's opinion relates to causation, reliability of that opinion is provided when the expert's opinion is based upon a reliable method for determining causation and the conclusion is analytically appropriate to that method." *Gray*, 2003 OK 10, ¶ 36, 65 P.3d 591, 607. "The reliability of the method is not shown merely because the expert states that causation exists." *Id.* "Generally, the district court should focus on an expert's methodology rather than the conclusions it generates." *Daubert*, 509 U.S. at 595. "An expert's opinion on causation must be more than *ipse dixit*." *Gray*, 2003 OK 10, ¶ 36, 65 P.3d 591, 607.

As explained in more detail above in Sections II.A-B, Mr. Griffith has failed to review ***any*** of the available of data that would allow him and Defendants to confirm or deny his purported expert conclusions, much less provide any methodology for his conclusions. Accordingly, Mr. Griffith's opinions as to causation are nothing more than *ipse dixit* and should be excluded under *Daubert*.

IV. CONCLUSION

For the multiple, independent reasons described above, Defendants respectfully request that this Court exclude the testimony of Mr. Griffith in its entirety.

Dated: April 23, 2019

Respectfully submitted,

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CERTIFICATE OF MAILING

Pursuant to 12 O.S. § 2005(D), and by agreement of the parties, this is to certify on April 23, 2019, a true and correct copy of the above and foregoing has been served via electronic mail, to the following:

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Nick Merkley

EXHIBIT 1

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA,

Plaintiff,

-vs-

PURDUE PHARMA, L.P.; et al.,

Defendants.

No. CJ-2017-816

* * * * *

VIDEOTAPED DEPOSITION OF TY GRIFFITH

TAKEN ON BEHALF OF THE DEFENDANTS

IN OKLAHOMA CITY, OKLAHOMA

ON FEBRUARY 22, 2019

COMMENCING AT 9:14 A.M.

* * * * *

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REPORTED BY: BETH A. McGINLEY, CSR, RPR

an EMT, basic.

Q Okay.

A There are different levels. At that time, there were three levels: basic, intermediate and paramedic.

Q Uh-huh.

A Now, there's just basic and -- and paramedic.

Q Uh-huh.

A But I'm a -- I was -- at that time, took and passed, the national registered EMT basic.

Q Got it. Okay. Thank you for that.

Did I understand you correctly, earlier today, to say that you believe your qualifications to testify as an expert on the issues outlined in the disclosure in this case is derived from your work experience?

A Yes, ma'am.

Q All right. Is there anything, other than your work experience in healthcare, that you believe qualifies you to provide the expert opinions you're planning to offer in this case?

MR. HALL: Object to the form.

THE WITNESS: I'm sorry?

MR. HALL: Go ahead.

A No, ma'am.

Q (By Ms. Patterson) Okay.

A Just my --

Q So let's --
A -- work experience.
Q I'm sorry?
A Just my work experience. I apologize.
Q Okay. So I want to go through your work experience.
A Okay.
Q And let's use your CV as sort of a cheat sheet to do that, and we'll work --
A Okay.
Q -- backwards.

You indicate, on Page 3, that you worked, at some point in time, as a lead therapy technician, from 1996 to 1999, at Stillwater Medical Center. Was that while you were in college?

A It was while I was in college. My wife -- I got married after my sophomore year and my wife was a year behind me and so I waited -- quote-unquote, "waited" there in Stillwater for her, for a year. So I finished school in 1998 but worked until the fall -- or the spring of 1999, while she finished her degree.

Q Okay. But you were not in any kind of hospital administration role at that point in time?
A I would say no.
Q And was -- during that period of time, you were

Q Oh, sorry.
A -- jump from position to position.
Q You're right. So you moved --
A Sorry.
Q -- moved into a different position. Was that a promotion?
A Yes, ma'am.
Q Okay. So you were promoted from the supervisor position to the management process administrator?
A Uh-huh.
Q And you held that position until 2003?
A Yes, ma'am.
Q All right. And both of those positions were in Oklahoma City. I see that. Okay.
Did you consider the management process administrator position to be a position in what you have defined as hospital administration?
A Yes, ma'am.
Q Okay. So that would have been your first position in hospital administration?
A Yes, ma'am.
Q And you used the term, earlier, "director." Did you -- do you equate that to a director-level position?
A It was a director-level position. I reported to the -- to the -- I reported to two people. I -- I

reported directly to the president, but I also reported to a vice-president. If you report to a vice-president, you're a director-level position.

Q Right, okay. And, again, the years that you held that position were years prior to the implementation of the HCAHPS survey, correct?

A The implementation of the formal HCAHPS survey from CMS, yes.

Q Okay. Let's look at Page 2 of your CV. It looks like, in 2003, you made a change and you moved to a new position with a new employer, Unity Health Center; is that right?

A Correct.

Q Okay.

A And -- and let me say something about Unity.

Q Uh-huh.

A If you go looking for that, you're not going to find it now.

Q Uh-huh.

A That has transitioned to be part of the SSM network, who I work for -- they -- they're now called St. Anthony's -- or SSM Health St. Anthony Shawnee. They have a long term, but that was -- Unity Health Center was the hospital in Shawnee. It's not that it closed, it just changed -- they were purchased by SSM, so, if you were

looking for that later, I just didn't want --

Q Got it.

A -- you to find --

Q Well, was it -- but when you were working there from 2003 to 2010, was it part of the SSM network?

A Not in an ownership capacity. It -- St. -- SSM has what -- it was kind of on affiliate status and it was an affiliate, but it was not owned by SSM.

Q Okay. Got it. Why did you leave the position at St. Anthony to go to the position at Unity Health Center in Shawnee?

A So one of the things that I -- as a management process administrator, my main role was to help with quality and satisfaction, and whatnot, and -- and -- and, honestly, cost, from a very hospital-based, department-to-department opportunity.

My contact with physicians during that time was based mostly just on those types of things, productivity and what we were -- what we were doing. When I -- and in healthcare, to advance or to kind of become mature -- a -- more mature in an organization, you need more physician contact, you need to be a -- a -- you need to be a physician guy, so to speak, and so -- to use a colloquial term.

So, as the management process administrator, my

contact with physicians was limited; you know, five to 10 percent of my position was physician contact. It wasn't nil, but it was limited.

Moving to the director of medical staff development, that is a physician/administrative type role and I recruited physicians, I was liaison of physicians, I ran clinics, I was involved in the hospital care, the hospitalist program. That is a -- that's -- my -- there -- there's, basically, a couple of paths in hospital administration: One of them is through nursing, but you have --

Q Uh-huh.

