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PART A

APR 2 4 2019

In the office of the Court Clerk MARILYN WILLIAMS

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA, Plaintiff, v. PURDUE PHARMA L.P., *et al.*, Defendants.	Case No. CJ-2017-816 Judge Thad Balkman William C. Hetherington Special Discovery Master

DEFENDANTS' MOTION TO EXCLUDE TESTIMONY OF DR. DANESH MAZLOOMDOOST AND BRIEF IN SUPPORT

THIS DOCUMENT WAS FILED IN ITS ENTIRETY APRIL 23, 2019, UNDER SEAL PER COURT ORDER DATED APRIL 16, 2018

The Defendants move this Court for an order excluding certain testimony offered by the State's purported expert witness, Dr. Danesh Mazloomdoost, pursuant to 12 O.S. §§ 2702-2705. The Court should exclude Dr. Mazloomdoost's testimony about the Defendants' marketing and its supposed effects in Oklahoma, for several reasons. First, Dr. Mazloomdoost is not qualified to opine on those subjects. Second, his opinions about the supposed effect of the Defendants' marketing lack sufficient evidentiary basis to be reliable. And third, his recitation of the State's narrative about the Defendants' supposed marketing campaign is not a proper subject matter for expert testimony. The Defendants thus respectfully request that their Motion to Exclude be granted, and for such other and further relief as the Court deems just and proper.

BRIEF IN SUPPORT

In support of this Motion, the Defendants show the following:

I. INTRODUCTION

Dr. Mazloomdoost is an anesthesiologist and pain management physician from Kentucky, whose self-described "expertise is in managing pain." Ex. A, Dec. 21, 2018 State's Expert Witness Disclosure of Danesh Mazloomdoost ("Mazloomdoost Disc.") 1; Ex. B, Mar. 7, 2019 Deposition of Danesh Mazloomdoost ("Mazloomdoost Dep.") 245:15. But Dr. Mazloomdoost does not seek to testify about treating pain or anesthesiology. Instead, he seeks to opine that the Defendants' pharmaceutical marketing caused an opioid epidemic in Oklahoma. Ex. A, Mazloomdoost Disc. 2. And he seeks to regurgitate the State's theory that the Defendants designed and implemented a coordinated misinformation campaign that coopted both doctors and industry groups. *Id.*

Dr. Mazloomdoost's training, education, and experience do not qualify him to offer those opinions. Nor is his testimony based on any scientific data or analysis. Rather, Dr. Mazloomdoost

offers only cherry-picked anecdotes and basic information about opioid prescribing trends to support his opinions. That does not suffice to provide a reliable basis for opining that pharmaceutical marketing and prescribing practices are correlated, much less that the Defendants' marketing in particular caused an opioid epidemic in Oklahoma specifically.

Dr. Mazloomdoost's attempt to personally recount the State's narrative about the Defendants' supposed misinformation campaign is equally impermissible. Dr. Mazloomdoost acts only as a mouthpiece for the State's theory, and such testimony would involve the exercise of no expertise, specialized knowledge, or reliable analysis. Nor would it assist the fact-finder in understanding the State's case. Dr. Mazloomdoost should not be permitted to parrot the State's talking points or imbue his lay opinions with the imprimatur of "expert" testimony when that testimony will not help the finder of fact at all.

Dr. Mazloomdoost's testimony is inadmissible and must be excluded under Oklahoma law.

II. LEGAL STANDARD[1]

The Court has "a special obligation" to prevent improper testimony from an expert witness. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147 (1999) (citing *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 589 (1993)); *accord Christian*, 2003 OK 10, ¶¶8-9, 65 P.3d at 598. Specifically, the Court may admit expert testimony only if it satisfies several prerequisites. First, the expert must be qualified by "knowledge, skill, experience, training or education" to offer the *specific* opinion in question. 12 O.S. § 2702; *Alexander v. Smith & Nephew, P.L.C.*, 98 F. Supp. 2d 1287, 1292-93 (N.D. Okla. 2000). Second, the testimony must be relevant—i.e., it "assist[s] the trier of

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[1] Because Oklahoma's statutes governing expert testimony, 12 O.S. §§ 2702, 2703, 2704, and 2705, parallel the language of Federal Rules of Evidence 702, 703, 704, and 705 in all relevant respects, both state and federal jurisprudence regarding the admissibility of expert testimony is instructive. *See, e.g.*, *Nelson v. Enid Med. Assocs., Inc.*, 2016 OK 69, ¶¶10-60, 376 P.3d 212, 217-31; *Christian v. Gray*, 2003 OK 10, ¶¶8-9, 65 P.3d 591, 598-99.

fact to understand the evidence or to determine a fact in issue." 12 O.S. § 2702. And third, the testimony must be reliable, meaning (a) the opinion is "based upon sufficient facts or data," (b) it is "the product of reliable principles and methods," and (c) "[t]he witness has applied the principles and methods reliably to the facts of the case." *Id.*; *see also Nelson,* 2016 OK 69, ¶¶10-14, 376 P.3d at 217. The party offering the expert's testimony—here, the State—has the burden of showing by a preponderance of the evidence that the testimony meets all three prerequisites. *Christian,* 2003 OK 10, ¶¶23-24, 65 P.3d at 603.

An opinion that is based only on speculative assumption or is not supported by reliable data must be excluded. *See, e.g., Guidroz-Brault v. Mo. Pac. R.R. Co.*, 254 F.3d 825, 829 (9th Cir. 2001) (expert may not rely on "unsupported speculation and subjective beliefs" (citing *Daubert,* 509 U.S. at 590-91)). The Court thus must closely inspect how the expert arrives at his conclusions, and exclude "opinion evidence that is connected to existing data only by the *ipse dixit* of the expert." *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997); *see also, e.g.*, Ex. C, *Shank v. Whiting-Turner Contracting Co.*, 17-CV-446-JED-FHM, 2018 WL 6681223, at *2 (N.D. Okla. Dec. 19, 2018) ("analytical gap" in expert's testimony requires its exclusion under *Daubert*). Under these basic principles, Dr. Mazloomdoost's testimony is inadmissible and must be excluded.

III. ARGUMENT

A. Dr. Mazloomdoost Is Not Qualified To Testify About Pharmaceutical Marketing In General, Let Alone The Effects Of The Defendants' Marketing In Oklahoma Specifically

Dr. Mazloomdoost is an anesthesiologist whose knowledge base and skillset revolve around the management of patients' pain. He is not qualified to offer expert testimony that "[t]he opioid epidemic is directly attributable to focused pharmaceutical marketing." Ex. A, Mazloomdoost Disc. 2. Dr. Mazloomdoost's "knowledge, skill, experience, training [and] education" do not qualify him to offer that specific opinion. 12 O.S. § 2702; *Whiting v. Boston*

Edison Co., 891 F. Supp. 12, 24 (D. Mass. 1995). Dr. Mazloomdoost's opinions about the Defendants' marketing and its purported relationship to an Oklahoma opioid epidemic are thus nothing more than improper lay opinion masquerading as expert testimony.

Courts across the country regularly hold that an expert must have specialized expertise to opine on the effects of marketing. This is especially so in a heavily regulated and complex environment like the pharmaceutical industry. For example, in *Pfizer Inc. v. Teva Pharmaceuticals USA, Inc.*, 461 F. Supp. 2d 271 (D.N.J. 2006), the court held that a rheumatologist was not qualified to opine about how pharmaceutical marketing affected doctors' choice between different drugs. *Id.* at 276. While the rheumatologist's medical expertise may have allowed him to opine on *general* factors that influence doctors' prescribing decisions, he was not qualified to opine on the *specific* effects of particular marketing efforts because he lacked "specialized expertise regarding sales or market analysis" and "had conducted no scientific studies or surveys concerning purchasing practices of other doctors in his field." *Id.*

Dr. Mazloomdoost lacks the necessary qualifications to opine about the influence of pharmaceutical marketing on opioid prescribing in Oklahoma. Dr. Mazloomdoost admits that he has no formal training in marketing. Ex. B, Mazloomdoost Dep. 28:5-8. It is no surprise, then, that his resume's list of research, publications, and presentations reveals no experience with or expertise in marketing. Ex. A, Mazloomdoost Disc. 19-22.

Dr. Mazloomdoost's personal experiences promoting his private practice and on the receiving end of pharmaceutical marketing as a doctor in Kentucky do not and cannot qualify him to offer "broad opinions on the prescribing practices . . . of all physicians," such as the effect of pharmaceutical marketing on doctors generally, much less those in Oklahoma. *Pfizer*, 461 F. Supp.

2d at 276. Indeed, such "[a] blanket qualification for all physicians to testify as to anything medically-related would contravene the Court's gate-keeping responsibilit[y]" to ensure that all expert testimony is both relevant and reliable. *Alexander*, 98 F. Supp. 2d at 1293. The Court should disqualify Dr. Mazloomdoost from testifying about the Defendants' marketing and its purported link to an opioid epidemic in Oklahoma.

B. Dr. Mazloomdoost Provides No Reliable Basis For His Opinions

Dr. Mazloomdoost's testimony about pharmaceutical marketing and its supposed effects in Oklahoma is also inadmissible for the independent reason that it is unreliable. Having no formal training in marketing or evaluating the effects of marketing, Dr. Mazloomdoost uses none of the tools a qualified expert would use to analyze the extent to which pharmaceutical marketing bears a causal relationship to a matter as complex as an opioid epidemic. But as the Oklahoma Supreme Court has emphasized, an "expert's opinion on causation must be more than *ipse dixit*." *Christian*, 2003 OK 10, ¶36, 65 P.3d at 607. Rather, the testimony must be "based upon a reliable method for determining causation," and his "conclusion" must be "analytically appropriate to that method." *Id.*; *see also, e.g.*, Ex. C, *Shank*, 2018 WL 6681223, at *2. *Daubert* motions thus traditionally explain why an expert's methodology is flawed or his conclusion is not analytically appropriate based on that methodology. Here, however, Dr. Mazloomdoost offers *no* methodology to criticize.

Dr. Mazloomdoost neither relied upon nor performed any scientific study to support his conclusions about the Defendants' marketing. But to satisfy the requirement of reliability, courts consistently require an expert to provide empirical data or analysis to support his assertion of a causal connection between pharmaceutical marketing practices and prescribing decisions. For instance, in *Pfizer*, the court held that a physician could not offer an opinion about the effects of pharmaceutical marketing on drug prescriptions when that physician "had conducted no scientific studies or surveys concerning purchasing practices of other doctors in his field." 461 F. Supp. 2d

at 276. Similarly, in *Advanced Medical Optics, Inc. v. Alcon, Inc.*, the court rejected a doctor's opinion about the causes of sales of a particular medical device because the doctor based his opinions only on personal observations of his colleagues' preferences and did not perform any research to find out if their views were widely shared. Ex. D, No. 03-1095-KAJ, 2005 WL 782809, at *4 (D. Del. Apr. 7, 2005).

Dr. Mazloomdoost's testimony falls well short of what counts as a reliable expert opinion. Dr. Mazloomdoost, in fact, provides no data or scientific analysis whatsoever to support his speculation that "[t]he opioid epidemic is directly attributable to focused pharmaceutical marketing." Ex. A, Mazloomdoost Disc. 2. Instead, Dr. Mazloomdoost offers personal anecdote and a perceived—but unexamined—correlation between opioid marketing and increases in opioid prescriptions generally, neither of which can produce a reliable opinion about whether the Defendants' marketing in particular caused an opioid epidemic in Oklahoma specifically.

At bottom, Dr. Mazloomdoost's opinion reflects an unscientific—and ultimately unsuccessful—attempt to establish some connection between his experiences receiving opioid marketing as a physician and an increase in opioid prescribing in Oklahoma. Dr. Mazloomdoost first describes encounters he had with pharmaceutical representatives in Kentucky and Texas who he believed utilized improper tactics to market opioids, as well as a handful of conversations he had with other non-Oklahoma physicians about their experiences with pharmaceutical marketing. *See, e.g.*, Ex. B, Mazloomdoost Dep. 170:2-12, 197:2-10, 298:14-300:4. Nowhere in his testimony does he indicate that these encounters specifically involved representatives of Janssen or J&J, and he recalled only three isolated encounters with representatives of Teva. *Id.* at 292:18-293:5, 307:14-18. Dr. Mazloomdoost then testifies that he reviewed "[s]omething in [the] ballpark" of ten call logs reflecting the marketing of opioids to Oklahoma physicians. *Id.* at 171:11-19, 272:6-

13. But Dr. Mazloomdoost did not review these call logs prior to reaching his conclusions; instead, the State's lawyers showed the logs to him only the day before his deposition. *Id.* at 274:5-11.

