In The Matter Of:

Greer v.
Eli Lilly & Company

Martin H. Teicher, M.D., Ph.D.
Vol. 1, October 29, 1996

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Original File oct29tei.v1, 245 Pages
Min-U-Script® File ID: 1636983652

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
JOAN LUCILLE ROSENBLOOM GREER,)
Personal Representative of the)
Estate of Michael Rosenbloom,)
Plaintiff) Civil Action
) No. 91-1790 JGP
ELI LILLY AND COMPANY,)
Defendant)
Deposition of Martin H. Teicher, M.D., Ph.D.
Tuesday, October 29, 1996
Goodwin Procter & Hoar
Exchange Place - 26th Floor
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Boston, Massachusetts
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[1] PROCEEDINGS

[2] 10:50 a.m. [3] MARTIN H. TEICHER, M.D., PH.D., [4] having been first duly sworn on oath, [5] was examined and testified as follows:

[6] EXAMINATION

[7] BY MS. GUSSACK:

[8] Q: Doctor, I am Nina Gussack; I represent [9] Ely Lilly. I understand that you have been deposed [10] before. Correct?

[11] A: Yes.

[12] Q: How many times?

[13] A: One event in three sessions.

[14] Q: Is that the Falk case that you're [15] referring to?

[16] A: Oh, no, that was – The Falk case was, [17] I guess, sworn testimony for recording. It was [18] recorded to show at the trial, a deposition, [19] something like that; testimony.

[20] Q: What was the case in which you were [21] deposed three times?

[22] A: It was my malpractice case.

[23] Q: And that case is concluded?

[24] A: Yes.

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[1] Q: You have in your expert report identified [2] some prior testimony. One was the Falk case that [3] I just mentioned.

[4] A: Yes.

[5] Q: Where else have you –

[6] MR. GREENWALD: Can we take a look at [7] that?

[8] MS. GUSSACK: Sure.

[9] BY MS. GUSSACK:

[10] Q: I have had previously marked as Teicher 2 [11] your expert report, and I believe on page 1 under [12] the heading Prior Testimony there is a reference to [13] cases in which you have previously testified.

[14] A: Yes.

[15] Q: We have mentioned Falk. Now, the other [16] two –

[17] A: The other two are criminal cases. That [18] was State of California v. Mildred Johnson and [19] State of California v. Gail Ann Ransom.

[20] Q: Have you testified in any other case [21] either at trial or by deposition other than those [22] listed in your expert report, Teicher 2?

[23] A: No.

[24] Q: Have you reviewed the transcripts of this

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[1] testimony?

[2] A: No, I have not.

[3] Q: Was the Falk case a case in which the use [4] of Prozac was at issue?

[5] A: Prozac was involved but the issue was [6] medical malpractice regarding adequate attention to [7] a patient who was suicidal, and Prozac wasn't the [8] specific issue at all.

[9] Q: And you were an expert witness for the [10] plaintiff in that case?

[11] A: Yes.

[12] Q: Now, the other two cases, Johnson and [13] Ransom you say are criminal cases. Those were [14] murder cases. Correct?

[15] A: Yes.

[16] Q: And you were testifying on behalf of the [17] defendant in both those cases?

[18] A: Correct.

[19] Q: And the defense for which you were [20] offering supportive testimony was that Prozac had [21] induced the defendant to act in a violent way. Is [22] that right?

[23] A: Prozac had diminished their capacity and [24] their judgment, yes.

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[1] Q: Doctor, you have brought with you today [2] four boxes of documents. Can you describe [3] generally what you have brought with you, what [4] categories of documents you have brought with you?

[5] A: Right. In response to the request for [6] documents I produced, I think, pretty much [7] everything you asked for. Two boxes contain [8] abstract books for conferences that I've been to in [9] which Prozac was discussed, and that's a lot of [10] bulk but not a lot of material.

[11] Q: When you say in response to our request [12] for documents, are you referring to requests that [13] were attached to your notice of deposition?

[14] A: Yes.

[15] Q: I'm showing you what's been marked as [16] Teicher 1, which is the notice of deposition with a [17] list of documents that we have requested you to [18] bring with you today. So my understanding is that [19] a substantial portion of the documents you have [20] brought with you today fall into these categories. [21] Is that right?

[22] A: Exactly, yes.

[23] Q: Is there any particular category in this [24] request for documents that you have not brought

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[1] materials that you have?

[2] A: No.