A -- to be a nurse for that.

Q Right, right.

A And one of them is as a physician --

Q Right.

A -- person.

Q Right.

A And I -- that's the path that I chose. I had a mentor that had worked with me at St. Anthony, who had moved out to -- to Unity --

Q Okay.

A -- and he had -- he was the COO.

Q Okay.

A And I moved out to work for him in this

assessment, yes.

Q Okay. And -- and do you know how it came to be that pain became part of the assessment that The Joint Commission required hospitals to look at in the late '90s and early 2000s?

A As I -- as I've referenced, I did read the accounting practices -- or the accounting office's understanding of that being brought in to -- as a -- as a portion of Press Ganey -- or, excuse me, not Press Ganey. I'm getting my --

Q Uh-huh.

A -- places confused here.

Q Uh-huh.

A Under the -- the General Accounting Office's report said it was brought in to be part of that survey or be part of that information in the '90s, as it was influenced by. I -- I can't say that I know -- I knew, before, why it was part. I don't -- I can't say, before I saw that document, I had knowledge of why Press Ganey -- or, excuse me, The Joint Commission started to work on that, no.

Q Okay. I'm very confused by the answer.

A Okay.

Q So let me make sure --

A Okay.

Q -- I understand. Are --

A You asked me if I knew why that Press -- Press Ganey -- excuse me, The Joint Commission was working on that. Prior to looking at the Office of Inspector General Office (sic), I did not have knowledge of why they started to work on that.

Q Okay. So prior to looking at one of the two documents that was provided to you two days ago --

A Correct.

Q -- by counsel for the State of Oklahoma, you had no knowledge or information about why The Joint Commission or any of these other bodies had started looking at pain back in the 1990s --

MR. HALL: Object to the form.

Q (By Ms. Patterson) -- is that correct?

A Correct.

Q All right. Do you know how far back in time the accrediting bodies in -- or surveying organizations, such as The Joint Commission or Press Ganey -- how far back it was that they began looking at pain and pain management as an aspect of patient satisfaction?

A No, I do not.

Q Did it start in the '70s? Did it start in the --

A I don't -- I don't -- my career started in

the -- in the '90s. I know we -- we cared about it when I started in 1996.

Q Okay. But -- but when The Joint Commission or Press Ganey or when any of these other surveying entities started asking hospitals or requiring hospitals to look at pain and pain management, you just don't know, as we sit here today, when -- when that sort of a trend started, do you?

MR. HALL: Object to the form.

A I believe that the Office of Ins- -- I keep wanting to say Office of Inspector General, but that's not the report --

Q (By Ms. Patterson) The General Accounting Office.

A The General Accounting Office --

Q Uh-huh.

A -- report stated that that was in the '90s, in the -- in the mid to late '90s, but I had no knowledge, before seeing that report, of when that was.

Q Okay. Let me -- I think I can put it this way: The only knowledge that you have, as we sit here today, of when pain became an element of -- or pain management was something that was being looked at by the accrediting bodies or the surveying bodies, is based on what you read in the article that was provided to you by plaintiffs'

committee --

A Yes.

Q -- right?

A Yes, absolutely.

Q So I'm trying to figure out: In your experience, Mr. Griffith, when was it that The Joint Commission began focusing on pain to such an extent that you believe hospitals -- as you put it, it was taken to the next level?

A I would say the mid '90s.

Q Mid '90s, okay. Which is, what, right around the time you were getting into healthcare?

A Yes, ma'am.

Q Okay. So in the mid '90s, it's your testimony, is when -- again, in your experience, is when The Joint Commissions (sic) started taking it up a notch in terms of -- of telling hospitals to focus on pain, among other things, correct?

A Yes.

Q Okay. Now, do you know what prompted The Joint Commission to start telling hospitals to focus on pain?

MR. HALL: Object to the form.

A I don't know all -- all things, no.

Q (By Ms. Patterson) Do you know any things that caused The Joint Commission to start telling hospitals to

start focusing on pain?

MR. HALL: Objection.

A My understanding, reading the AIG report -- or the Office -- the General --

Q (By Ms. Patterson) The GAO?

A -- the GAO report, that -- that there was influences from companies to make sure that that became a focus of care.

Q So your statement that -- everything you just said --

A Uh-huh.

Q -- is based on what you read in the General Accounting Office report two days ago?

A Yes.

MR. HALL: Object to the form.

Q (By Ms. Patterson) Okay. Prior to reading the General Accounting Office report that was given to you by the lawyers for the State two days ago, did you have any information, at all, Mr. Griffith, as to what led The Joint Commission to start requiring hospitals to focus on pain sometime in the mid 1990s?

MR. HALL: Object to the form.

A My experience in healthcare was that we focused on pain from the beginning of my career.

Q (By Ms. Patterson) I appreciate --

A Tho- --
Q -- that.
A Those things led to things that, perhaps, were not as -- were not good.
When it started and how it started, I -- I'm -- I was not privy to that knowledge before given -- being given that report.
Q Okay.
A But my experience was -- is that whether I knew the genesis, I understood the Exodus, Leviticus, Numbers and Deuteronomy.
Q Okay. I get that. I'm asking you right now, though, about the genesis --
A Okay.
Q -- okay? All right.
A Did I know that there was influence on -- on The Joint Commission? No, I did not.
Q Okay.
A I know that -- I knew that The Joint Commission took that very seriously.
Q Okay.
A I knew that The Joint Commission wanted us to focus on it and we made changes --
Q Sure, I understand that.
A -- and we tried to improve on that --

Q You -- you've said that --
A -- in my experience.
Q You've said that many times --
A Sorry.
Q -- and I get that. I get that, at some point, and you've now told me in the mid 1990s, the message, as far as you understood it, became very clear, from The Joint Commission, that The Joint Commission wanted hospitals, that wanted to stay accredited, to focus on pain, right?
A Yes.
Q Okay. My question is, though: Do you know, other than what you read in the General Accounting Office document that was provided to you, by these lawyers representing the State, two days ago --
A Correct.
Q -- did you have any information, prior to two days ago, about what might have caused The Joint Commission to start asking hospitals to put a focus on pain?
MR. HALL: Object to the form.
A I was --
Q (By Ms. Patterson) Yes or no.
A I was --
MR. HALL: Same objection.