Based on this handful of personal anecdotes and cherry-picked call logs—as well as his unsubstantiated conjecture from "some data" he reviewed about Oklahoma that there are "parallels and correlations" between the "rural" and "impoverished" populations in Oklahoma and Kentucky—Dr. Mazloomdoost testifies that he is "strongly suspicious that what [he had] seen in Kentucky . . . is very similar to what exists in Oklahoma" with respect to opioid marketing and its effects. *Id.* at 13:2-6, 14:3-10, 176:16-177:5. Finally, he sets his stories and speculation alongside generalized information about the rise of opioid prescriptions in Oklahoma—and declares that, aha!, there must be causation. *See id.* at 108:6-11, 186:10-187:8, 270:8-12. But Dr. Mazloomdoost provides no data, calculations, or other scientific analysis in support of his theory. And his guesswork cannot establish a reliable basis for drawing a supposed correlation between the Defendants' marketing and opioid-related issues in Oklahoma.

Moreover, even if Dr. Mazloomdoost had performed the sort of expert analysis necessary to establish such a correlation, *correlation*, without more, is insufficient to establish a *causal* relationship between marketing and opioid prescribing. *Norris v. Baxter Healthcare Corp.*, 397 F.3d 878, 885 (10th Cir. 2005) (noting that "correlation does not equal causation" and rejecting expert opinion that breast implants cause disease because opinion was based "solely on differential diagnosis and case studies"). Two events may be "closely related but bear no causal relationship because they are both caused by a third, unexamined variable." Fed. Judicial Ctr., Reference Manual on Scientific Evidence 309 (3d ed. 2011). Thus, "'[a]n expert's failure to enumerate a comprehensive list of alternative causes and to eliminate those potential causes'" renders his specific-causation testimony inadmissible. *Hall v. ConocoPhillips*, 248 F. Supp. 3d 1177, 1193

(W.D. Okla. 2017) (quoting *Chapman v. Procter & Gamble Distrib., LLC,* 766 F.3d 1296, 1310 (11th Cir. 2014), *aff'd,* 886 F.3d 1308 (10th Cir. 2018)).

Dr. Mazloomdoost makes no effort to account for alternative causes. To the contrary, he concedes that it would be "speculation" for him to try to identify all parties responsible for the opioid epidemic. Ex. B, Mazloomdoost Dep. 315:5-12. Nor does Dr. Mazloomdoost account for conceded facts that refute his theory that the Defendants' purportedly misleading marketing caused the opioid epidemic in Oklahoma. When asked about the statements in the FDA-approved "box warning" for Duragesic, for example, Dr. Mazloomdoost agreed that box warnings provide "a reason to be concerned or have some caution" about a drug and that the risks discussed in the box warning for Duragesic were not misleading. *Id.* at 216:18-217:2, 224:20-226:1, 226:12-228:2, 228:22-230:9, 230:23-231:6, 231:18-232:5, 232:16-23. He also testified that he "assumes" that those box warnings are included with every prescription issued by a pharmacist. *Id.* at 215:5-11. Yet, Dr. Mazloomdoost did not consider this box warning in reaching his conclusions—he testified that he had "not read it line for line like we did right now in I don't know how long." *Id.* at 234:8-15. Put another way, Dr. Mazloomdoost made no attempt to research or consider facts refuting his assumption that the Defendants' marketing was uniformly misleading. His failure to do so further reveals the unreliability of his causation opinion. *See, e.g., Hall,* 248 F. Supp. 3d at 1191 ("Because [the expert] did not acknowledge, account for, or even search for evidence . . . which refutes her theory, [the expert's] opinion on . . . causation is unreliable.").

Dr. Mazloomdoost's anecdotes about observing pharmaceutical marketing as a doctor cannot save his causation opinion. Courts have held that one doctor's "personal experience" with pharmaceutical marketing is an insufficient basis to opine on the causes of other doctors' prescribing decisions. *See, e.g., Pfizer,* 461 F. Supp. 2d at 277-78 ("The fact that [a doctor] received

frequent visits from Pfizer representatives, and that several of *his* patients requested Celebrex prescriptions does not alone support a conclusion that Celebrex's prescriptions were heavily influenced by advertising and promotion."). Indeed, Dr. Mazloomdoost testified that even he would not "accept the anecdotal evidence coming from somebody else until it's been published . . . in a peer-reviewed journal." Ex. B, Mazloomdoost Dep. 94:18-20.

Worse yet, Dr. Mazloomdoost's personal experience has nothing to do with marketing efforts directed at doctors in Oklahoma specifically. Dr. Mazloomdoost has never practiced medicine in Oklahoma. *Id.* at 180:18-23. Nor has he ever had any conversations with Oklahoma physicians about the marketing materials they were provided by a drug manufacturer. *Id.* at 176:10-14, 309:24-310:4. His only experience in any way involving Oklahoma occurred during his fellowship in Houston, Texas, where he encountered patients—not doctors—from Oklahoma. *Id.* at 175:7-176:8, 176:20-23. Dr. Mazloomdoost thus has no personal insight into doctor-facing marketing efforts in Oklahoma at all.

The handful of Oklahoma call logs Dr. Mazloomdoost received from the State the day before his deposition do not salvage his opinion either. As an initial matter, Dr. Mazloomdoost reached his opinions long before he reviewed the call logs: he did not know they existed until the day before his deposition. *See id.* at 274:5-11. Dr. Mazloomdoost's attempt to backfill his opinions based on late-obtained information is inherently unreliable, as it reveals that his opinion was never based on "sufficient facts or data." 12 O.S. § 2702. Regardless, Dr. Mazloomdoost cannot and does not testify that the small handful of call logs collected and selected by the State is representative of Oklahoma doctors, that it is a large enough sample to reach any broader conclusions about prescribing trends in Oklahoma, or that he performed any calculation or other scientific analysis to even try to reach any such conclusions. Instead, he simply assumes that

because he has seen supposedly misleading national marketing presentations, and the opioid epidemic is "a national problem," the Defendants' marketing must have been the same—and had the same effects—in both Kentucky and Oklahoma. *Id.* at 176:16-177:12. But using information about one place to draw conclusions about what happened in a *different* place is an unreliable basis for expert testimony without analysis indicating that the conclusion is geographically transferable. *See, e.g., Lebron v. Sec'y of Fla. Dep't of Children & Families*, 772 F.3d 1352, 1368, 1370 (11th Cir. 2014) (excluding as unreliable expert testimony about Florida TANF recipients where that testimony was based on studies of TANF recipients in Illinois and California and there was no "qualified expert to comment on the extent to which these results can be extrapolated to the population at issue in this case"). And, here, Dr. Mazloomdoost provides no such evidence or analysis beyond assumptions about unspecified "data" supposedly showing unexamined "similarities" between Oklahoma and Kentucky. *See* Ex. B, Mazloomdoost Dep. 13:2-6 ("I've reviewed some data over Oklahoma to find similarities . . . between what I've been exposed to in Kentucky as well as Oklahoma, and there, indeed, are quite a lot of similarities."). To the contrary, Dr. Mazloomdoost effectively admitted that he cannot extrapolate his personal experiences to those of doctors elsewhere, because he does not "make any assumptions as to what other physicians base their decisions on." *Id.* at 106:5-11. Dr. Mazloomdoost's unsupported and unreliable opinion about the Defendants' marketing and its supposed effects in Oklahoma should be excluded.

For whatever tactical reason, and in a rush to trial, the State has elected not to retain a causation expert, an expert in marketing, or an expert in statistics here. That does not mean that this Court should reward that strategic decision by undermining the standards—long accepted by courts in Oklahoma and throughout the nation—that control the use of experts at trial, or by permitting lay or unreliable testimony to bear the cloak of expert testimony.

In sum, Dr. Mazloomdoost's say-so about the supposed effects of the Defendants' marketing in Oklahoma is unreliable and must be excluded. (And for similar reasons elaborated in the Defendants' motions for summary judgment, even if the Court admitted Dr. Mazloomdoost's testimony (it should not), that testimony is insufficient to create a material fact dispute about causation.)

C. **Dr. Mazloomdoost Should Be Barred From Parroting The State's Narrative**

Dr. Mazloomdoost also seeks to endorse the State's theory that the Defendants caused an opioid epidemic in Oklahoma by designing and implementing a coordinated misinformation campaign that coopted both doctors and industry groups. But, as noted, expert testimony is admissible only if it involves "scientific, technical, or other specialized knowledge" that will "assist the trier of fact to understand the evidence or to determine a fact in issue." 12 O.S. § 2702. Thus, "where the normal experiences and qualifications of laymen . . . permit them to draw proper conclusions from the facts and circumstances," a purported expert's opinions about those facts and circumstances will not help the fact-finder and therefore are inadmissible. *Gabus v. Harvey*, 1984 OK 4, ¶18, 678 P.2d 253, 256.

That is exactly the case with many of Dr. Mazloomdoost's opinions here. Much of Dr. Mazloomdoost's testimony about the Defendants' marketing simply seeks to parrot the State's narrative. For example, Dr. Mazloomdoost asserts that "[p]harmaceutical companies conveyed the message that opioids are safe, effective, and underutilized." Ex. A, Mazloomdoost Disc. 2. And he opines that "[m]any of the guidelines that laid a foundation of misinformation were drafted by key opinion leaders and clinicians who consulted for the pharmaceutical industry." *Id.* That is not the proper subject matter for an expert opinion. The fact-finder is as well-positioned as Dr. Mazloomdoost to reach conclusions about the State's evidence and argument. Indeed, evaluating

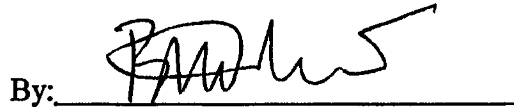
the record is the fact-finder's core function, and a role that an expert cannot usurp. *See, e.g.*, *Lang v. Kohl's Food Stores, Inc.*, 217 F.3d 919, 924 (7th Cir. 2000) (excluding expert report that did "little more than parrot" plaintiffs' beliefs because "[r]elaying the plaintiffs' likely testimony is not an example of expertise"); Ex. E, *Wells v. Allergan, Inc.*, No. Civ-12-973-C, 2013 WL 7208221, at *2 (W.D. Okla. Feb. 4, 2013) (excluding expert testimony "regurgitat[ing] the evidence through various factual narratives" because it "improperly assumes the role of Plaintiffs' advocate and invades the province of the jury" (alteration in original) (internal quotation marks omitted)); Ex. F, *Baldonado v. Wyeth*, No. 04-C-4312, 2012 WL 1802066, at *4 (N.D. Ill. May 17, 2012) (precluding expert from offering a "narrative history[]" of the defendant's promotion of hormone therapy); *Highland Capital Mgmt., L.P. v. Schneider*, 379 F. Supp. 2d 461, 469 (S.D.N.Y. 2005) ("[A]n expert cannot be presented to the jury solely for the purpose of constructing a factual narrative based upon record evidence."). Dr. Mazloomdoost should not be permitted to act as the State's megaphone here.

IV. CONCLUSION

For all these reasons, the Court should grant the Defendants' Motion to Exclude and issue an order barring the State from introducing Dr. Mazloomdoost's testimony about (1) the Defendants' marketing and its supposed effects in Oklahoma, and (2) his personal endorsement of the State's narrative that the Defendants caused an opioid epidemic in Oklahoma via a coordinated misinformation campaign.

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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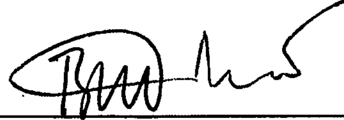

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EXHIBIT A

Exhibit M - Dr. Danesh Mazloomdoost, M.D.

A. Dr. Mazloomdoost is expected to testify about the following subject matters:

- Dr. Mazloomdoost is an anesthesiologist and pain management physician.
- Dr. Mazloomdoost is expected to testify regarding how opioids have historically been used in pain management, how that use has evolved, and what caused such use and evolution of use.
- Dr. Mazloomdoost is expected to testify regarding the appropriate use of opioids for pain management.

B. Dr. Mazloomdoost is expected to testify about the following facts, and/or opinions:

- The U.S. comprises 4.6 percent of the global population but consumes over 75 percent of oxycodone, and 99 percent of hydrocodone.
- Hydrocodone has been one of the most prescribed drugs in America for years – more often prescribed than high blood pressure, cholesterol, or diabetes drugs.
- Despite such heavy reliance on opioid medications, Americans are reporting more chronic pain across all age groups and rank highest in the world for prevalence of pain.
- Addiction and overdose have exceeded all other forms of accidental death.
- Messaging by pharmaceutical companies that opioids are a safe and effective in managing pain and are a one-size-fits-all solution for almost any complaint of pain are not supported by science.
- Opioids as effective treatment for chronic pain is not supported by science.