[3] Q: Is there any category of documents that [4] is listed here for which you have no responsive [5] documents?

[6] A: Yes.

[7] Q: Can you tell me which those are?

[8] A: I think I have a list. (Pause) Yes. So [9] 22 and 23.

[10] Q: Number 22 requested any documents, [11] advertisements or communications regarding your [12] availability as a consultant or expert witness. [13] Have you ever advertised your availability as a [14] consultant or expert witness in litigation?

[15] A: No.

[16] Q: And I take it that is why you have no [17] such documents?

[18] A: Right.

[19] Q: Okay. And with respect to number 23, the [20] request was documents which reflect your [21] relationship with any expert consulting or witness [22] referral service. I take it you have no documents [23] because you do not have such a relationship?

[24] A: Exactly.

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[1] MS. GUSSACK: Let's have marked as [2] Teicher 6 the document that Dr. Teicher has [3] provided responsive to the request for production [4] appended to the notice.

[5] MR. GREENWALD: What are we calling [6] that document? "Statement of what I didn't bring"?

MS. GUSSACK: We can call it that, we can call it that.

(Teicher Deposition Exhibit 6 marked for identification.)

BY MS. GUSSACK:

Q: Doctor, have you prepared any notes or documents for today's deposition?

A: Yes, I have some notes. These are all the notes I prepared. They're mostly just handwritten notes to myself as I was reading the material.

Q: And when did you prepare these, sir? Let me change that to say: Do I understand you correctly to say that these are notes that you made as you reviewed documents or material that had been provided to you by plaintiff's counsel?

A: Yes.

Q: Has that been an ongoing process over a

period of weeks and months?

A: I'd say over maybe the last week or two.

Q: And that would coincide, wouldn't it, with the production of an extensive set of documents provided to you by plaintiff's counsel. Correct?

A: Correct.

Q: And if I can tell from the records you have produced today, Mr. Greenwald's office has provided you around October 16 with a series of documents and deposition transcripts. Correct, sir?

A: He did provide documents on or about that date. He's also provided documents before that date and after that date.

Q: Have you made any notes during the course of your role as an expert witness in this matter that you have not brought with you?

A: No.

Q: Have you made any notes during the course of your role as an expert witness in this matter which you have disposed of?

A: No.

Q: Did you have any materials in your

possession responsive to the request for production attached to Teicher 1 which you disposed of?

A: No. Well, a couple of other things that Attorney Greenwald had sent me were duplicates and I did dispose of some duplicates.

Q: What kinds of things were duplicates?

A: They were – A number of the correspondences regarding people at Lilly, they were kind of e-mails. For some reason I had four or five of those that were duplicates. There are probably even more duplicates, but I noticed those as duplicates.

Q: You're referring to internal Lilly documents and memoranda?

A: Yes, yes.

Q: Where would you have obtained the first set of documents that you had?

A: They were all from Attorney Greenwald.

Q: I see. So to the extent that you have any internal Lilly documents, memoranda or the like, you received those from Mr. Greenwald?

A: Yes.

MR. GREENWALD: Or my office.

MS. GUSSACK: Yes.

BY MS. GUSSACK:

Q: Doctor, you have brought with you a folder that is labeled Billing. Is that your handwriting on the folder?

A: Yes.

MR. GREENWALD: Can we have this marked as Teicher 7.

(Teicher Deposition Exhibit 7 marked for identification.)

BY MS. GUSSACK:

Q: Does Teicher 7 include all of your records regarding billing in the Rosenbloom matter, Doctor?

A: I believe so.

Q: Now, sir, when were you first retained by Mr. Greenwald with respect to this matter?

A: In 1991.

Q: And what were you retained at that time for?

A: To review material.

Q: What kind of material?

A: To review material relating to the death of Mr. Rosenbloom and to render an opinion.

Q: And at that time did you believe that you

were evaluating the role of Prozac in Mr. Rosenbloom's death?

A: Yes.

Q: Did you issue a report at that time?

A: Yes.

Q: And is that report one that was used in litigation in which Lilly was involved?

A: Yes.

Q: Did you also understand that you were being retained to offer an opinion with respect to obtaining insurance proceeds for life insurance?

A: I believe –

MR. GREENWALD: Objection.

BY MS. GUSSACK:

Q: Is that familiar to you?

A: Not really, no.

Q: Sir, do the billing records contained in Teicher 7 contain your time going back to 1991 when you were first retained in this matter?

A: Yes.