A I was given that information. My experience -- what I'm here to testify today about was my experience with how the HCAHP questions, which is a linear back to -- to -- to The Joint Commission, influenced what we were doing within the hospitals and how I believe that that influenced physicians into doing --

Q (By Ms. Patterson) We're going to get to that.

A I know you are.

Q We're going to get to that.

A The idea that, because I didn't know that -- where The Joint Commission influenced, could -- meant I didn't know anything beyond that, is --

Q I'm not saying that.

A -- outside of the --

Q That's not what I'm saying at all.

A -- realm of possibility.

I knew that we were focusing on it. Whether I knew how it got on that book or not, until two days ago, is irrelevant to the idea of what happens with patients.

Q I understand that you may think it's irrelevant to that, and we're going to get to that --

A Uh-huh.

Q -- in a minute, but I'm still back here on when this focus began, because you've made a pretty big deal about the fact that, at some point in time, this focus by

The Joint Commission became pretty apparent to the hospital community --

A That was -- when I --

Q -- right?

A -- got to the hospitals --

Q Right.

A -- it was a focus when I was working, yes.

Q Okay. And all I'm asking you --

A Yeah.

Q -- very simply: Before getting a copy of a document that was provided to you, by the lawyers for the State of Oklahoma, two days ago --

A Sure.

Q -- did you have any knowledge or information about what caused The Joint Commission, back in the mid 1990s, to start asking hospitals to focus on pain?

MR. HALL: Same objection, asked and answered.

A I knew we focused on it.

Q (By Ms. Patterson) Right.

A Whether I knew why, I -- I -- it -- it was not my -- it was... it was not our place to ask why. It was only our place to do and die.

Q Okay.

A We knew that it was a big deal.

Q I get that, Mr. Griffith --

A And so if you --
Q -- and you've said that --
A -- ask me do I -- did I know how it got there, no.
Q Okay. That's all I wanted to know.
A Okay.
Q Thank you. Now, we can move on to something else.
A Thank you.
Q Okay. Now, you read something in the Joint Accounting Office -- I'm sorry, the General Accounting Office document that you were provided two days ago that, sounds like, had some commentary on what might have led The Joint Commission to focus on pain. You've read something in that document about that, correct?
MR. HALL: Object to the form.
Q (By Ms. Patterson) Is that right?
MR. HALL: Object to the form.
A I have -- I read the General Accounting document.
Q (By Ms. Patterson) Okay.
A Yes.
Q All right. Other than reading, in the General Accounting Office document, about what might have -- and, obviously, that document is going to speak for itself.

Q Can you tell me what the percentage increase is?
A I cannot.
MR. HALL: Same objection.
Q (By Ms. Patterson) Can you give me a nominal increase --
MR. HALL: Same objection.
Q (By Ms. Patterson) -- based on number of prescriptions per year?
MR. HALL: Same objection.
A I --
Q (By Ms. Patterson) Or number -- number of diagnoses per year?
MR. HALL: Same objection.
A I believe there's to be an increase. I cannot give you a percentage.
Q (By Ms. Patterson) Okay. Why not?
MR. HALL: Same objection.
A Because you asked me to be completely truthful and honest and I want to be completely truthful and honest and, with that -- with that, I -- I didn't calculate those things. I just saw them move up the list.
Q (By Ms. Patterson) All right. So -- and, again, you worked at hospitals and healthcare facilities of different sizes -- those four that we mentioned are different sizes, in terms of number of beds and number of

average census per day --

A Yes --

Q -- correct?

A Yes, ma'am.

Q All right. So, as we sit here today, you're unable to provide me with any data or statistics on the percentage increase in the ICD-9 diagnoses for the hospitals that you've worked at from, let's say, 2000 to the present?

A It --

MR. HALL: Same objection.

A It's been my experience that those I- -- those diagnosises have gone up.

Q (By Ms. Patterson) Right, I understand that. I'm asking you: Can you tell me how much they've gone up? Can you --

A I cannot.

Q Okay. And you've not gone back and looked at any data, since you were retained to act as an expert witness in this case, to try to determine how much the ICD-9 diagnoses have gone up at the hospitals in which you've worked?

A Correct.

MR. HALL: Same --

Q (By Ms. Patterson) Okay.

external.

A Okay.

Q Okay? So -- and let me just kind of give you an idea of what I'm looking for. I want to ask you about what data you have actually pulled and looked at with -- with regard to the hospitals where you've worked.

A Uh-huh.

Q And then I'm going to ask you some questions about what data, if any, you've looked at on a national level.

A Okay.

Q And then I'm going to ask you what data you've looked at, if any, for hospitals just in the State of Oklahoma.

A Okay.

Q Okay?

A I understand.

Q And so let's talk -- let's talk, first, about the diagnosis for chronic pain, whether it's an ICD-9 or ICD-10. I don't want to get hung up on those differences.

A Okay.

Q There -- there have been diagnosis codes for chronic pain going back to the -- to the mid '90s --

A Correct.

Q -- right? Okay.

A Or before, yes.
Q Right. And, again, I'm just limiting my questions to the mid '90s because that's the only period of time I think you can testify about, right?
MR. HALL: Object to the form.
Q (By Ms. Patterson) Since the mid '90s, when you've been in hospital administration?
A I was in the hos- -- I got into the -- I got into hos- -- healthcare in the mid '90s and --
Q Right.
A -- hospital administration in the early 2000s.
Q And I'm not hearing you say you've done any research or reading or study about diagnosis codes or -- or levels of pain medications being prescribed prior to the period of time you got into the healthcare field; is that right?
A Correct.
Q Okay. So my questions are -- can only be, then, focused on what, if any, study or research you've done since you got into this field, which is the mid 1990s?
A Correct.
MR. HALL: Object to the form.
Q (By Ms. Patterson) Okay. So, now that we've got our time frame established, what I'm wanting to know from you is: At any time -- well, strike that.

Can you tell me, for the facilities in which you have worked during that period of time -- can you tell me the percentage increase, if any, in the diagnosis for chronic pain at those facilities from the mid 1990s until today?

MR. HALL: Object to the form.

A I can tell you they've increased.

Q (By Ms. Patterson) But you can't tell me the level at which they've increased?

A Correct.

Q Can you tell me -- well, strike that.

And you've not pulled any data, for the purpose of formulating your expert opinion in this case, to determine how much those diagnoses codes have increased, have you?

MR. HALL: Object to the form.