- When considering the science of pain processing in the body and the adverse impact of opioids, the rationale for opioid use in chronic pain settings becomes even more sparse, particularly for around-the-clock exposure.
- The opioid epidemic is directly attributable to focused pharmaceutical marketing.
- Pharmaceutical companies conveyed the message that opioids are safe, effective, and underutilized, despite inadequate long-term studies. This messaging has dominated medical didactics and guidelines for decades. Many of the guidelines that laid a foundation of misinformation were drafted by key opinion leaders and clinicians who consulted for the pharmaceutical industry.
- Industry-biased didactics also influenced governmental agencies relied upon by healthcare practitioners as an unbiased source of education.
- Guidelines and texts promoting liberal opioid use were often funded directly and/or indirectly by pharmaceutical companies. *Responsible Opioid Prescribing* by Scott Fishman, MD, for instance, advocated sanctioning physicians who withheld opioids and used the term Pseudo-Addiction, a non-scientific rationale for opioid escalation in patients we would now qualify as having an opioid use disorder.
- The lack of evidence basis and heavily industry biased programming has created an environment in which healthcare practitioners and patients alike are confused about effective practices in addressing pain and in large part attribute management with opioid prescriptions.
- Opioid use, especially long term, lowers the threshold for pain, expands the perceived region of pain, and sensitizes the injury to more types of pain.

- Opioids sensitize the pain at the level of the brain by causing changes within the nerves targeted by opioids.
- Opioids do not fix damage, only temporarily numb it with the drawback of increased sensitivity to pain after it wears off.
- The test for medically unnecessary opioid prescriptions used by the State is very conservative, and demonstrably more forgiving than what Dr. Mazloomdoost would deem inappropriate.
- Opioids are medically unnecessary and harmful in most cases of current practice norms.
- Opioids are inappropriate as a first-line or mainstay treatment of pain.
- Opioids have adverse effects on multiple organ systems with detrimental impact on quality of life and mortality from opioid-related harms other than overdose.

C. A summary of the grounds for each opinion is as follows:

- The basis for the testimony Dr. Mazloomdoost is expected to offer is based on his education, knowledge, experience, training, and familiarity with the relevant medical literature.
- Dr. Mazloomdoost grew up in Kentucky, raised by an Anesthesiologist/Pain Specialist and a dual-trained Anesthesiologist/Psychiatrist. Dr. Mazloomdoost's parents established the first multi-disciplinary pain clinic Kentucky, a region that would later become the epicenter of the opioid epidemic. Dr. Mazloomdoost pursued his medical training at Johns Hopkins and MD Anderson and returned after his anesthesiology and pain fellowship to join his parent's practice. Dr. Mazloomdoost

continues to care for patients in some of the most heavily opioid-prescribing counties in the nation.

- An extensive body of medical literature on pain management and opioids, including the following references:
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D. Dr. Mazloomdoost's Compensation

Dr. Mazloomdoost is being compensated at the following rate: $850 per hour for testimony and preparation.

E. Dr. Mazloomdoost's Qualifications

Dr. Mazloomdoost's qualifications are reflected in his *curriculum vitae* attached as Exhibit M-1.

F. Dr. Mazloomdoost's Publications

A list of Dr. Mazloomdoost's recent publications is contained in his *curriculum vitae*, see Exhibit M-1.

G. Dr. Mazloomdoost's Prior Testimony

A list of cases Dr. Mazloomdoost has testified in at trial or deposition in the preceding four (4) years is attached in Exhibit M-2.

EXHIBIT M-1

Danesh Mazloomdoost, MD

Medical Director, Wellward Regenerative Medicine
101 N. Eagle Creek Dr. Lexington KY 40509
443.762.3505 (c)
DrDanesh@wellwardmed.com
www.wellwardmed.com

Occupation

Medical Director 2010 - Present
Wellward Regenerative Medicine (formerly Pain Management Medicine)
www.wellwardmed.com

101 N. Eagle Creek Dr. Lexington KY 40509
859.275.4878 (p)
859.276.5400 (f)

Goals:

In context to the opiate epidemic evolving since the 1990s, the field of *genuine* pain management has been usurped by a fallacy of narcotic maintenance. Contrary to evidencebased guidelines, the common view of pain management has become a last-resort option that blurs the line between ineffective symptom palliation by life-long opiate maintenance and true medical workup for disease treatment. But beyond the layperson's view, academia has taken tremendous leaps in knowledge about the multitude of chronic pain conditions and the nervous system that relays it. My goal is to bring this academic knowledge within reach of everyday individuals and renew the perception of what a sound pain specialist does; specifically:

1. Interpreting the messages relayed by our body when we feel pain;
2. Developing treatment plans to fix treatable causes of pain;
3. Intercepting, modulating, or overriding pain signals prior to its perception in the brain;
4. Educating about therapeutic and preventative strategies to pain management incorporating physiologic, lifestyle, behavioral, and psychological factors; and
5. Utilizing advancing technology in Regenerative medicine to concentrate pluripotent stem cells and repair mechanisms at the site of injury.

Education

Fellowship: Pain Management; 07/2009-
07/2010 MD Anderson Cancer Institute

Residency: Anesthesiology; 07/2006-07/2009
Johns Hopkins School of Medicine

Internship: Internal Medicine; 07/2005-07/2006
University of Cincinnati

Medical School: 07/2001-07/2005
Johns Hopkins University School of Medicine

Undergraduate: Management BS; Chemistry Minor; 08/1997-
05/2001 Case Western Reserve University

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Research

Publication: Leite VF, Buehler AM, El Abd O, Benyamin RM, Pimentel DC, Chen J, Hsing WT, Mazloomdoost D, Amadera JE "Anti-nerve growth factor in the treatment of low back pain and radiculopathy: a systematic review and a meta-analysis" *Pain Physician.* 2014 Jan-Feb;17(1):E45-60.

Publication: Pimentel DC, El Abd O, Benyamin RM, Buehler AM, Leite VF, Mazloomdoost D, Chen J, Hsing WT, Amadera JE. "Anti-tumor necrosis factor antagonists in the treatment of low back pain and radiculopathy: a systematic review and meta-analysis" *Pain Physician.* 2014 Jan-Feb;17(1):E27-44. Review.

Publication: D Koyyalagunta, D. Mazloomdoost, "Radiofrequency and Cryoablation for Cancer Pain" *Techniques in Regional Anesthesia and Pain Management* Volume 14, Issue 1, Pages 1-40 (January 2010)

Publication: D. Mazloomdoost, MR Perez, AW Burton "Spinal Cord Stimulation" *Waldman's Pain Management, 2nd Edition;* Chapter 174;1303-1310; Saunders 2011

Publication: D. Mazloomdoost, MR Perez, M Fukshansky, AW Burton "Spinal Cord Stimulation"
Benzon's Essentials of Pain Medicine and Regional Anaesthesia 3rd Edition, Chapter 61; Pages 439-447
Saunders: 2011.

Publication: A Carinci, D. Mazloomdoost, A Schiavi, D Towsley, J Stonemetz; "Documentation, Economic, and Legal Issues" *Johns Hopkins Anesthesiology Handbook,* Pages 21-34, Mosby 2009.

Publication: A Carinci, M Crooks, B Lenox, D. Mazloomdoost, P Christo, MD; "Chronic Pain," *Johns*
Hopkins Handbook of Anesthesiology Pages 411- 463, Mosby 2009.
Publication: P Christo, D. Mazloomdoost, "Interventional Pain Treatments for Cancer Pain" Ann N Y Acad Sci. 2008 Sep;1138:299-328.

Publication: P Christo, D. Mazloomdoost, "Cancer Pain and Analgesia" Ann N Y Acad Sci. 2008
Sep;1138:278-98.

Publication: D. Mazloomdoost, P Embi, "Impacts of PDA-based Access to Clinical Data in a Teaching
Hospital: Perceptions of Housestaff Physicians", American Medical Informatics Association Annual Symposium Proceedings. 2006; 1025.

Publication: Meigooni AS, Kleiman MT, Johnson JL, Mazloomdoost D, Ibbott GS. "Dosimetric characteristics of a new high-intensity 192Ir source for remote afterloading", Med Phys. 1997 Dec;24(12):2008-13.

Poster: D. Mazloomdoost MD "Seizure Complication of Regional Technique in AKA-revision of a Patient with Phantom Pain" American Society of Anesthesiology, New Orleans LA October 17-21 2009.

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Poster: D. Mazloomdoost MD, M. Lesley, S. Agarwal, A. Sharma, J. Broatch, S. N. Raja. "A Web-based Survey of the Spread of Symptoms in Complex Regional Pain Syndrome (CRPS)" American Pain Society, San Diego Ca, May 7-9, 2009

Poster: D. Mazloomdoost MD, MD; H Al-Grain. "Assets and Liabilities of Challenging Cases in Developing Nations; A Resident's Perspective" American Society of Anesthesiology, Orlando FL October 18-22 2008.

Poster: D. Mazloomdoost MD, MD; B. Jamerson, PharmD, S. Raja, MD. "Actigraphy-Based Evaluation of Sleep Improvement during Treatment of Chronic Neuropathic Pain with Transdermal Fentanyl" American Pain Society, Tampa Fl; May 8-10, 2008

Poster: D. Mazloomdoost MD, MD; M Jeffries, MD. "Vaporizer Malfunction: A Case of Improper Positioning" American Society of Anesthesiology, San Francisco, CA October 12-16 2007.

Contributer: Z Abdeen, G Greenough, M Shaheen, M Tayback. "Nutritional assessment of the West Bank and Gaza Strip." USAID Report 2002

Contributer: "Call to the Nation: to Eliminate Racial and Ethnic Disparities in Health" American Public Health Association, Oct 6, 2000

Contributer: PJ Bernhadt, SM Humphrey, TC Rindflesch, "Determining Prominent Subdomains in Medicine." AMIA Annual Symposium Proc 2005; 46-50.

Previous Project: Web-based Epidemiologic Assessment of Complex Regional Pain Syndrome; Mentor: Srinivasa Raja.

Previous Project: Actigraphic and Subjective Assessment of Quality of Life Improvements in Neuropathic Pain. Mentor: Srinivasa Raja.

Previous Project: *Utility of Semantic Interpretation of Medline Abstracts to Generate Drug Profiles*—National Institute of Health; National Library of Medicine; Mentor: Thomas Rhindflesch, PhD; 2005.

Previous Project: *Abstracting Novel Genetic Influences on Pathologic Processes Using SemRep and SemVis*—National Institute of Health; National Library of Medicine; Mentor: Thomas Rhindflesch, PhD; 2005.

Previous Project: *Mental Health Status of Afghan Refugees in Iran*—Johns Hopkins University & Tehran Psychiatric Institute; Mentor: Mohammad Mohammadi, MD 2002.

Previous Project: Grid Radiation Efficacy Compared to Open Filed Radiation In Killing Prostate Cancer Cells—Department of Radiation Oncology, University of Kentucky; Mentor: Ali Meighooni, PhD; 1996-1997.

Previous Project: *Sensation Seeking as a Contributor to Addictive Propensity: Murine-model of Addiction* Psychology Department—Department of Psychology, University of Kentucky; 1995-1996.

Previous Project: *Multifrequency Electromagnetic Radiation Effects on Neuronal Axon Regeneration*—Neurology and Biomedical Research Department, University of Kentucky; 1994-1995.

Danesh Mazloomdoost, MD
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Presentations

Presentation: D. Mazloomdoost MD, "Next Evolution in Pain Management" 1 hour AMA PRA Category 1 CME Presented at St. Joseph Hospital, Blakely Auditorium, Lexington Kentucky October 14, 2017.

Presentation: D. Mazloomdoost MD, "Next Evolution in Pain Management" 1 hour AMA PRA Category 1 CME Presented at St. Joseph Hospital, Blakely Auditorium, Lexington Kentucky September 26, 2017.

Presentation: D. Mazloomdoost, MD, "When, Why, & How of opioids: New Treatment Guidelines on Treating Pain" 4.5 hour AMA PRA Category 1 CME presented to Lexington Medical Society April 29, 2017.

Presentation: D. Mazloomdoost MD, "Paradigm Shift in Pain" 1 hour AMA PRA Category 1 CME Presented at St. Joseph Hospital, Blakely Auditorium, Lexington Kentucky November 2, 2016.

Presentation: D. Mazloomdoost MD, "Paradigm Shift in Pain Management for Kentucky's Workman's Compensation Population" Presented at Kentucky Department of Workman's Compensation in Frankfort Kentucky April 22, 2016.