Q: In Teicher 7 is a bill dated April 26, 1991, for three hours' time and it refers to two hours for time spent reviewing medical records.

A: Yes.

Q: Whose medical records did you review?

A: Dr. Sandler's. And I guess in terms of that, it also included the police reports, some other information that was available about the accident, about the suicide.

Q: In 1991, sir, other than the police report and Dr. Sandler's records, what do you believe you reviewed?

A: Those are the two things.

Q: Was there any other bill at or around the time of 1991 that you are familiar with?

A: Not that I'm aware of.

Q: I want to show you two small blue sheets, and in fact perhaps we could have these marked as 7-A and 7-B. 7-A would be something labeled "Prozac time." Sir, does that say "me" in the corner?

A: Yes, and that's probably Cynthia McGreenery. This refers to Cynthia McGreenery; she wrote that.

MS. GUSSACK: Let's have that marked 7-A.

(Teicher Deposition Exhibit 7-A marked for identification.)

BY MS. GUSSACK:

Q: Sir, I have had marked as Teicher 7-A a sheet that is labeled "Prozac time" with the handwritten notation "me" in the left-hand corner reciting dates from June 5, '96, through June 20, '96, with time recordings. I understand from your testimony that this refers to time incurred by Ms. McGreenery?

A: Yes.

Q: Who is Ms. McGreenery?

A: She is my clinical research administrator.

Q: And how long has she been your clinical research administrator?

A: Oh, about two years; and she's been with me for about eight years.

Q: What was she prior to her role as administrator?

A: Secretary basically.

Q: Now, sir, does 7-A which you have a copy of before you refer to time that Ms. McGreenery spent in responding to the subpoena that was directed to you?

A: Yes.

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(Teicher Deposition Exhibit 7-B marked for identification.)

Q: Teicher 7-B is a paper that is labeled "Prozac time" and in the left-hand corner has "Marty" written in it.

A: Yes.

Q: Does this refer to time that you spent, sir, responding to the subpoena?

A: Yes.

MS. GUSSACK: May I have marked as 7-C this document labeled Greer billing at $400 per hour.

(Teicher Deposition Exhibit 7-C marked for identification.)

BY MS. GUSSACK:

Q: Dr. Teicher, 7-C is a document that is labeled "Greer billing at $400 per hour" with categories of date, time, minutes and hours. First of all, can you tell me what year does that refer to?

A: 1996.

Q: So that as recently as the past two weeks of October you have incurred this amount of time as reflected in 7-C in reviewing materials for this

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case?

A: Yes.

Q: Have you submitted a bill to Attorney Greenwald for this time?

A: No.

Q: So, Doctor, is this time that you personally incurred in reviewing material?

A: Correct.

Q: And when I use the word material, are you referring to the documents, transcripts, and other material that Attorney Greenwald or his office has provided to you?

A: Yes.

Q: Is there anything else that you have reviewed that is reflected in this billing statement other than what I just described?

A: Nothing else that I reviewed.

Q: So this time, for instance, does not reflect your going and doing a literature search or reviewing articles in the library or from your personal files?

A: Well, there are articles that were brought and so some of the time was spent reviewing articles that were in my files. I did do a couple

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of literature searches for a few minutes which are in here.

Q: And reflected in the billing statement?

A: Yes.

Q: Is there any narrative that goes along with 7-C which describes exactly what you were looking at and what you were doing during these time periods?

A: No, there is not.

MS. GUSSACK: 7-D, please.

(Teicher Deposition Exhibit 7-D marked for identification.)

BY MS. GUSSACK:

Q: I have had marked as 7-D a bill dated August 12, 1996, submitted to Mr. Pavsner which reflects five hours of time spent reviewing and preparing counterarguments to motion to compel.

A: Yes.

Q: Can you tell me exactly what you were doing that resulted in this bill identified as 7-D?

A: I reviewed the motion to compel and wrote a list of counterarguments to that motion.

Q: Now, sir, does this bill reflect time that you spent in drafting an affidavit to counter

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the motion to compel?

A: Yes.

Q: Did you draft that affidavit?

A: Yes. Or I drafted the material for it.

Q: Well, what do you mean by that?

MR. GREENWALD: Objection.

A: What I meant is that I wrote a lengthy letter to Mr. Pavsner that had all my reasons and from that, he drafted the motion.

Q: And that letter would be contained in your correspondence file with counsel that you've brought here today?

A: It should be, yes.

Q: You've given me a notebook of notes that you have taken. Is there a separate file of correspondence with counsel?