A No -- my expert opinion was my expert opinion from the beginning. I have not pulled any other data to influence my expert opinion.

Q (By Ms. Patterson) Well, I don't think you've pulled any data on anything, have you?

A I've pulled data. I --

Q When?

A I -- I have -- over my career, I've looked at ICD-10 --

Q Okay.

A -- ICD-9 and ICD-10 diagnosis, and I've looked at -- at the spend that we've done on our own employees and seen --

Q Right.

A -- it go from the -- like, lower on the list -- and I'm not going to say exact numbers, because I want to be truthful and honest --

Q Right.

A -- a hundred percent, but lower on the list, that chron- -- chronic medications were lower on the list and, as we went through the years, especially as we focused more and more from The Joint Commission, as we were instructed to do, on pain, and then we get into IC -- or HCAHPS surveys, I've seen those opioids come up the list, I've seen those chronic diagnosis codes, which mean -- if you have a chronic diagnosis code of pain, normally you have that so that you qualify for a pain medication, and those have come up the list. Can I tell you the exact percentages? No. Because I want to be above-board and completely truthful and honest, but they have come up.

Q Okay. In your experience?

A In my experience.

Q At the hospitals where you've worked?

A At my experience, in the hospital I've worked, which is the only thing I can testify to.
Q Which is -- which is four hospitals?
A Which is four hospitals in --
Q Three of --
A -- two states.
Q -- which were in the -- in the state of Oklahoma?
A Correct.
Q Okay. How many hospitals are there in the state of Oklahoma?
A I believe -- I -- I -- I couldn't tell you exactly. I have a number, I think, but I don't -- I don't know.
Q Can you give me the number that you think and I'll understand --
A I believe it's --
Q -- that it's an estimate.
A I believe it's 260 hospitals.
Q About 260 hospitals. Do you have any number of how many hospitals there are in the United States that are subject to this -- or have been subject to this Joint Commission focus on pain since the mid 1990s?
MR. HALL: Object to the form.
Q (By Ms. Patterson) Thousands?

MR. HALL: Object to the form.

A There's a lot of hospitals in the United States. I -- I don't want to --

Q (By Ms. Patterson) Thousands?

A I don't want to proctor a guess on that because I don't -- I don't have any -- I don't know.

Q Okay. Well, if there are over 200 hospitals in the state of Oklahoma, safe to say that there are probably thousands of hospitals across the United States that, since the 1990s, have been subject to this focus that you've told me about, from The Joint Commission, on pain?

A I just --

MR. HALL: Object to the form.

A I would say that there are lots of hospitals influenced by The Joint Commission.

Q (By Ms. Patterson) Okay.

A Yes.

Q And you've -- have you, at any point in time --

A Uh-huh.

Q -- at any point in time -- and I'm not just limiting this to since you became an expert in this case.

Have you, at any point in time, reviewed or analyzed data as it relates to the hospitals in the state of Oklahoma and whether or not the increase -- whether or not there has been an increase in diagnoses for chronic

pain since the late 1990s?

MR. HALL: Object to the form.

A I have not reviewed any data, outside my own review of -- during my career, of understanding those codes, to influence my expert -- ex- -- testimony.

Q (By Ms. Patterson) So -- so your testimony on -- on whether or not there has been an increase in the number of chronic pain diagnoses is limited to what you know from the three hospitals that you've worked at in the State of Oklahoma?

MR. HALL: Object to the form, mischaracterizes his testimony.

A My understanding of hospital administration is my understanding of hospital administration. I can't tell you what goes on at every hospital, but I know what goes on at my hospital.

Q (By Ms. Patterson) Right.

A And I talk to other administrators and I would say that my -- my -- my experience is not unique, but you would have to ask them.

Q Right. Have you talked to any other hospital administrator -- and, if so, I want you to tell me who. Have you ever talked to any other hospital administrator at another hospital in the state of Oklahoma, about the -- about whether or not their chronic pain diagnoses have

gone up since the late 1990s?

A No.

Q Okay. So, to the extent you're offering an opinion here today -- or part of your opinion here today is that there has been an increase in chronic pain diagnoses since the late 1990s, that is based on the data that you've had an opportunity to review at the three different hospitals that you've worked at in Oklahoma?

A I would say yes.

MR. HALL: Same objection.

Q (By Ms. Patterson) And that's not -- and your opinion is not based on data that you've looked at related to any other hospital in the state of Oklahoma, is it?

MR. HALL: Object to the form.

Q (By Ms. Patterson) Because you haven't looked at data regarding any other hospital in the state of Oklahoma; isn't that right?

MR. HALL: Same objection.

A My opinions are based upon my experience in my time at those hospitals.

Q (By Ms. Patterson) Right. Which means you haven't looked at data about whether or not there has been an increase, at all, in chronic pain diagnoses at other hospitals in Oklahoma? You've never looked at that, have you?

Q -- number you --
A -- if I pulled all the medications, back in the '90s, versus now, what we -- for the patients?
Q Let me back up and try to ask it in a much more simple way.
A Okay.
Q There are, as you said a moment ago, 200-plus hospitals in the state of Oklahoma --
A Yes.
Q -- give or take, right?
A Correct.
Q Okay. Have you ever looked at data from any of those other hospitals in the state of Oklahoma, regarding the level of opioid medications that are being prescribed and administered in those hospitals, from 1990 to today?
MR. HALL: Object to the form.
A I have not, because they don't influence my personal experience in the places that I was, and I haven't reviewed more data --
Q (By Ms. Patterson) Right.
A -- that might -- that would -- that would, in some way -- you would -- did that influence your opinion? I have not gone out and reviewed data, purposefully, because it's -- these are my opinions.
Q Right, I understand what your opinions are.

Q (By Ms. Patterson) Are you aware --
THE WITNESS: I think I said yes.
Q (By Ms. Patterson) I'm sorry?
A I thought I said yes to that one.
Q Okay.
A I -- I'm sorry, I --
Q All right. And the record will reflect -- we'll see.
A Okay.
THE WITNESS: Did I?
Q (By Ms. Patterson) Can you provide us --
THE WITNESS: Sorry.
Q (By Ms. Patterson) -- with any statistics or data regarding how, if at all, the prescribing behavior by physicians, as it relates to opioids, has been impacted at either of the three hospitals you've worked at in Oklahoma, since the implementation of the HCAHPS survey?
MR. HALL: Object to the form.
A I can only provide my opinions that were based upon my im- -- my experiences at those hospitals.
MS. PATTERSON: Objection, nonresponsive.
Q (By Ms. Patterson) I'm asking: Can you provide us any statistics or data upon which those opinions --
A I'm not a statistician.
Q -- are purportedly based --

A Sorry. I apologize. Go -- go ahead. I'm sorry.