Presentation: D. Mazloomdoost, MD, FDA CORE REMS Program on ER/LA Opioid, 2 hour AMA PRA Category 1 CME Presented at Kentucky Medical Association Physician's Day at the Capital; Frankfort KY February 10, 2016

Presentation: D. Mazloomdoost MD, "Discogenic Pain" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

Presentation: D. Mazloomdoost MD, "Evolution of Low Back Pain" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

Presentation: D. Mazloomdoost MD, "The Future of Pain Management" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

Presentation: A.Z. Omidy PhD, D. Mazloomdoost MD MD, "Motivational Interviewing" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

Presentation: D. Mazloomdoost, "Lumbar Sonoanatomy" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

Presentation: D. Mazloomdoost, "Vertebral Augmentation: Kyphoplasty & Vertebroplasty" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

Presentation: D. Mazloomdoost, "Physical Exam for Diagnosing Pain" Presented at First International Congress of Pain/12th Scientific Congress of Iranian Pain Society, Tehran University Medical Center, Tehran Iran, May 13-15, 2015

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Presentation: D. Mazloomdoost MD, "Pain Pathways and Sites to Intervene" Presented at Musculoskeletal Pain Series at Baptist Regional Medical Center, Corbin KY, December 04, 2014

Public Speaker: D. Mazloomdoost MD, FedUP Rally, Washington DC, September 28, 2014 http://goo.gl/lvH1bQ

Presentation: D. Mazloomdoost MD, "Understanding the Language of Pain" Presented for the St. Joseph Nursing Graduates, Lexington KY, February 13, 2014

Presentation: D. Mazloomdoost MD, "Redefining Pain Management: Evolution of the Opiate Epidemic and Preempting Chronic Pain" Presented at the Lexington Medical Society, Lexington KY, March 12, 2013

Presentation: D. Mazlooomdoost, "The Art of Mind-Reading & Manipulation: Working with Difficult Patients" Presented at Iranian American Medical Association Javaan Conference Breckinridge CO January 16, 2011.

Presentation: D. Mazloomdoost MD, MD "The Basic Sciences of Spinal Cord Stimulation" Grand Rounds Presentation; MD Anderson Department of Pain Management; April 26, 2010.

Presentation: D. Mazloomdoost MD, MD; M. Perez, MD; D. Novy, PhD; "Neonatal Opiate Abstinence Program" Grand Rounds Presentation; MD Anderson Department of Pain Management; March 30, 2010.

Presentation: D. Mazloomdoost MD MD, M. Perez MD, "Cancer Pain Management" Presented at Kidney Cancer Association National Patient Conference; MD Anderson, Houston Tx April 24, 2010.

Presentation: D. Mazloomdoost MD, MD; S. Mehregan, MD; H. Mahmoudi, MD; A. Soltani, MD; P. Embi MD; "Identifying Barriers to Improved Information Access in an Internet Poor Infrastructure" American Medical Informatics Association Annual Symposium, Chicago, Il; November 9-12, 2007.

Presentation: D. Mazloomdoost MD, "Information Retrieval Behaviors of Residents in Iran" Iranian American Medical Association Annual Convention, New York, NY May 27-30, 2006.

Presentation: D. Mazloomdoost MD, BS; T. Rhindflesch, PhD; "Utility of Semantic Interpretation of Medline Abstracts to Generate Drug Profiles" Iranian American Medical Association Annual Convention Las Vegas, NV May 29-30, 2005.

Danesh Mazloomdoost, MD
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Professional Leadership

Speaker of House Kentucky Medical Association
Voted in September 2016 for 3-year term

Reviewer for Anesthesiology and Pain Medicine, Publisher Hoensbroek, Limburg: Kowsar Corp. NLM 101585412

Lexington Medical Society, 2010-present Vice-President 2016-2017

Kentucky Medical Society, 2010-present

- Delegate 2013, 2014, 2015
- Commission on Young Physicians – 2014-present
- Commission on Public Health – 2014-present
- Community Connector 2014: 1 of 8 members in the inaugural class

Doximity Fellow, 2013

- Responsible for critiquing and curating the most relevant medical literature in Pain Medicine and Pediatric Pain Medicine circulated to over 50% of US physicians. Also serves as a Doximity liaison providing product advice and strategic guidance to the company.

Physicians for Responsible Opiate Prescribing; 2011 – present

- Executive Board Member 2013 - present

Hope Center Board of Directors, 2012-2016

American Medical Association, 2011-present

American Society of Anesthesiology; 2006-2011

American Society of Regional Anesthesia & Pain; 2013-present

Activities & Honors

Medical Mission to Honduras via Hackett Hemwall Association 3/03/17 – 03/17/17

American Medical Political Action Committee's Campaign School (2013)

Sustainability Assessment of Volunteer Specialty Clinic in Rural Iran (04/09) Children of Persia.

Medical Mission to Asmara, Eritrea (10/07 & 1/09) Physicians For Peace (PFP); Participate in difficult airway cases. Photo-essay on shortfalls of international medical missions and donations.

Hospital Special Surgery Rotation, New York – Intensive rotation on Ultrasound guided peripheral blocks (12/2008)

Johns Hopkins Housestaff Council, Anesthesiology Delegate ('06-'08)

Maryland Resident Delegate to American Society of Anesthesiology Resident Council ('07-'09)

Johns Hopkins Resident Delegate to Maryland Society of Anesthesiology ('06-'09)

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Committee Chair: Johns Hopkins Public Health Education Council ('08) Develop health education curriculum to integrate with Baltimore Public School Elementary Education System. **Delegate to Overseas Teaching Committee of American Society of Anesthesiology** ('07-'09)

President of Iranian American Medical Association, JAVAAN Committee ('06-'07) coordinate committees presenting at the annual national convention.

Treasurer of Iranian American Medical Association, JAVAAN Committee ('05-'06)

Informatics Research Fellow National Institutes of Health ('05)

Johns Hopkins Physician for Human Rights-Juvenile Justice ('01-'05)—Co-Founder (2001-'05) Develop & teach curricula on: 1) Hygiene/Sex Ed, 2) Violence Prevention, 3) Women's Empowerment to high school students in juvenile detention centers

Johns Hopkins Medical Institute Student Assistance Program Liaison ('02-'05)—co-coordinate programs with staff psychologists to improve medical student mental hygiene

Johns Hopkins Information Technology Curriculum Reform Committee ('02-'05)—student developer of pilot program to incorporate technology resources into current medical education curriculum

Johns Hopkins Middle Eastern Student Association ('01-'03)—co-president; Advocate and educate on Middle East issues and cultures

Johns Hopkins SHARE('01-'02)—Collect reusable surgical material for donations to developing nations

Case Western Reserve University Senior Award in Economics ('01)

Truman Scholar Finalist ('00)

Surgeon General's Office, Department of Health and Human Services Internship('00)

Anti-tobacco campaign in Iran ('00)--developed educational material for anti-tobacco campaign coordinated by Iranian American Medical Association

Universal Health Care Action Network Internship ('00-'00) Think-tank for universal health care. Interviewed community health leaders and businesses on impact of the uninsured in Cleveland, OH.

Case Western Reserve University Presidential Academic Scholarship ('97) Merit-based full scholarship to Case Western Reserve University

Personal & Interests

Photography

Travel/extended-stay in: Iran (>6 months), Denmark (>6 months), France (>2months), Spain (1 month), Germany, Italy, Switzerland, Norway, Sweden, Finland, Russia, Estonia, Eritrea, Honduras.

Languages: English, Persian, French

Born: Louisville, Kentucky

EXHIBIT M-2

Dr. Mazloomdoost's Prior Testimony

1. George Young vs YOUNG PAINTING THERESE A LEVAN M.D. and HON. JOHN B. COLEMAN - deposed 2017, entered 2018

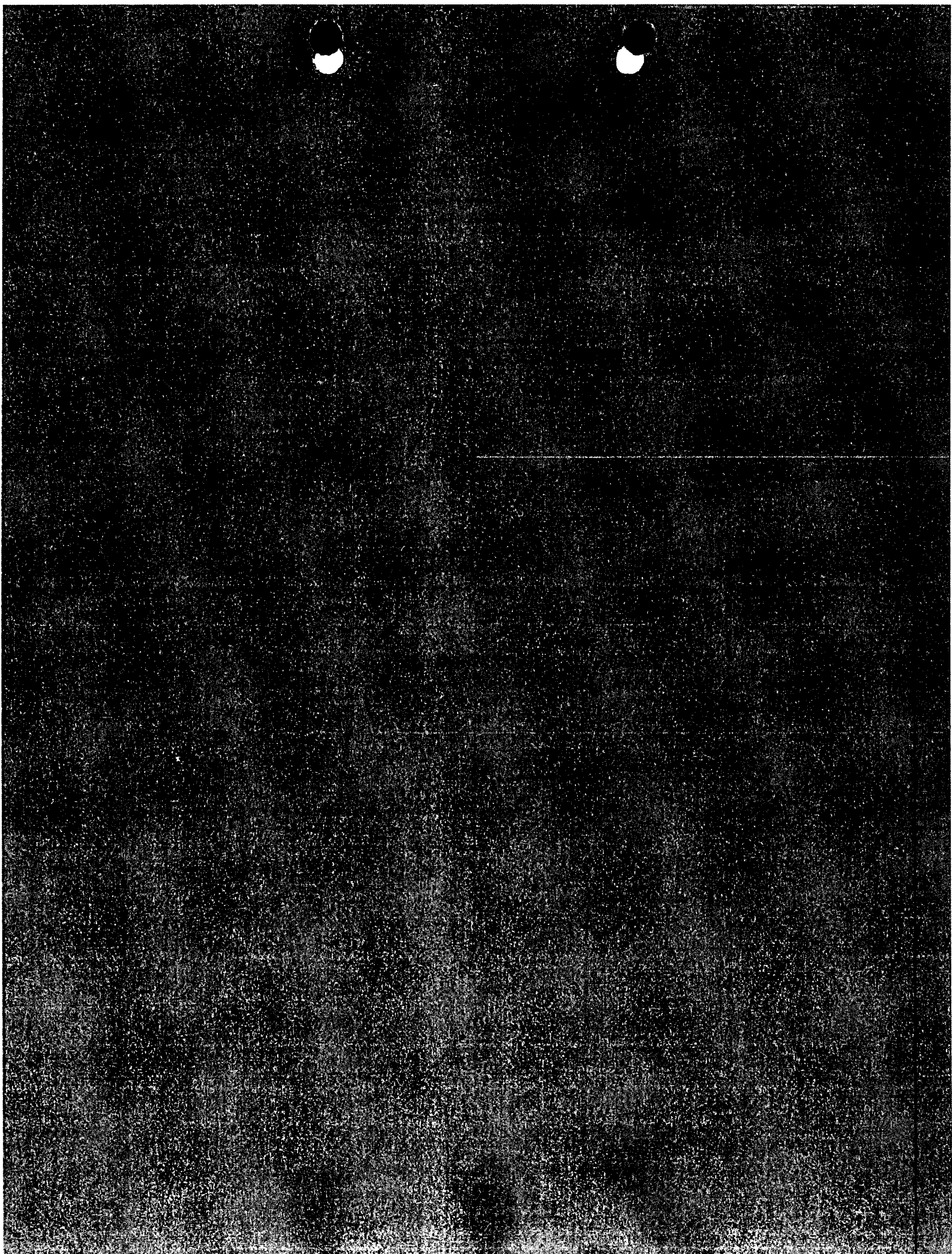

EXHIBIT B

1 IN THE DISTRICT COURT IN AND FOR CLEVELAND COUNTY
STATE OF OKLAHOMA

2

3 STATE OF OKLAHOMA, ex rel.,
4 MIKE HUNTER, ATTORNEY GENERAL
OF OKLAHOMA,
5 Plaintiffs,
6 -vs- Case No. CJ-2017-816
7 PURDUE PHARMA L.P.; PURDUE
8 PHARMA, INC.; THE PURDUE
FREDERICK COMPANY; TEVA
9 PHARMACEUTICALS USA, INC.;
CEPHALON, INC.; JOHNSON &
10 JOHNSON; JANSSEN PHARMACEUTICALS,
INC.; ORTHO-McNEIL-JANSSEN
11 PHARMACEUTICALS, INC., n/k/a
JANSSEN PHARMACEUTICALS, INC.;
12 JANSSEN PHARMACEUTICA, INC.
n/k/a JANSSEN PHARMACEUTICALS,
13 INC.; ALLERGEN, PLC f/k/a
ACTAVIS PLC, f/k/a ACTAVIS, INC.,
14 f/k/a ACTAVIS PLC, f/k/a ACTAVIS,
INC., f/k/a WATSON PHARMACEUTICALS,
15 INC.; WATSON LABORATORIES, INC.;
ACTAVIS LLC; and ACTAVIS PHARMA,
16 INC., f/k/a WATSON PHARMA, INC.
17 Defendants.