A: Yes. I had given that to you. That's right here.

MS. GUSSACK: Mr. Greenwald has it. May I have it?

MR. GREENWALD: I would like to hold off on this for a minute because I haven't finished looking through it. If you could come back to it.

Okay?

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MS. GUSSACK: Sir, I am going to have marked as Exhibit 8 a five-page document labeled Documents Reviewed.

(Teicher Deposition Exhibit 8 marked for identification.)

BY MS. GUSSACK:

Q: Doctor, did you prepare this document and, if so, when?

A: I prepared this document. I prepared this document partially last night and partially this morning.

Q: Now, sir, from the title of Exhibit No. 8, Documents Reviewed, is it fair to assume that this is a list of materials that you have reviewed prior to today's deposition?

A: Yes. Unfortunately, a partial list.

Q: What is it that didn't find its way into this list?

A: A number of documents that I didn't have time to list.

Q: I'm not asking you to do it, but can you by looking at these cartons of materials that you have brought here today identify which materials you reviewed but did not make their way into this

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list?

A: Yes.

Q: Which box would they be in?

A: A lot of those are right there (indicating).

MR. GREENWALD: By "right there," I just think the record ought to reflect that in front of Ms. Gussack are five stacks of documents. That's what you're referring to?

THE WITNESS: Yes.

MR. GREENWALD: All right.

BY MS. GUSSACK:

Q: Doctor, have you ever spoken with Dr. Sandler about this matter?

A: Yes, I have.

Q: When did you do that?

A: He called me shortly after Mr. Rosenbloom had committed suicide. I don't have the exact date but I would say it was approximately within a month of the suicide. He called me, very distressed, and asked if he could talk to me about a patient of his that had recently committed suicide.

[23] Q: And at this time you had not been [24] retained by counsel with regard to this matter?

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[1] A: Correct.

[2] Q: Tell me everything you can recall about [3] the conversation.

[4] A: He called, he asked if he could speak to [5] me. He told me he's a psychiatrist in Washington.[6] He told me that he knows Fred Goodwin well, who was [7] the head of the National Institute of Mental Health [8] at the time. He told me that he had been in [9] practice for many years, thirty, thirty-five comes [10] to mind, I'm not sure if that's exactly correct.[11] He said that he had never had in his practice a [12] patient commit suicide. He had his first patient [13] commit suicide. He felt that this was one of if [14] not the least likely patients that he was treating [15] to commit suicide. He was totally taken by [16] surprise by the case, and he asked if he could [17] describe it to me and if I might think that Prozac [18] had some involvement.

[19] He proceeded to explain that he was a [20] prominent attorney in Washington, D.C., that he had [21] in fact – I think he told me he had won the [22] largest settlement against the FCC or something [23] like that, and that he had been in treatment for [24] approximately six years, most of which was

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[1] psychotherapy for depressive neurosis, that only [2] very recently had he put him on medication; that [3] there were a number of events going on in his life [4] that had made him clinically depressed but he did [5] not think that he was at all suicidal, not at all a [6] suicidal risk, and less than a week, maybe five, [7] six days after starting Prozac he jumped off a [8] bridge. It was a horrible accident, a horrible [9] event. He fell a great distance and it was really [10] devastating. And that he was totally taken by [11] surprise. He was genuinely very upset.

[12] And that's basically what he told me.

[13] Q: And what did you say to him?

[14] A: I told him that I was sorry to hear what [15] happened and sort of offered my condolences and [16] concerns, that it's a horrible event for a [17] psychiatrist to have a patient commit suicide. And [18] I told him a little bit about what we had recently [19] reported in terms of Prozac and suicide. His [20] particular question that he had was, can it occur [21] early in the course of treatment? And I believe my [22] response to him was that the earliest that we're [23] aware of or were aware of at the time was three [24] days after starting medication. And I think I also

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[1] indicated – I believe I also indicated to him [2] that the first two weeks are a particularly [3] worrisome time in antidepressant treatment. So [4] early events can occur.

[5] Q: Why are the first two weeks particularly [6] troublesome in antidepressant treatment?

[7] A: Antidepressants take time to work. They [8] do not work immediately. There's usually a lag and [9] the lag can be two weeks, the lag can be a month [10] even in a patient who is eventually going to [11] respond to the medication. During that time the [12] antidepressant can create side effects which could [13] actually exacerbate a patient's risk for suicide.[14] They may make them anxious, restless, akathisic. [15] They may produce insomnia. They can all exacerbate [16] their symptoms of their depression during that [17] period of time, which would increase risk and [18] vulnerability.