Q Can you provide me any data or statistics upon which your stated opinion is based, as it relates to the impact of the implementation of the pain management dimension on the HCAHPS survey on prescribing behavior at the facilities where you have worked since entering hospital administration?

MR. HALL: Object to the form.

A I'm not a statistician, so I cannot provide you with those numbers.

Q (By Ms. Patterson) And you don't have to be a statistician to provide me with those numbers.

A Correct.

MR. HALL: Object to the form.

Q (By Ms. Patterson) So can you provide me with any data?

A My testimony is based upon my experience. I cannot bring you data of the numbers -- for numbers, to give to you at this time.

Q But that data is out there. If you wanted to, or had wanted to, you could have pulled data from -- let's just say the facility that you're working at right now. You could pull data, couldn't you, about how the chronic pain diagnoses has changed, if at all, in the past 20

years, couldn't you?

MR. HALL: Object to the form.

A I'm not sure I could do that. With the private -- privatization rules and State rules, I'm not sure I could do that. I -- it -- it may be possible, I just don't know that that is possible.

Q (By Ms. Patterson) Okay. And you haven't looked into whether or not that's possible?

MR. HALL: Object to the form.

A I did not, because my opinions were based upon my experience up to that point. I didn't want to pull data to -- to -- to influence those opinions. I -- I wanted -- I would come to testify about my opinions and my experiences and I didn't want data be -- to be pulled in to -- to influence my opinion. My opinion was my opinion, based upon my experience.

Q (By Ms. Patterson) So even if the -- even -- even if the data might have not supported your opinion, you just chose to -- you chose not to want to look at the data because you didn't want it to influence your opinion?

MR. HALL: Object to the form.

A I didn't want to be accused of influencing my opinion by the data.

Q (By Ms. Patterson) Got it.

A Either way.

Q All right.

MR. HALL: Same objection.

Q (By Ms. Patterson) Since being retained to serve as an expert witness in this case, have you communicated with or gathered data from hospital administrators at any other hospital in the state of Oklahoma, about the impact of the HCAHPS survey or the inclusion of the pain management dimension in the HCAHPS survey, on how they operate their hospitals?

A No.

Q Since -- well, strike that.

At any point in time during your professional or academic career, have you communicated with or gathered data from any other hospital or a hospital administrator in the state of Oklahoma, about how the inclusion of the pain management dimension, in the HCAHPS survey, has impact- -- impacted how they operate their hospital?

A No.

Q Since being retained as an expert witness in this case, have you communicated with or gathered data from hospital administrators at any other hospital in the state of Oklahoma, about how the inclusion of the pain management dimension, in the HCAHPS survey, has impacted prescribing behavior at their facilities?

MR. HALL: Object to the form.

A My experience is based upon my experience. I was not influenced and did not survey or did not talk to a lot of other -- or any other hospital administrators based on this opinion. We talk shop a lot when we're around each other. Can I say that I asked -- asked, "Do you share this opinion?" No, I have not.

Q (By Ms. Patterson) Okay. So the answer to my question is no?

MR. HALL: Object to the form.

A It's more nuanced than that, but if that's what you'd like.

Q (By Ms. Patterson) No, I -- I -- let -- let me ask it again and, if you can't answer it "yes" or "no," that's fine. But the question is: Since being retained to serve as an expert witness in this case, have you communicated with or gathered data from any hospital administrator, at any other hospital in the state of Oklahoma, about the impact of the inclusion of the pain management dimension, on the HCAHPS survey, on the prescribing behaviors at their hospitals?

A I'm sorry, I --

MR. HALL: Same objection.

A -- thought the second question was had I ever. I thought the first question was, "Have you, since the in-- since the" --

Q (By Ms. Patterson) I'm -- I'm asking you -- I'm asking you the questions --
A Right.
Q -- both ways and --
A Okay, but the --
Q Just so you know, I'm asking you the question --
A Right, but I thought the first one was, "Have you, since the retainer," and the answer is: No, I have not spoken to anyone about this since the retainer.
Q Okay. But --
A Have I ever spoken to anyone? I'm sure, as we -- in my 18-year career, eight-year career, however we want to say it, have I talked to other people about HCAHPS? Absolutely.
Q It's not just about HCAHPS. It's more --
A And about pain? It's part of it.
Q And that's not what -- that wasn't the question, either.
A Okay.
Q The question is specific to what you said your opinion was.
A Okay.
Q So let me try it again, okay?
A I do not believe so. I'll -- I'll give you that. I do not believe I have done that.

Q Right, and I understand that. I just need to get it clear on the record, so let me ask --

A Okay. Yes, ma'am.

Q -- my question again.

A Okay.

Q Have you communicated with or gathered data from any other hospital or hospital administrator in the state of Oklahoma, at any time during your professional or academic career, about the impact of including the pain management dimension on the HCAHPS survey, as it relates to the prescribing behaviors at their hospitals?

MR. HALL: Object to the form.

A Not to any other administrators, no.

Q (By Ms. Patterson) Okay. At any other hospitals?

A At any other hospitals.

Q Okay.

A I mean, in our own hospital --

Q Right, I'm --

A -- of course, we talked about that stuff --

Q Sure, I'm talking about outside --

A -- all the time.

Q -- your hospital. You understand that, right?

A I do understand that.

Q All right.

A -- nursing employees --
Q Uh-huh, uh-huh.
A -- other administrators within my facility, other administrators within SSM, other executives at the hospitals I was at, nursing executives, accounting executives -- we talked about these things in -- in our individual hospitals all the time.

You -- you don't go out -- you know, you're probably, like, "Well, why don't you talk about it with other people?" You don't always go out and say, "We've got a problem with this," because you -- you know, you don't go out and say, "We've got problems with certain things." We all knew we had problems with certain things, but you don't necessarily go out and talk about that.

But, within our organizations, with our physicians, with our leadership, with our other hospital administrators, directors and above, certainly we spoke about the HCAHPS survey and what -- what was going on with our opioids going up in our communities.

Q Okay. And that -- the discussions you're talking about were within your own hospital organization?
A I would say within the hospital organizations, yes.
Q And -- and you say, "We knew we had problems"?
A We felt like we did, yes, because --

Q Well, what -- can you be more specific? What problems did you know that you had?