18
19 VIDEOTAPED DEPOSITION OF DANESH MAZLOOMDOOST, MD
20 TAKEN ON BEHALF OF THE DEFENDANTS
21 ON MARCH 7, 2019, BEGINNING AT 9:05 A.M.
22 IN OKLAHOMA CITY, OKLAHOMA
23

REPORTED BY:
24 Shannon S. Harwood, CSR, RPR
Job No. 3245656
25 Pages 1 - 319

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866 299-5127

1 an expert witness in this case; is that correct?
2 A. Yes.
3 Q. Who retained you?
4 A. The law firm that's here. I forget the name,
5 Nix and Patterson.
6 Q. And you were retained to be an expert witness,
7 correct?
8 A. Yes.
9 Q. Outside of that expert witness retention
10 agreement, do you have -- do you have any other
11 relationships with the law firm of Nix Patterson?
12 A. No, I don't.
13 Q. I'm going to hand you what's been marked as
14 Exhibit 1.
15 (Deposition Exhibit No. 1 was marked for
16 identification and made part of the record.)
17 Q. (By Mr. Ehsan) And ask you if you've seen
18 this document before?
19 A. Not to my recollection. I may have among the
20 documents that I've reviewed.
21 Q. You understand that you were to be deposed
22 today, correct?
23 A. Correct.
24 Q. Do you have knowledge one way or another if
25 that -- that understanding came through looking at this

1 particular document?

2 A. Possibly.

3 Q. What, if anything, did you do to prepare for

4 today's deposition?

5 A. Nothing in particular. I'm basing it off my

6 other expertise. I reviewed some data about Oklahoma

7 and that's pretty much it.

8 Q. So let me break that down if you don't mind.

9 A. Sure.

10 Q. Specifically as to this deposition, did you

11 review any documents to prepare for this particular

12 deposition?

13 MR. CUTLER: I'm going to object to the form

14 and to the extent you're asking about discussions with

15 counsel, preparation you had with counsel for this

16 deposition specifically, I'm going to instruct you not

17 to go into the substance of that. As to, you know,

18 documents that underlie your opinions and stuff like

19 that, you can talk about that and you can talk generally

20 what you did to prepare, just --

21 THE WITNESS: Sure.

22 MR. CUTLER: -- warn you not to go into

23 substance of attorney/client discussions.

24 A. So, you know, I -- I collated some -- some

25 information over the course of -- of my career and I put

1 that in as much of a summary form as I could in the
2 disclosure statement. I've reviewed some data over
3 Oklahoma to find similarities to identify to determine
4 if there are similarities between what I've been exposed
5 to in Kentucky as well as Oklahoma, and there, indeed,
6 are quite a lot of similarities.
7 Q. (By Mr. Ehsan) Well, Doctor, my question was
8 different. Just as to this deposition, not your
9 disclosure, did you review documents to prepare for the
10 deposition today?
11 A. I'm not sure --
12 MR. CUTLER: Same objection. Same
13 instruction.
14 A. Yeah, I -- I feel like that answered the
15 question.
16 Q. (By Mr. Ehsan) So, Doctor, for example, did
17 you look at any articles last night in order to refresh
18 your recollection regarding any particular facts in
19 preparation for today's deposition?
20 A. Nothing --
21 MR. CUTLER: And, sorry, just let me -- before
22 you launch into your answer, let me get my objections
23 in. I'm going to object to the form. Same instruction
24 regarding attorney/client privileged information, but
25 you can answer that question to the extent you can do so

1 without going into that.

2 A. Sure. Yeah, I mean, I didn't -- I didn't do

3 anything to refresh my memory. I -- like I said, I've

4 reviewed articles about Oklahoma's statistics; the fact

5 that Oklahoma has a very similar socioeconomic profile

6 as Kentucky does; that the areas most afflicted are

7 similar in geographic and demographics; the -- the dire

8 status or the dire nature; the fact that Oklahoma is

9 also in the top five for states afflicted by the opioid

10 epidemic similar to Kentucky. So, you know, I'm not

11 sure what else you're referencing or wanting to know.

12 Q. (By Mr. Ehsan) And, Doctor, I'm not asking

13 about the substance of your opinion. I'm talking about

14 the process here.

15 A. Uh-huh.

16 Q. So it seems as, if I understood you correctly,

17 you looked at some statistics related to Oklahoma, but I

18 just want to make sure I understand that was in

19 connection with preparing for today's deposition as

20 opposed to preparing for your expert disclosure?

21 MR. CUTLER: Object to the form.

22 Mischaracterizes his testimony, and same instruction

23 regarding privilege.

24 A. Yeah, I don't -- I don't know how to answer

25 that any more --

1 Q. (By Mr. Ehsan) Okay.

2 A. -- clearly.

3 Q. Doctor, did you meet at all with any lawyers

4 in preparation for this deposition?

5 A. As in -- as lawyers here? Lawyers in general?

6 What are you referencing?

7 Q. Okay. Doctor, I think -- let me ask the

8 question again. Did you meet with any lawyers, any

9 lawyers in preparation for today's deposition?

10 A. So --

11 MR. CUTLER: And, yeah, I may be able -- and

12 same instruction regarding privilege, but it is okay for

13 you to talk generally about what you did to prepare

14 for --

15 THE WITNESS: Okay.

16 MR. CUTLER: -- your deposition today.

17 A. Okay. So I did meet with the lawyers here

18 yesterday.

19 Q. (By Mr. Ehsan) Go ahead.

20 A. And that's about it.

21 Q. Okay. And I apologize for interrupting your

22 answer. And how long would you approximate you met with

23 lawyers yesterday?

24 A. A few hours. I'm not sure exactly how long it

25 went.

1 A. Yeah, I -- I don't have any formal training.
2 Q. (By Mr. Ehsan) Do you have any formal
3 training in epidemiology?
4 MR. CUTLER: Object to the form.
5 A. Again, as -- as a medical student, you get
6 education within epidemiology, public health, but I
7 don't have a degree offered.
8 Q. (By Mr. Ehsan) Do you have any formal
9 training in health care economics?
10 A. I do actually --
11 MR. CUTLER: Object to the form.
12 A. Sorry. I do actually. My undergraduate
13 degree was business management and we -- everybody picks
14 an area to have a subspecialty in and I actually carved
15 out health care economics as my -- my specialty
16 training.
17 Q. (By Mr. Ehsan) Do you have any formal
18 training in statistics?
19 MR. CUTLER: Object to the form.
20 A. I -- I receive a lot of statistical training,
21 both in the medical -- in my medical training as well as
22 in my business training. I've taken statistics courses
23 since I was in high school. I think I even had an AP
24 statistics class in high school.
25 Q. (By Mr. Ehsan) Do you have any formal

1 training regarding accounting?

2 MR. CUTLER: Object to the form.

3 A. Again, as part of my undergraduate degree in

4 business management, I do have some accounting.

5 Q. (By Mr. Ehsan) Do you have any formal

6 training related to health care marketing?

7 MR. CUTLER: Object to the form.

8 A. I don't have formal training. However, I've

9 got practical hands-on training. I'm a small business

10 owner in Kentucky. I've been managing the practice that

11 I took over from my parents since 2010, and given that

12 we are a small practice, we -- we've done a tremendous

13 amount of marketing, especially for the fact that we

14 swim against the current, because the -- the mindset in

15 Kentucky was so opioid centric when it came to pain

16 management that anything outside of that was very, very

17 unfamiliar.

18 So one of the objectives that I had, the

19 reason I returned to Kentucky was because the opioid

20 epidemic was so bad there and it became my -- my

21 personal mission to try to change the mindset of health

22 care. In fact, that's one of our mission statements in

23 our practice is we're -- we exist to transform health

24 care into a better state, because we are not delivering

25 the appropriate care to patients. So I'm very confident

1 in my marketing background.
2 Q. (By Mr. Ehsan) You currently -- excuse me,
3 run a -- the Wellward Regenerative Medicine Clinic in
4 Kentucky; is that correct?
5 A. That's correct.
6 Q. And in that capacity, do you see patients who
7 suffer from pain?
8 MR. CUTLER: Object to the form. Vague.
9 A. Yeah, it is a vague question, but of course.
10 Q. (By Mr. Ehsan) Do you see patients in your
11 practice -- let me back up and ask the question.
12 Do you have a clinical practice?
13 A. I do.
14 Q. In your clinical practice, do you see pain
15 patients?
16 A. I see plenty of pain patients.
17 Q. Do you see patients who have been diagnosed
18 with chronic non-cancer pain?
19 A. I do, yeah.
20 Q. Have you ever had a patient with chronic
21 non-cancer pain for whom you've prescribed opioids?
22 A. You know, I inherit a lot of patients who have
23 been initiated on opioids, and for a variety of reasons,
24 they come to me for a variety of conditions. My
25 strategy with all those patients is de-escalation,

1 specific. Now, if there's something that you're trying
2 to drive towards, I'm happy to review a document or
3 transcript or whatever.
4 Q. (By Mr. Ehsan) But, Doctor, I'm asking you,
5 in preparation for this deposition. I don't know what
6 you reviewed. Did you review and rely on any deposition
7 transcripts?
8 MR. CUTLER: So I -- I think this may be --
9 this is the misunderstanding. Are you asking if he
10 reviewed -- has reviewed yet deposition transcripts in
11 regard to his expert opinion or are you asking about
12 specifically for preparing with his attorneys to -- for
13 this deposition today, because the latter is
14 attorney/client privilege and work product. The former
15 he can go into. I'm not sure what you're asking about.
16 Q. (By Mr. Ehsan) In formulating your expert
17 opinions, Doctor, the lawyer didn't tell you what your
18 expert opinions are, Doctor -- well, we'll get to that
19 in a second, but Doctor, in formulating your expert
20 opinion in this case, did you review any deposition
21 transcripts?
22 A. I did not review transcripts. I have reviewed
23 or have -- have heard some of the statements made.
24 Q. That's fine. Are you aware of sitting here
25 today, not through your lawyers, but in any other way

1 about anecdotes of patients doing well on opioid
2 medications?
3 MR. CUTLER: Object to the form.
4 A. So, you know, the -- the reason that -- that I
5 question some of those is because a lot of the patients
6 that I've seen who anecdotally said they were benefiting
7 from opioids, when we really dug down to it, a lot of
8 them were self medicating, that they had some mood
9 disorder, behavioral or -- or emotional disorder that
10 the opioid was helping to numb.
11 In those patients, when we -- when we provided
12 them the appropriate care, psychiatric care,
13 psychological counseling, and we de-escalated their
14 medications, they universally do better. So it's very
15 difficult for me, I can -- I can speak on the cases that
16 I've seen. I can speak anecdotally, and whether you
17 choose to believe them or not, it's your prerogative,
18 but I am not going to accept the anecdotal evidence
19 coming from somebody else until it's been published --
20 publicized -- publicized in a peer-reviewed journal, and
21 then I might take it into consideration, but to just
22 take somebody's anecdotal evidence as something that's
23 going to change my opinion, I would -- I would not agree
24 to that.
25 MR. CUTLER: Counsel, when you get a chance,

1 we're about two hours in, to take a break?
2 MR. EHSAN: Yeah, we can take a break. This
3 is a natural break point, so I'll just ask you just one
4 follow up if you don't mind.
5 Q. (By Mr. Ehsan) So in order for you to accept
6 someone else's anecdotal evidence, you would need it
7 published; is that correct?
8 MR. CUTLER: Object to the form.
9 Mischaracterizes his testimony.
10 A. If I had a colleague who came to me that I
11 trusted and I knew, provided me the anecdote and
12 answered questions that I have, yeah, I would take that
13 into consideration, but to -- to hear just an anecdote
14 off the street, no, that doesn't sway me.
15 MR. EHSAN: Why don't we take a break.
16 THE VIDEOGRAPHER: We're going off the record
17 at 10:56 a.m.
18 (A recess was taken from 10:56 a.m. to
19 11:16 a.m.)
20 THE VIDEOGRAPHER: We're going back on the
21 record at 11:16 a.m.
22 Q. (By Mr. Ehsan) Doctor, before we took a
23 break, we were talking about the various -- well,
24 shortly before we took the break, we were talking about
25 the various sources of information that you rely on to

1 A. I -- I don't know if those labels are often --
2 I mean, I -- you know, I know I've looked at them. I
3 can't tell you specifically if I've read one in detail.
4 Q. (By Mr. Ehsan) What is your understanding
5 what a package insert is?
6 MR. CUTLER: Object to the form. Vague.
7 A. The -- the piece of paper that comes with
8 medication.
9 Q. (By Mr. Ehsan) And do you have an
10 understanding of what information is conveyed in the
11 package insert?
12 MR. CUTLER: Object to the form. Outside the
13 scope. He's not here to testify about package inserts.
14 Vague.
15 A. Yeah, I -- I mean, I'll be honest, I don't
16 know the process that goes into those package inserts or
17 really I don't -- I don't think people -- I don't think
18 physicians -- well, I would -- that would be just my
19 opinion, but I personally -- I know what you're talking
20 about, the package inserts. I don't know if I've ever
21 read one in great detail.
22 Q. (By Mr. Ehsan) So in your clinical practice,
23 you don't make it a habit of reading the package inserts
24 for the medications you prescribe?
25 MR. CUTLER: Object to the form.

1 Mischaracterizes his testimony. Nothing to do with his
2 disclosure.
3 A. I make my decisions about what medications I
4 prescribe by the education I receive.
5 Q. (By Mr. Ehsan) Do you have an opinion one way
6 or the other if other physicians follow your practice in
7 prescribing?
8 MR. CUTLER: Object to the form. Entirely --
9 entirely speculative.
10 A. I don't -- I don't make any assumptions as to
11 what other physicians base their decisions on.
12 Q. (By Mr. Ehsan) To the extent that you've
13 reviewed a -- strike that.
14 You have at least looked at a package insert
15 before in your clinical practice?
16 MR. CUTLER: Object to the form.
17 A. I've seen them, yes.
18 Q. (By Mr. Ehsan) Do you have a recollection of
19 the information that was contained in it sitting here
20 today?
21 MR. CUTLER: Object to the form. Are you just
22 asking about any package insert, opioids?
23 Q. (By Mr. Ehsan) Again, Doctor, have you --
24 MR. EHSAN: I appreciate you objecting to the
25 form and moving on. I don't -- you are not allowed to

1 have speaking objections and I would appreciate not
2 wasting my time with speaking -- speaking objections.
3 MR. CUTLER: You're wasting his time if you're
4 asking about any -- this is case is not about any
5 medication. If you're asking him if he's ever --
6 MR. EHSAN: Again --
7 MR. CUTLER: -- I mean, ask a question that's
8 relevant to the case.
9 MR. EHSAN: Again, this is my --
10 MS. PATTERSON: Winn -- Winn, we get to ask
11 questions.
12 MR. EHSAN: It's my six hours. I get to ask
13 the questions. You can object. I'm not saying --
14 MR. CUTLER: And that's what I'm doing.
15 MR. EHSAN: -- but you're having --
16 MR. CUTLER: Same objections.
17 MR. EHSAN: -- you are -- you are speaking
18 objections over and over again.
19 Q. (By Mr. Ehsan) Doctor, you said you looked at
20 a package insert before in your career; is that correct?
21 A. Correct.
22 Q. Now, to the best of your recollection --
23 recollection sitting here today, what kind of
24 information was contained in that package insert?
25 MR. CUTLER: Object to the form. Vague.

1 Q. (By Mr. Ehsan) If you don't know, you can say
2 you don't know.
3 MR. CUTLER: Object to the form. Vague. Same
4 objections.
5 A. Yes, so I'm not sure where -- where the line
6 of questioning is intended to go, because the opinions
7 I'm having here today are based out of my clinical
8 experience and the applicability or the correlations
9 between Kentucky and Oklahoma, what impact from
10 pharmaceutical marketing had, what impact the
11 misinformation had.
12 I can -- I can attest to that, but as far as
13 giving you great deal of information about package
14 insert, what its utility is, how it's used, what form it
15 comes in, what content is on there, I -- I don't know.
16 Q. (By Mr. Ehsan) So in rendering your opinion
17 about physicians being misinformed about the medication,
18 you did not find it relevant to look at the package
19 inserts for the medications at issue; is that correct,
20 Doctor?
21 MR. CUTLER: Object to the form.
22 Mischaracterizes his testimony. Again, his disclosures
23 have nothing to do with package inserts and asked and
24 answered.
25 A. The statistics are -- are pretty appalling

1 about how many people are misusing, abusing and seeing
2 adverse effects from opioids. How that evolved or how
3 that developed, you know, I can -- I can -- I can say
4 that there is clear evidence of misinformation that was
5 provided by both educational platforms and individual
6 reach outs. As far as what package inserts say, I'm not
7 sure.
8 Q. (By Mr. Ehsan) Did you review the package
9 inserts for any of the opioids at issue in this case
10 before preparing your expert disclosure?
11 MR. CUTLER: Object to the form. Vague.
12 A. I don't recall.
13 Q. (By Mr. Ehsan) Doctor, I'm going to hand you
14 what's been marked as Exhibit 6.
15 (Deposition Exhibit No. 6 was marked for
16 identification and made part of the record.)
17 Q. (By Mr. Ehsan) Doctor, do you recognize this
18 document?
19 A. Yes.
20 Q. And what is this document?
21 A. This is the summary of disclosures that I
22 submitted.
23 Q. Before being retained as an expert witness in
24 this case, did you have knowledge of the allegation in
25 this particular lawsuit?

1 to make a clinical decision.

2 Q. (By Mr. Ehsan) Do you recall this study has a

3 method -- methodology section?

4 MR. CUTLER: Object to the form.

5 A. I'm sure it does.

6 Q. (By Mr. Ehsan) Where it would lay out exactly

7 how long the use of the studies were that they were

8 looking at?

9 MR. CUTLER: Object to the form.

10 A. Sure.

11 Q. (By Mr. Ehsan) And the title of the article

12 is Opioid Compared to Placebo or Other Treatments From

13 Chronic Low Back Pain; is that correct?

14 MR. CUTLER: Object to the form.

15 A. Yes, sir.

16 Q. (By Mr. Ehsan) You can put that document

17 aside. Thank you. Now, you -- if you flip to the next

18 page of your disclosure where you actually have the

19 opinions, not the articles -- I apologize. You have to

20 go back a few pages, to the second page. We're still

21 under section B or opinions, correct?

22 A. Yes, sir.

23 Q. And you see the second bullet point, you state

24 that, "The opioid epidemic is directly attributable to

25 focus pharmaceutical market." Do you see that?

1 A. Yes, sir.
2 Q. Do you have specific pharmaceutical marketing
3 in mind when you say that the opioid epidemic is
4 directly attributable to pharmaceutical marketing?
5 A. I have to --
6 MR. CUTLER: Object to the form. Vague.
7 A. I have personal experience with -- with
8 representatives of pharmaceutical companies from whom
9 I -- I got information that was inaccurate and I
10 challenged them on it knowing that this is the same
11 information that they're taking to less-informed
12 clinicians in my area of expertise.
13 I've reviewed call logs from Oklahoma that
14 reflect situations where a representative is trying to
15 convey to a primary care doctor that the risk of a
16 fentanyl patch is less than the short-acting medication
17 that they're writing for, with no foundation, with no
18 research or science behind that. The speculative
19 statement that the peaks and troughs of short-acting
20 opioids is what causes the addictive potential of an
21 opioid versus the long exposure of a chronic opioid that
22 has this mellow effect of -- mellow distribution of
23 medication, has never been proven, and yet, that's --
24 that's a precise of example of disinformation or
25 incorrect information that, to me, is almost

1 manipulative to try to get that person to try.
2 And -- and the manipulation went further.
3 They would even help the clinician try to identify
4 specific patients to switch from a short-acting opioid
5 to a fentanyl patch, which to me, is -- is a gross
6 overreach of -- of pharmaceutical rep. So there are
7 ample examples of how the opioid epidemic is directly
8 attributable to focus pharmaceutical marketing.
9 Q. (By Mr. Ehsan) How many call logs did you
10 look at, Doctor, in coming to your opinion?
11 A. I --
12 MR. CUTLER: Object to the form.
13 A. I don't -- I don't think it's imperative for
14 me to review a whole bunch of it. If it happens once,
15 that's catastrophic to me. And it's not just -- it's
16 not just that. I mean, I've -- I've interviewed or
17 talked to colleagues, particularly in rural parts of my
18 state, where they -- they -- the facts that I have or
19 the misinformation that I have to correct on them
20 reflects the same kind of language, the same kind of
21 statements that I've heard from pharmaceutical reps. So
22 however many call logs that I reviewed, to me, is
23 irrelevant. The fact that it even happens, to me, is he
24 egregious.
25 Q. (By Mr. Ehsan) And these call logs were

1 Oklahoma call logs or Kentucky?
2 A. These were specifically Oklahoma call logs.
3 Q. How did you come about to these particular
4 call logs? Did you identify them yourself through a --
5 searching an entire database of call logs?
6 MR. CUTLER: Object to the form. Excuse me.
7 Vague.
8 A. Yeah, I mean, I -- I obtained them through the
9 process of researching this and getting information from
10 various sources.
11 Q. (By Mr. Ehsan) My question is, Doctor, where
12 did you -- how did you come about the specific call logs
13 that formed your basis of your opinion that these call
14 logs demonstrated focus marketing campaign to influence
15 prescribers?
16 MR. CUTLER: Object to the form. You can
17 answer that question.
18 A. Okay. So I -- I received it from -- in the
19 documents that I reviewed provided by the legal team.
20 Q. (By Mr. Ehsan) Did you ask to see -- or have
21 you reviewed other call logs from various opioid
22 manufacturers other than the ones that you received from
23 counsel?
24 MR. CUTLER: Object to the form.
25 A. No, the -- frankly -- frankly, I was kind of

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1 appalled by the fact the detail within which those call
2 logs are even drafted. And -- and the thought processes
3 that go into how they can influence a clinician into
4 prescribing more drugs, I mean, we're not -- we're not
5 selling cars. We're not selling boxes of Kleenex that
6 you're trying to brand compare.
7 These are medications that have dire harms
8 along with them and to be -- to be so casually trying to
9 influence increased sales, there is -- there is a very
10 fine line between drug dealing and pharmaceutical
11 marketing, and in many of those statements, I feel like
12 that line gets crossed.
13 Q. (By Mr. Ehsan) Doctor, I'm asking you a more
14 specific question. Did you or did you not, in fact,
15 look at other call logs besides what was provided from
16 counsel?
17 MR. CUTLER: Object to the form.
18 A. No, I have not.
19 Q. (By Mr. Ehsan) How many call logs -- do you
20 have a sense of how many call logs you actually did
21 review?
22 MR. CUTLER: Object to the form.
23 A. Not really, no.
24 Q. (By Mr. Ehsan) Was it in the tens, in the
25 hundreds, in the thousands?

1 A. I'd say probably in the tens.
2 Q. And do you know how many total call logs were
3 produced in this case?
4 MR. CUTLER: Object to the form. Calls for
5 speculation. Vague. Outside the scope of his --
6 Q. (By Mr. Ehsan) Asking if you know, Doctor --
7 MR. CUTLER: -- expert testimony?
8 A. I don't know, but -- but I also think the
9 relevance of -- of -- of personal experience,
10 conversations with multitude of physicians, particularly
11 one of my practices is in a rural environment, and those
12 are the areas that were specifically targeted by a lot
13 of pharmaceutical marketing campaigns. Simply because
14 those are less connected physicians, they're more --
15 they're in more remote areas. They're vulnerable to
16 just -- the scope and scale of problems that they see is
17 tremendous, and so they rely on outside sources of
18 information to help them triage and -- and treat the
19 patient population they see.
20 When it becomes a norm within the community
21 that an opioid is prescribed for a pain issue, that
22 creates this momentum where the clinicians start to
23 prescribe, the patients start to demand it, and the fear
24 starts to develop where if I don't write this
25 medication, I'm losing this patient. In those

1 environments, that -- that kind of mindset runs rampant.
2 The fact that those call logs reflected some
3 of those -- that -- that thinking, some of the processes
4 that I first hand saw just simply confirmed what I
5 suspected.
6 MS. PATTERSON: Objection. Nonresponsive.
7 Q. (By Mr. Ehsan) Doctor, did you speak to any
8 Oklahoma physicians in preparation for your expert
9 disclosure?
10 A. I have not, but when I was training at MD
11 Anderson, it's just across the border, we had numerous
12 Oklahoma patients come in. I remember one in particular
13 who was prescribed Actiq. She was now in cancer
14 remission and she was -- she was on thousands of
15 morphine equivalence a day.
16 I had a conversation with my -- and they were
17 from Oklahoma.
18 I had a conversation with my attending about
19 the patient saying, you know, this doesn't seem right to
20 me. I mean, the patient if they -- if every time they
21 don't take their Actiq, they get this exorbitant amount
22 of pain, there's something wrong in this. We're not --
23 we're not appropriately treating the patient and there
24 was really not a great response out of that.
25 That was directly attributable to the -- the

1 reps that we were seeing that said, you know, if a
2 patient has had cancer in the past, they are allowed to
3 continue their Actiq just simply because of a historic
4 presence of cancer, in spite of the fact the patient
5 didn't really have an active note of pain. It was
6 primarily the opioid dependency that was causing her to
7 have withdrawal symptoms of pain every time she stopped.
8 So yes, I've seen a lot of Oklahoma patients.
9 MS. PATTERSON: Objection nonresponsive.
10 Q. (By Mr. Ehsan) Doctor, I'm asking you if you
11 talked -- if you saw or talked to Oklahoma doctors?
12 A. I'm sorry, I misunderstood your question. I
13 have not directly had a conversation with an Oklahoma
14 physician, but I reserve the right to. If this proceeds
15 to trial, I would like to have those conversations
16 because I -- I'm strongly suspicious that what I've seen
17 in Kentucky is -- is heavily -- is very similar to what
18 exists in Oklahoma.
19 Q. And that's an opinion you hold as of now?
20 A. I -- I -- I think that's an opinion that I
21 hold attributable to both my experience at MD Anderson
22 seeing Oklahoma patients and how those patients were
23 being treated at home, as well as my -- my review of the
24 data that I've seen about Oklahoma, the parallels and
25 correlations between our two states.