A We were seeing an increase of chronic pain management diagnosises and there was no change to the environment that we were in. It's not like things got heavier. So people were have- -- were being diagnosed with more chronic pain and nothing had changed.

In fact, we were probably less of an agrarian society, less of an -- an environment that would cause injuries that would cause chronic pain, probably less so, as we moved along and, yet, we would have more -- more chronic pain diagnosises in the hospital and in the -- in the clinics, so --

Q Do you have any -- sorry, I didn't mean to interrupt. Go ahead.

A No, I -- so the evidence was those things that we talked about before in our communities, when you said, "We have a problem with it," we also knew -- we would see more people into our -- into our emergency department, what's called obtunded, which means unconscious, and, usually, it's because they had mixed some sort of opioid that they had received with alcohol. And so we were seeing more patients in the emergency room obtunded.

I got to say we didn't see -- in -- in those small communities I was in, we didn't see a dearth of

overdoses, we did see some, and we're seeing in our -- in my downtown hospital now, we see overdoses, for sure, but we were seeing more evidence that things in the community were happening when people were embracing these medications and it was affecting their lives.

So we knew that there were issues happening in the community. We believed -- I believed that one of the things was, was we wrote more scripts for narcotics than we used to and that, in turn, was causing more issues.

MS. PATTERSON: Objection, nonresponsive.

Q (By Ms. Patterson) All right, Mr. Griffith. Let me ask you this question.

A I -- can I ask what I didn't respond on that? I'm -- I'm sorry, I -- I want to -- okay, sorry.

Q The period of time we've been talking about from the late '90s to the present, when you say, based on your experience at your hospitals, there's been an increase in the diagnosis of chronic pain --

A Uh-huh.

Q -- have you noticed an increase in the diagnosis of any other medical conditions during that same period of time?

MR. HALL: Object to the form.

A Yes.

Q (By Ms. Patterson) Like, what?

A Obesity, I would say, is a new one, yes.
Q Okay. What about mental health issues?
MR. HALL: Object to the form.
A No, in that -- but my situation is somewhat unique.
Q (By Ms. Patterson) Uh-huh.
A Because the -- two of the facilities that we're talking about that I've experienced at -- I had experience at, had mental health units.
Q Uh-huh.
A So, to be above-board and completely honest, I can't say that we saw more because we were a center for that.
Q Right. Okay.
A So it -- it would -- my -- my experience with that may be skewed, because St. Anthony had the second largest --
Q Right.
A -- mental health facility in the country -- in the na- -- in the state. Excuse me. Maryville had a mental health unit. And so, you know, when you have that and you have psychiatrists and you're in that group and it's in your medical record, it -- it -- it skewed high already, so it wasn't that I saw an increase in that.
Q Let me ask you this: Do you -- are you aware of

any national statistics that exist regarding the diagnosis of chronic pain and whether or not that has increased, just generally -- and I'm not just talking about in the hospital setting, I'm just talking about generally. Has the diagnoses by medical professionals of chronic pain increased over the last 20 years?

A I believe that's the Pres- -- the President's report states that, that I was given.

Q Okay. Other -- other than what you read in the President's report, which you were given two days ago, do you -- are you aware of any other data on that?

MR. HALL: Object to the form.

A I did not pull other data. I -- my experience is that it's more.

Q (By Ms. Patterson) Okay. And that's --

A But did I pull data? No, I did not.

Q Again -- and I'm only -- your experience is based on the hospitals that you've worked in. So I'm --

A Correct.

Q -- asking you a much broader question.

A Okay.

Q Have you pulled and looked at any data about whether or not the diagnoses across-the-board of chronic pain has increased and, if so, how much, in the last 20 years?

MR. HALL: Object to the form.

A I have not pulled that data. All politics is local. I cared about the people in my community.

Q (By Ms. Patterson) Got it. And I --

A And my community was sicker.

Q And I understand that, Mr. Griffith, and I -- literally, I'm just trying to find out the scope of what you did or didn't do.

A Okay.

Q I understand you're focused on your hospitals and --

A Right.

Q -- focused on the patients that you're responsible for caring for, okay?

A Okay.

Q But you're here presenting a test- -- a -- some expert testimony which is much broader than -- well, it's appearing -- or purporting to be much broader than based on just the three hospitals that you've worked at; wouldn't you agree?

MR. HALL: Object to the form.

A I would agree that my experience is based on my experience. Is my experience unique? Having talked to other administrators about other things, I do not believe my experience is unique.

Q (By Ms. Patterson) All right. Let's look at the first page of Exhibit 1 and under Item B.

A Are you talking about this first page or this first page?

Q I'm sorry, the -- the -- the disclosure document.

A That is on Exhib- --

Q Yeah --

A -- Exhibit H.

Q -- it's the first page of Exhibit H. It's a little confusing.

A Yes, ma'am.

Q In the first section there, you talk about the fact that, in 2006, the Centers for Medicare and Medicaid Services, which we all know as CMS, implemated -- implemented a nationwide survey called the HCAHPS survey to measure patient perspectives of hospital care. That's an accurate statement, correct?

A Correct.

Q All right. And I think I asked you earlier -- I know we touched on this, but do -- do you know what groups or entities were involved in the development of the HCAHPS survey?

MR. HALL: Object to the form.

A I -- by evidence of what was on the survey, I

believe The Joint Commission had influence on the survey because of the way we were asking questions and stating --

Q (By Ms. Patterson) And -- and all I'm asking is what groups. I mean --

A The Joint Commission.

Q Okay. Are you aware of any other entities or institutions or individuals that were involved in the development of the HCAHPS survey, other than The Joint Commission?

MR. HALL: Same objection.

A I do not know that.

Q (By Ms. Patterson) Okay. And I asked you, earlier, if you were familiar with the Agency for Healthcare Research and Quality and you said you thought you've --

A Vaguely.

Q -- heard of it?

A I -- vague- -- yes, I've --

Q Do you --

A -- heard of it, I -- but I don't know if they have influence, I apologize.

Q Okay. And -- and if they -- and if that entity, the AHRQ, did have involvement in the development of the HCAHPS survey, you don't have any idea of what kind of involvement that that organization had, do you?

MR. HALL: Object to the form.

A I -- I do not know who had influence, besides the evidence of The Joint Commission's influence on the -- on the survey. I do not know who else. You can ask me a list. I don't know who --

Q (By Ms. Patterson) Sure.