1 Oklahoma and Kentucky rank in the top five for
2 opioid related complications, opioid prescribing, opioid
3 overdoses. The demographics that are affected are very
4 similar. Tends to be rural. Tends to be impoverished
5 populations.
6 So the -- the correlations are very -- are
7 evident, on top of the fact that you can't tell me that
8 a pharmaceutical company is going to go state by state
9 and have -- have globally different strategies,
10 marketing strategies in those -- in those areas. This
11 is a national problem and the strategies that used --
12 that were used were national.
13 The physicians that would go to the
14 conferences that I went to went to national conferences
15 and the messages were very clear, that opioids were safe
16 and effective and they are allowed to have that false
17 sense of security that they can write as much as they
18 want.
19 MS. PATTERSON: Objection. Nonresponsive.
20 Q. (By Mr. Ehsan) Doctor, if you stay with the
21 second page of your disclosure, the fifth bullet point,
22 you talk about the textbook -- or not textbook, the book
23 Responsible Opioid Prescribing by Dr. Scott Fishman. Do
24 you see that?
25 A. Yes, sir.

1 Q. And you identify it as a text promoting
2 liberal opioid use, correct?
3 A. Yes, sir.
4 Q. Have you read the book Responsible Opioid
5 Prescribing?
6 A. I've read parts of it.
7 Q. Are you aware of who Dr. Scott Fishman is?
8 A. Yes.
9 Q. Were you aware that he was deposed in this
10 case?
11 A. No, I wasn't.
12 Q. So I assume you did not read the transcript of
13 his deposition?
14 A. If you'd like to share it, I'd be happy to
15 opine on it.
16 Q. Sitting here today, you don't know one way or
17 the other what his opinions were about the book
18 Responsible Opioid Prescribing, correct?
19 A. No, sir.
20 MR. CUTLER: Object to the form.
21 Q. (By Mr. Ehsan) And if he testified that the
22 book was actually trying to highlight the risks of
23 opioids and the risk of addiction with opioids, would
24 you -- would you agree or disagree with that?
25 MR. CUTLER: Object --

1 A. If that -- sorry.
2 MR. CUTLER: Hold on. Object to the form.
3 Lacks foundation. Calls for speculation. Go ahead.
4 A. If that was the intent, then he failed. I
5 mean, the -- the content that was in that book, the
6 things that stood out for me, one was pseudoaddiction.
7 Never been proven in scientific literature. What is the
8 point of even talking about that, if -- if your intent
9 is to quote unquote prescribe opioids safely? That was
10 a license to kill. You're seeing patients that have
11 clear evidence of substance use disorder or opioid use
12 disorder and you're making the interpretation that this
13 is -- this is just a call for more medication. To me,
14 that's not responsible at all. That's -- that's poor
15 medicine, so I --
16 MS. PATTERSON: Objection. Nonresponsive.
17 A. Well, I think the question is, is was I aware
18 that the intent was to write for responsible opioid
19 prescribing, to me, it was completely the opposite
20 and -- and when you look at who was the one -- who
21 produced that book, it was funded indirectly -- directly
22 by pharmaceutical companies. So what incentive did
23 Dr. Fishman have to say, yeah, no, we --we should peel
24 back on the -- on the opioid prescribing?
25 To me, it was let's put our foot on the gas.

1 In fact, there were statements physicians should be
2 sanctioned for not writing enough medications. Combine
3 that with pseudoaddiction, who's to say that -- I mean,
4 physicians for the longest time were in fear that if
5 they don't write enough medications they'll be in
6 trouble.
7 When the HCAHPS surveys were reflecting
8 outcomes based on patient satisfaction scores of how
9 their pain was managed, and then emergency room
10 physicians were -- were docked pay or hospitalists were
11 docked pay for insufficient control of medications and
12 the messaging is all about insufficient opioid
13 prescribing, I mean, it's -- it was a very tactful way
14 of getting physicians to write more medications. They
15 had that fear of sanctioning.
16 MS. PATTERSON: Objection. Nonresponsive. No
17 foundation and speculation.
18 Q. (By Mr. Ehsan) Doctor, you've never practiced
19 medicine in Oklahoma, have you?
20 A. I've never had a license in Oklahoma.
21 Q. Have you practiced medicine without a license?
22 A. I've never practiced -- I've never practiced
23 in Oklahoma.
24 Q. And you were never an emergency room doctor in
25 any state; is that correct?

1 MR. CUTLER: Object to the form.

2 A. I'm an anesthesiologist and pain specialist,

3 but I've had many conversations with emergency room

4 physicians just based on the relationship of -- of

5 taking admissions.

6 Q. (By Mr. Ehsan) And it's your opinion based on

7 reading excerpts or portions of Dr. Fishman's book that

8 he failed, I think you said miserably, but I may be

9 wrong, he failed at trying to -- trying to educate

10 readers about the risks of opioids; is that correct?

11 MR. CUTLER: Object to the form.

12 Mischaracterizes his testimony.

13 A. Yeah, I -- I stand by what I said earlier.

14 Q. (By Mr. Ehsan) Just to confirm, though, you

15 didn't read the whole book; that's -- is that correct?

16 MR. CUTLER: Object to the form.

17 A. I may have. I don't recall. There's a lot of

18 literature that I have read. Do you remember every

19 single book that you've ever read in detail?

20 Q. (By Mr. Ehsan) Doctor, I'm not asking if you

21 remember the book in detail. I'm asking if you read the

22 book cover to cover. There's a difference.

23 A. I --

24 MR. CUTLER: Object to the form. You can

25 answer his question.

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1 representative identified in the call notes?
2 A. No, however, there were similarities with
3 physicians that I've -- I've encountered in Kentucky.
4 Like, for instance, I remember one of the call notes
5 reflected a gentleman where the -- the representative
6 stated something about him having been in practice for
7 40 years, which if you do the math, would put him at the
8 very least in his 60s, if not 70s. And he was a
9 physician that -- I don't remember where he was located,
10 but that demographic of physician, the older physician,
11 the one who sees a high volume of patients and there
12 were illusions to his high volume, who in Kentucky and
13 Oklahoma were -- were in the rural regions of the state,
14 those were the physicians that were in particular
15 targeted because of recognizing their vulnerability.
16 And what was fascinating was reading how the
17 pharmaceutical rep progressively over the course of
18 several months of visits had increased that physicians
19 writing habits from 30 to 60 milligram of morphine
20 equivalent a day to 320 milligrams of oxycontin a day,
21 which is equivalent to around 500 milligrams a day. So
22 we're talking about 10- to twenty-fold increase in
23 prescribing habits over the course of several years.
24 Same things were happening in Kentucky. Exact
25 same things. Physicians that I've talked to started

1 out, you know, gingerly prescribing medications, but
2 with the coaxing and encouragement of their
3 pharmaceutical reps were encouraged to continue to
4 escalate. The similarities are uncanny. I mean, the --
5 the strategic development, the response to physicians,
6 the way that -- the content that was being distributed
7 to the physicians based on the call logs themselves,
8 it's uncanny how the -- how similar the strategies were.
9 MS. PATTERSON: Objection. Nonresponsive.
10 Q. (By Mr. Ehsan) Doctor, is it your opinion
11 that rural, older physicians are vulnerable to being
12 misled by pharmaceutical representatives?
13 MR. CUTLER: Object to the form.
14 Mischaracterizes his testimony.
15 A. I think that those are physicians that were
16 specifically targeted. And when you look at the growth
17 of opioids both in Oklahoma as well as in Kentucky, the
18 rural regions, and interestingly, the southeast regions
19 of both states, had the same kind of influence where
20 their growth of opioid prescribing was far greater than
21 the rest of the state.
22 The areas that were more urban, more affluent
23 had less growth than -- than the rural regions, which to
24 me, it kind of confirms that the strategic -- the
25 strategic development of marketing was aligned in most

1 of these regions, that they were targeting the
2 physicians that were already overwhelmed with high
3 volume patients, were not -- not capable of looking into
4 the research in depth and took people at their word and
5 they -- they were able to influence those physicians
6 more readily than, say, for instance, an academic
7 physician in the bastion of -- of medical infrastructure
8 academia.
9 MS. PATTERSON: Objection. Nonresponsive.
10 Q. (By Mr. Ehsan) Have you been personally
11 swayed by a pharmaceutical representative to prescribe
12 something you didn't think was right for your patient?
13 MR. CUTLER: Object to the form.
14 A. I -- I have been marketed to for sure.
15 Whether I took them at their word or looked into the
16 research myself is a different matter, but -- but a lot
17 of the statements that I was reading in the call logs in
18 Oklahoma had been attempted on me as well.
19 The notion that, you know, you can -- you can
20 opioid rotate in order to avoid side effects, there's
21 never been any research on that, but that's a
22 commonality that was expressed to me as well as in the
23 call logs.
24 Q. (By Mr. Ehsan) I want to try asking my
25 question again, Doctor. Have you personally been swayed

1 by a pharmaceutical rep's discussions with you to
2 prescribe an opioid which in retrospect you believe was
3 not in your patient -- your patient's best interest?
4 MR. CUTLER: Object to the form.
5 A. You know, I don't know how you would
6 characterize that. How would you know if you would have
7 made a different decision if you hadn't heard something?
8 I think that's very speculative. It would be very, very
9 hard for me to answer that question.
10 Q. (By Mr. Ehsan) Just looking back at your own
11 practice, do you believe you prescribed opioids
12 inappropriately for any of your patients?
13 MR. CUTLER: Object to the form.
14 A. Again hard to say. What's an appropriate
15 prescription? What's an appropriate level of
16 medication? I can tell you what's not an appropriate
17 level of medication, but it's very hard for me to
18 quantify what would be an appropriate.
19 Q. (By Mr. Ehsan) Well, if you can quantify what
20 is not appropriate, have you ever prescribed for a
21 patient in such a way that in retrospect you believe it
22 is not appropriate?
23 MR. CUTLER: Object to the form.
24 A. I don't think so.
25 Q. (By Mr. Ehsan) And -- and in speaking -- just

1 of -- of the depth of that. When I moved to Kentucky
2 and I had this concern over how opioids were being
3 utilized, how pain was being addressed, I set up an
4 appointment to speak with the president of the board of
5 medical licensure. I expressed to him my concerns. I
6 said, you know, I would be happy to volunteer to help
7 address this, and there was very little interest. Not
8 because there wasn't concern, but because they had been
9 bombarded or barraged with misinformation to the point
10 where they didn't know what was right and they didn't
11 know who to trust.
12 Q. (By Mr. Ehsan) Did --
13 MS. PATTERSON: Objection. Nonresponsive.
14 Q. (By Mr. Ehsan) Did this person from the state
15 medical licensure board say, I've been bombarded with so
16 much material I don't know who to trust?
17 MR. CUTLER: Object to the form.
18 A. In specific words, no, but did they take
19 action, no. So the -- the conversation, the tenor of
20 the conversation was, well, we have patients who are
21 suffering. We have concerns that -- that we're unable
22 to address. If we were to change course, what would we
23 do now? Nobody has the proper information. Yet, a lot
24 of that was just the verbatim statements that would be
25 found in, say, for instance, the content in Responsible

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1 Opioid Prescribing by Dr. Fishman.

2 I -- I ran into one of my attendings, Larry

3 Driver, at a conference just a few months ago. He was

4 one of my attendings at MD Anderson and he was a strong

5 proponent of opioids. And we started talking about, you

6 know, the changes that have taken place in medicine, and

7 he said, you know, I do think that we -- we were

8 probably unduly influenced by pharmaceuticals and I -- I

9 agree that we probably over prescribed at a certain

10 time. It's not -- it's not coincidence. It was a

11 specific targeted endeavor to expand the scope of opioid

12 prescribing.

13 MS. PATTERSON: Objection. Nonresponsive.

14 Also move to strike the hearsay.

15 Q. (By Mr. Ehsan) Doctor, my question was

16 specifically the conversation you had with the state

17 board licensure physician, is it -- were you told that

18 he was influenced by pharmaceutical companies or is that

19 your conclusion based on the content of the

20 conversation?

21 MR. CUTLER: Object to the form.

22 A. Your question assumes a form of dialogue that

23 isn't realistic. People don't come out and say, I'm

24 overwhelmed. People don't come out and say, I'm -- I'm

25 biased because I have influence from pharmaceutical

1 companies. But the statements that were made, the
2 global impression of physicians reflected the same --
3 same kinds of concerns or the same kind of push back
4 that I saw in the call logs for Oklahoma, which was that
5 we have patients suffering. We're told that this is
6 a -- this is a treatment for it, therefore, we need to
7 put these two together and that's the solution.
8 Q. (By Mr. Ehsan) When did you first move to
9 Kentucky?
10 A. I grew up in Kentucky. I left for my college
11 and medical training and then came back in 2010.
12 Q. So as of 2010, were you, Dr. Mazloomdoost,
13 able to ascertain that there was a lack of support for
14 the use of opioids in several conditions for which
15 they're being prescribed by physicians in the community?
16 MR. CUTLER: Object to the form.
17 A. So throughout my medical training, it was a
18 concern. I always had that concern because I had the
19 privilege of -- of growing up in the epicenter of an
20 epidemic among physician parents who were trying as best
21 as they could to quell that growth.
22 And so when I went into medical school and saw
23 the way things were being addressed, the mindset within
24 health care, interacted with pharmaceutical reps who
25 were -- were saying the same things that I read in the

1 saying, I have suicide disease, that's an emergency.
2 That's something that we need to take action on now.
3 If somebody comes into the emergency room and
4 says, I have suicidal ideation, there is -- there is
5 no -- no stop at -- at go. You -- you take care of that
6 immediately. So if you're -- if you're wanting to
7 convey that patients are having this conversation or
8 having this language, then -- then the -- then we need
9 to address it immediately. It's not something that I
10 would wish a person to call a condition.
11 Q. (By Mr. Ehsan) And I'm not asking whether the
12 patient has suicidal ideations. I'm asking whether that
13 -- that's the reference to the disease. For example,
14 the disease known commonly as leprosy is -- the medical
15 terminology is Hansen's disease, correct?
16 MR. CUTLER: Object to the form.
17 A. I don't recall.
18 Q. (By Mr. Ehsan) We can move on. Doctor, I'm
19 going to hand you what's been marked as Exhibit 11.
20 (Deposition Exhibit No. 11 was marked for
21 identification and made part of the record.)
22 Q. (By Mr. Ehsan) And, Doctor, I'll represent to
23 you that this is the package insert or label for
24 Duragesic Transdermal Patches from the year 2005. And
25 if you go to the very last page of the document, you see

1 that it bears an electronic signature of Bob Rappaport,
2 who happened at the time to be the FDA, of 2/4/2005. Do
3 you see that?
4 A. Yes.
5 Q. Just want to talk you through this label. And
6 would you agree with me that one of these package
7 inserts would accompany a medication that's prescribed
8 to a patient?
9 MR. CUTLER: Object to the form. Vague.
10 A. Not sure. I -- I assume the pharmacy gives
11 that out.
12 Q. (By Mr. Ehsan) Are you aware -- are you
13 familiar with the book called the Physician Desk
14 Reference?
15 MR. CUTLER: Object to the form.
16 A. Yes.
17 Q. (By Mr. Ehsan) You're younger than I am, so
18 it may have been on its way out, but are you aware that
19 the Physician Desk Reference was a compilation of all
20 package inserts for drugs in one compendium?
21 MR. CUTLER: Object to the form.
22 A. I believe so.
23 Q. (By Mr. Ehsan) As of 2005, there were also
24 potentially electronic or digital services available
25 from which you could actually look up a package insert

1 online, correct?

2 MR. CUTLER: Object to the form.

3 A. I would assume so. I mean, frankly, in

4 medical school, we didn't get a whole lot of training on

5 medical -- medication inserts. We just assumed that was

6 a pharmacy thing.

7 Q. (By Mr. Ehsan) If you look at the -- the

8 actual package insert, do you see that the page contains

9 a box that has bolded language contained within it?

10 MR. CUTLER: Object to the form.

11 A. I see.

12 Q. (By Mr. Ehsan) Are you familiar with the box

13 warning?

14 MR. CUTLER: Object to the form. He's not

15 here to testify about package inserts, so I'm going to

16 object to this whole line of questioning as outside the

17 scope of his expert testimony.

18 Q. (By Mr. Ehsan) If you -- if you know what a

19 box warning is, doctor?

20 MR. CUTLER: Same objection.

21 A. I know what box warnings are, yes.

22 Q. (By Mr. Ehsan) And what is your understanding

23 of what a box warning is?

24 A. It's a --

25 MR. CUTLER: Object to the scope.

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1 A. Yeah, it's a reason to be concerned or have
2 some caution around something.
3 Q. (By Mr. Ehsan) In fact, a box warning -- is
4 it your understanding, Doctor, that a box warning is the
5 highest level of warning that the FDA provides in a
6 package insert for -- for prescribers?
7 MR. CUTLER: Object to the form. Object that
8 it's outside the scope of his expert testimony.
9 A. Yeah, frankly, I'm not sure.
10 Q. (By Mr. Ehsan) Do you see under the Duragesic
11 label, there's a -- there's a statement Full Prescribing
12 Information? Right under the Duragesic logo at the top.
13 A. Yes.
14 Q. And it states, Full Prescribing Information,
15 correct?
16 A. Yes.
17 Q. And you understand that this document contains
18 the full prescribing information as approved by the Food
19 and Drug Administration for this drug?
20 MR. CUTLER: Object to the form. Object --
21 object as outside the scope.
22 A. Yeah, so I'm not sure where you're going with
23 the line of questioning. My concern isn't -- isn't with
24 the -- with the package inserts or what they reflect or
25 what -- what utility they have, because frankly, as a

1 clinician, I'm aware of these. We don't -- we don't --
2 we don't go into detail of these.
3 Like I said, we assume that this is a
4 pharmaceutical -- pharmacy type of content. We
5 understand that -- that medications have
6 contraindications. We understand that they have
7 utilizations, but when we base our decisions, we're not
8 referencing these.
9 Q. (By Mr. Ehsan) Where do you get the
10 contraindications from the medication from?
11 MR. CUTLER: Object to the form.
12 A. From -- from our literature, from our
13 conferences, from our colleagues, from our training.
14 Q. (By Mr. Ehsan) Are you aware of any
15 pharmacists that can prescribe a Schedule II narcotic?
16 MR. CUTLER: Object to the form.
17 A. No.
18 Q. (By Mr. Ehsan) So this information really
19 wouldn't be of tremendous use in assessing a patient by
20 the pharmacist, correct?
21 MR. CUTLER: Object to the form. Calls for
22 speculation.
23 A. Yeah, I'm not sure what point you're making.
24 Q. (By Mr. Ehsan) I'm just curious how you
25 interpret the term Full Prescribing Information when it

1 those -- those elements are not in the forefront of
2 physicians minds.
3 It's the content that they're given and that
4 they're bombarded by from the pharmaceutical reps that
5 is in the front of their minds. So when I say that, you
6 know, I'm not familiar with this, it's not that I have
7 never seen this. It's that the concentration of times
8 I've reviewed this versus the information that I've been
9 bombarded by with the pharmaceutical rep is
10 disproportionate. The content that I've seen in CMEs or
11 the content that I've heard in national conferences is
12 disproportionate to the warnings that are here.
13 Q. (By Mr. Ehsan) Do you think that you,
14 Dr. Mazloomdoost, would then -- could someone persuade
15 you that this drug isn't -- doesn't have a risk of
16 addiction despite this box warning based on bombarding
17 you with TV commercials?
18 A. Well --
19 MR. CUTLER: Same -- same objection as to
20 vague. Calls for speculation. Outside the scope of his
21 expert testimony.
22 A. Well, let's -- let's describe how -- how
23 pharmaceutical influence material portray addiction. So
24 in -- in one of the REMS, Risk Evaluation Mitigation
25 Strategy, content that I once reviewed, it positioned

1 two groups -- two individuals; one who was portrayed as
2 a young lady who has a history of addiction with very
3 mild condition versus a gentleman, middle aged, with
4 osteoarthritis. And the question was, which is an
5 appropriate opioid administration. This was content
6 that was delineated by the pharmaceutical company.
7 So in essence, what they've done is they've
8 pitted these two extraordinarily -- extraordinary
9 streams, one of which is an egregious case of addiction,
10 the other one where I don't think anybody in a sensible
11 mind would say that this is a safe patient to prescribe
12 opioids versus someone who is moderately a poor choice
13 for opioid management.
14 So the positioning that the onus of addiction
15 is on the patient and the physician completely
16 circumvents the impact that the medications have, the
17 addictive potential that they have. It doesn't
18 characterize it to the full potential that it -- it
19 really is.
20 Q. (By Mr. Ehsan) Turn, doctor, to the next page
21 of the package. Oh, by the way, before we go there,
22 going back to that first paragraph, this information
23 here isn't just talking about fentanyl, but it discusses
24 hydromorphone, Methadone, morphine, oxycodone, and
25 oxymorphone; is that correct?

1 MR. CUTLER: Object to the form.
2 A. That's correct.
3 Q. (By Mr. Ehsan) And you would agree that all
4 these medications carry a risk of abuse; is that
5 correct?
6 MR. CUTLER: Object to the form.
7 A. All opioids carry the risk of abuse.
8 Q. (By Mr. Ehsan) Given that these are all
9 Schedule II opioids, they carry the highest risk of
10 abuse; is that correct?
11 MR. CUTLER: Object to the form.
12 A. Yes.
13 Q. (By Mr. Ehsan) If you go to the next page of
14 that box, the third full paragraph that starts
15 "Duragesic is only," do you see that?
16 A. Uh-huh.
17 Q. It states, "Duragesic is only for abuse in
18 patients who are already tolerant to opioid therapy of
19 comparable potency." Do you see that?
20 A. Yes.
21 Q. Can you read the next sentence, please?
22 A. "Use in non-opioid tolerant patients may lead
23 to fatal respiratory depression."
24 Q. Would you agree that that's a correct
25 assessment of the risk?

1 A. Yes.

2 MR. CUTLER: Object to the form.

3 Q. (By Mr. Ehsan) So, in fact, this particular

4 opioid would not be a first line therapy for any

5 patient, correct?

6 MR. CUTLER: Object to the form.

7 A. I would say the utility of this medication is

8 quite narrow and only in -- in terminal cancer

9 situations is when I've -- I've used it, and even then,

10 I'm not a big fan of it because of the pharmacodynamics

11 of the medication.

12 Q. (By Mr. Ehsan) But just the fact that before

13 you can take this medication you already have to be

14 opioid tolerant means that it wouldn't be a first line

15 opioid therapy, because how could you be opioid tolerant

16 if you've never taken an opioid before --

17 MR. CUTLER: Objection --

18 Q. (By Mr. Ehsan) -- do you understand that,

19 Doctor?

20 MR. CUTLER: Object to the form, to the extent

21 it's asking about specific instances in which Duragesic

22 have been prescribed as first line use calls for

23 speculation. Vague.

24 A. Yeah, sorry. Can you clarify your question?

25 Q. (By Mr. Ehsan) Sure. Doctor, you have the

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1 ability to prescribe Schedule II opioids, correct?
2 A. Yes, sir.
3 Q. In your medical judgment reading this
4 statement that use in non-opioid tolerant patient may be
5 -- may lead to fatal respiratory depression, that
6 suggests that you would not want to use Duragesic in
7 patients who are not opioid tolerant?
8 MR. CUTLER: Object to the form.
9 A. Agree to that.
10 Q. (By Mr. Ehsan) And for someone to be opioid
11 tolerant before they receive Duragesic necessarily
12 requires them to have been prescribed opioid at some
13 point in the past, correct?
14 MR. CUTLER: Object to the form.
15 A. That's the definition of opioid tolerant or
16 opioid naive.
17 Q. (By Mr. Ehsan) And it goes on to say that,
18 (As read) Overestimating the Duragesic dose when
19 converting patients from one -- from another opioid
20 medication can result in fatal overdose with the first
21 dose. Do you see that?
22 A. Yes, I do see that.
23 Q. Would it be a fair interpretation that you
24 have to be careful in estimating the dosage of Duragesic
25 that the patient will require when converting them from

1 a non Duragesic patch to a Duragesic patch?
2 A. Yes, sir.
3 MR. CUTLER: Object to the form. Calls for
4 speculation.
5 Q. (By Mr. Ehsan) Now, would that be something
6 the pharmacist does or is that something the prescribing
7 physician would have to do?
8 MR. CUTLER: Object to the form. Calls for
9 speculation. Outside the scope of his expert testimony.
10 A. So the physician makes the decision about
11 writing for the medication. You know, all of these
12 warnings, it's interesting to reread these, because when
13 you look at unbranded marketing, a lot of these concerns
14 are -- are marginalized that, quote, unquote if a
15 medication is taken as prescribed, you're not going to
16 get addicted, assuaging patients that the medication is
17 not as addictive as, say, for instance, this warning
18 label would -- would state. I think that's a good
19 example of how this labeling conflicts with the
20 marketing messages that were -- that were conveyed by
21 pharmaceutical companies.
22 Q. (By Mr. Ehsan) Specifically, Doctor, if you
23 could read the next paragraph?
24 A. "Duragesic is only for use in patients who
25 are -- sorry.