A -- else, besides --

Q Okay.

A -- by the evidence of The Joint Commission's wording being on the final survey --

Q Got it.

A -- that they had influence.

Q Okay. Do you know, Mr. Griffith, if any of the defendants in this case played any role, at all, in the development of the HCAHPS survey?

MR. HALL: Object to the form.

A I know, in the linearness of how this happened, there were -- from the defendants in this case, according to the -- the accounting office report, had influence on The Joint -- on The Joint Commission and the creation of a fifth vital sign, which influenced the HCAHPS survey.

Did -- do I know that any of the defendants had influence on the HCAHPS survey? I cannot say that, but it does not exist in a vacuum. It exists lineraly -- linearly with The Joint Commission's focus on pain.

Q (By Ms. Patterson) Okay. So -- so -- and by the way, do you understand who the defendants are in this case?

A Yes, I believe so.

Q If you'll look at the front of --

A Yeah, I think I'm --

Q -- Exhibit 1, you can see them all --

A -- familiar with --

Q -- listed there.

A -- Johnson and -- and -- and Purdue, and I believe there's another --

Q Teva?

A Obviously, Teva and --

Q Yeah. And take a moment to look at that.

A Yes.

Q If you'll -- and let me finish, because we're talking over --

A I --

Q -- each other.

A I apologize.

Q My -- no -- I just wanted to give you an opportunity to -- and point out to you that there is a list in front of you, at the -- on the front part of Page 1, of the defendants in this case, okay? And so I wanted to give you an opportunity to look at that.

Okay, have you had a chance to look at that?

A Yes, ma'am.

Q Okay. So my question, then, is: The only information that you have that would possibly indicate that any of the defendants in this case had any influence over The Joint Commission, with regard to its focus on pain, is based on what you've read in the General Accounting Office document that was provided to you by counsel for the State; is that correct?

MR. HALL: Object to the form.

A Yes, that is correct.

Q (By Ms. Patterson) Okay, thank you.

THE WITNESS: I'm going to do my best to go slower.

Q (By Ms. Patterson) Again, looking at the first page of your expert disclosure, in that first paragraph under Section B, it says -- or you say, "The HCAHPS survey included questions designed to illicit patients' perspectives regarding multiple facets, quote, 'dimensions' of hospital care, including nurse and physician communication, staff responsiveness, cleanliness, and overall rating of hospital." Do you see that?

A Yes.

Q And then you go on to say, "Another dimension

tested through the HCAHPS survey was pain management," correct?

A Correct.

Q And when you talk about the pain management dimension, which is also what you referred to up in Section A, that -- that is the three questions that have been included on the HCAHPS survey regarding pain management, correct?

A Correct.

Q All right. Do you -- do you know what those three questions ask?

A "During your hospital stay, did the -- did you -- did you need pain medication?"

Q Uh-huh.

A "Did -- during the hospital stay, how often was your pain management well-controlled?"

Q Uh-huh.

A And, "During your hospital stay, how often did the hospital staff do everything they could to help you with your pain?"

Q Uh-huh. Okay. And I think those are the three that you have set forth there and I -- do you know who developed the scoring mechanism for the HCAHPS survey?

A No, but it is similar to The Joint Commission's survey, so one thing leads to the other: I believe that

The Joint Commission would have influence on how the scoring mechanism was placed, but I do not know that as a factual --

Q Okay.

A -- event.

Q And -- and do you know what kind of validation studies were done with regard to the scoring paradigm for the HCAHPS survey?

A No, I --

MR. HALL: Object to the form.

A I do not know -- I'm not privy to that knowledge.

Q (By Ms. Patterson) Okay. Now, underneath the -- the three questions that you've set out there -- and, again, I'm looking at the first page of your expert disclosure -- you go on to state, "Of all the dimensions that contributed to a hospital's overall score on the HCAHPS survey, the three most indicative of a hospital's performance were: One, physician communication; two, nurse communication; and, three, pain management." Do you see that?

A Yes, ma'am.

Q What is the basis for that statement?

A Statistics.

Q I'm sorry?

A Statistics.

Q What statistics?

A When we would survey patients from Press Ganey or -- or HealthStream or NRC, we would get what's called a key driver report.

Q Uh-huh.

A And the key driver report -- the purpose of the key driver report, in the -- in the old days with The Joint Commission, and then the HCAHPS survey, was to tell you where to focus.

My example of this is: People believe that hospital food is pretty bad and some people focus a lot on hospital food. It doesn't help overall patient satisfaction, because it is low on the key driver sur- -- on the key driver -- key driver list.

So you can have wonderful food and have bad satisfaction and, from an HCAHPS standpoint, or, before that, in The Joint Commission, in just a Press Ganey standpoint, or you can have amazing -- you know, chefs in each room -- that's an overexaggeration -- but you can have wonderful food and have bad satisfaction or terrible food and have good satisfaction.

The key driver, statistically -- because Press Ganey would give us the statistics of what was the key drivers to your overall satisfaction.

In the reports that we would get, in the vast majority of those that I can remember, the one, two or three -- and they changed places. Sometimes, it was -- of those three, they would kind of go up and down -- what was the most important driver to overall satisfaction, was communication with physicians, communications with nurses, and -- and how the patient felt about their pain management. Those would go up and down on the key driver report.

Q Okay. So what you were just talking about, this key driver report, you used an example of the Press Ganey survey?

A Yes.

Q Okay. And that was the survey that was in existence prior to the implementation of HCAHPS, right?

A Yes, but --

MR. HALL: Object to the form.

Q (By Ms. Patterson) Is that -- is that correct?

MR. HALL: Object to the form.

A It did exist before the HCAHPS.

Q (By Ms. Patterson) Okay.

A But it existed after HCAHPS, as well.

Q Right.

A Because we continued to surv- -- use the -- that method to survey patients because HCAHPS is delayed, so

it -- it takes a long time for HCAHPS scores to come back to you. It's too late to make changes by the time you get the official HCAHPS report from CMS. You continue, always, to have to survey a real-time, as --

Q Mr. Griffith --

A -- as close to --

Q -- I hate to interrupt you. I have a limited amount of time and --

A Sorry.

Q And I'm -- I'm not asking you about Press Ganey. That's why I'm stopping you right here. That's not what your report is about, is it? So what I asked you about is the statement --

MR. HALL: Object to the form.

Q (By Ms. Patterson) -- here on your report that says, of the dimensions that contributed to the hospital's overall score on the HCAHPS survey, the most indicative were those three that I mentioned.

A They are the most indicative.

Q Okay. And I want to know on what you base that statement.

MR. HALL: Object to the form.

A Statistics that we get from -- from analyzing the HCAHPS survey reports.

Q (By Ms. Patterson) And those statistics are in

something called a key driver report?

A Yes.

Q And you're telling me that the key driver report, from time to time, shows that there's a different impact of those three categories and so -- is that right?

MR. HALL: Object to the form.

A Yes. Sometimes, they're higher; sometimes, they're lower. But those three, usually, are the top three in --

Q (By Ms. Patterson) Always?

A -- my experience.

MR. HALL: Object to the form.

A I hate to use the word "always." Sometimes, might -- one might drop to four, but in the vast majority of them, in my experience, they were one, two or three.

Q (By Ms. Patterson) Have you done any research on that or compiled any data or reviewed any data, for purposes of making the statement in your expert report, to support that statement?

A No, I have not.

Q Are you aware of any data that has been published or is publicly available that would support your statement here that the three most indicative dimensions on a hospital's performance are those three that you've listed: Physician communication, nurse communication and

pain management?

A I --

MR. HALL: Object to the form.

A I listed those under my personal experience. I have not look- -- reviewed data to inform that opinion.

Q (By Ms. Patterson) Okay. Or support that opinion?

MR. HALL: Object to the form.

A Correct.

Q (By Ms. Patterson) Okay. The next statement there, you say, is, "In 2007, hospitals were required to report the HCAHPS scores in order to receive annual updates to certain federal funding," correct?

A Yes.

Q And the reporting is made to CMS, correct?

A Correct.

Q And CMS is a -- as we said earlier, an agency of the federal government, correct?

A Correct.

Q Okay. Your disclosure goes on to state that, "Starting in 2012, a hospital score on the HCAHPS survey became a direct factor in calculating federal funding." Do you see that?

A Yes.

Q And that was something that was promulgated by

in the survey results of the other hospitals at which you have not worked, are you?

A Of the --

MR. HALL: Object to the form.

A -- individuals, no. I would say from the regional standpoint. Because, usually, those -- those would have a region, like an AHA region.

Q Uh-huh.

A And in regions, I would know the key dri- -- you -- you could see the key drivers of -- in the remembrance of the reports that I've seen in the past, you could see the key drivers in the region.

Q (By Ms. Patterson) I get that you can see them --

A Yeah.

Q -- in the region, but --

A Do I know the individual hospitals? No, I do not.

MR. HALL: Same objection.

Q (By Ms. Patterson) And you don't know if pain management was a key driver within the other hospitals within the state of Oklahoma that you did not work at --

MR. HALL: Same objection --

Q (By Ms. Patterson) -- do you?

MR. HALL: -- asked and answered.

MS. PATTERSON: No, it hasn't been answered.

Q (By Ms. Patterson) Can you answer that?

A I've -- I -- I've never seen another hospital's individualized report.

Q Thank you.

A I know the aggregate report.

Q But you haven't seen their individual --

A I have not seen their individual report.

Q Thank you. That's all I'm looking for.

A Places that I have not worked.

Q Thank you.

MR. HALL: Counsel, we've been on the record for about an hour.

MS. PATTERSON: Sure.

MR. HALL: Can we take a break?

MS. PATTERSON: Sure.

MR. HALL: Thanks.

THE VIDEOGRAPHER: Just a moment. Going off the record, 3:47.

(Recess was had from 3:47 p.m. to 4:07 p.m.)

THE VIDEOGRAPHER: We are back on the record, 4:07.

Q (By Ms. Patterson) Mr. Griffith, we're back on the record.

You used a term, earlier today, "value-based

think we said was about, what, 18 or so years, right?

A Uh-huh.

Q So during the 18 or so years that you have been in hospital administration, how many times have you seen a physician write more prescription -- or a -- a prescription or more prescriptions, in order to improve a pain management score?

A Again --

MR. HALL: Same objection.

A -- I'm not --

Q (By Ms. Patterson) Is it --

A I'm not going to put a number on it. Sorry.

Q Okay. And that -- and have you kept data on that, such that you could put a number on it?

MR. HALL: Same objection.

A No, I have not.

Q (By Ms. Patterson) Have you looked at data on that?

A I, purposely, did not review data before my expert testimony, so that it would not seem that it was influencing my opinions of an -- as an expert.

Q Okay. And I guess what I'm trying to figure out is: If it's your testimony, as an expert, that physicians have written more prescriptions in order to improve pain management scores at the hospital where -- hospitals where

a couple days ago by counsel for the State?

A I have not looked, page-for-page, for this, but, if you're saying it's complete, I believe you.

Q Okay. And you say you've reviewed both of those since they were provided to you by the counsel for the State?

A Yes, these are the two documents provided to me.

MS. PATTERSON: Okay. With that, I'll pass the witness.

MR. TAM: Can we take a break, a short break?

MR. HALL: Yeah.

THE VIDEOGRAPHER: Just a moment. Going off the record, 4:52.

(Recess was had from 4:52 p.m. to 5:03 p.m.)

THE VIDEOGRAPHER: We are on the record, 5:03. This is the beginning of Disk 4.

EXAMINATION

BY MR. TAM:

Q Mr. Griffith, we just returned from a break. Again, my name is Jonathan Tam and I represent Purdue. Are you ready to resume?

A Yes.

Q So you were just asked some questions about your observations about sales reps. Do you -- do you recall that?

A Yes.
Q And did you -- is it your testimony that you observed an increase in the number of sales reps who visited doctors?
A Yes.
Q And that observation is based on your experience; it's not based on any data, is it?
MR. HALL: Object to the form.
A All of my observations are based upon my observations. My opinions are based upon my observations.
Q (By Mr. Tam) But that's -- but your opinion is not based on any data that monitors or tracks the number of visits by sales reps, is it?
A I had no counter of sales reps, no.
Q Sorry, just so I understand your -- your answer, you said you have no count of --
A No counter. You know, like a -- you know, a -- balls and strikes, you know, there's no counter of how many sales reps I saw, no.
Q And there was no report you consulted?
MR. HALL: Object to the form.
A No.
Q (By Mr. Tam) And so -- and I don't mean this in a pejorative sense. I mean, your opinion is based on your eyeball test?