[19] Q: Did you tell that to Dr. Sandler or did [20] you just make the general statement that the first [21] two weeks are particularly troublesome?

[22] A: To the best of my recollection, I told [23] him that the first two weeks were particularly [24] troublesome and did not get into the details.

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[1] Q: Now, sir, how is it that you have this [2] recollection of this conversation six years later?

[3] A: How do I have the memory? I guess there [4] are two factors. One is that it was actually a [5] very poignant phone call. The person who called [6] I perceived was in genuine distress and I think [7] that that made an impact on me. The second reason [8] was that later I was approached over the phone by [9] Attorney Greenwald, who asked me if I would [10] evaluate a case, and he started to describe the [11] case and I said "Wait a second, I know about this [12] case," so there was that coincidence that kept it [13] fresh.

[14] Q: When Attorney Greenwald contacted you [15] about this case had he already talked to Dr. Cole [16] as far as you know?

[17] A: I do not believe so.

[18] Q: Were you involved in any way in having [19] Dr. Cole retained as an expert in this case?

[20] MR. GREENWALD: Objection. What do [21] you mean, involved?

[22] MS. GUSSACK: Participate in any way, [23] call him; talk to him about the case. Involved.

[24] A: I believe I may have had some

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[1] involvement. I certainly believe I had discussed [2] with Attorney Greenwald the fact that I was one of [3] the authors of the article and that Dr. Cole was [4] another one of the authors on the article and that [5] Dr. Cole is a very senior and highly regarded [6] psychiatrist.

[7] Q: Now, did you call Dr. Cole and tell him [8] about the case and urge him to become involved in [9] the case?

[10] A: No, I did not.

[11] Q: Did Dr. Sandler describe to you the type [12] of patient practice that he was engaged in [13] generally?

[14] A: No, he did not.

[15] Q: Do you have any knowledge, sir, as to [16] whether Dr. Sandler treats patients that are [17] similar to the type of patients you have treated at [18] McLean?

[19] A: I really don't know the answer about the [20] practice.

[21] Q: Do you believe it to be similar to the [22] kind of patients that you see at McLean?

[23] MR. GREENWALD: Objection. He said [24] he doesn't know what kind of practice he has.

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[1] A: I really don't know.

[2] Q: Sir, have you ever provided psychotherapy [3] for patients for six years without prescribing [4] medications?

[5] MR. GREENWALD: Objection.

[6] A: Not to my knowledge.

[7] Q: What is the longest that you have ever [8] treated a patient with depression before you [9] prescribed medication, antidepressant medication?

[10] MR. GREENWALD: Objection.

[11] Q: Or medication to treat depression.

[12] MR. GREENWALD: Objection. I didn't [13] know whether you were done. You can just record [14] one objection to the end of the whole question.

[15] A: The longest I've provided psychotherapy [16] in lieu of antidepressant medication? That's a [17] difficult question. I can't directly answer that. [18] I would guess years.

[19] Q: Why is it difficult to answer?

[20] A: It's difficult to answer because I have [21] provided another form of somatic treatment.

[22] Q: And what is that?

[23] A: Light therapy.

[24] MS. GUSSACK: I would like to have

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[1] marked as Exhibit 9 a one-page handwritten [2] document.

[3] (Teicher Deposition Exhibit 9 marked [4] for identification.)

[5] BY MS. GUSSACK:

[6] Q: Exhibit 9 is a document dated August 2, [7] 1990, and it bears the numbering in the bottom [8] right-hand corner MHT00021. Is this your [9] handwriting, sir, on Exhibit 9?

[10] A: Yes.

[11] Q: Are these the notes that you made during [12] the phone call that you received from Dr. Sandler?

[13] A: Yes.

[14] Q: Would you please read them?

[15] A: It starts out "Colleague of" and it's [16] blank and this is where it was Fred Goodwin, [17] "49-year-old male, no previous history of major [18] mood disorder," MMD abbreviated. "Occasional [19] adjustment disorder. Attorney. Significant [20] professional difficulty. Break-up partnership, [21] malpractice suit, all came together. Developed [22] MMD," major mood disorder, "started Prozac, five [23] days later committed suicide. Left with real [24] concern" –

[1] Q: Let me ask you to stop there for a [2] second, sir, to ask who was left with real concern [3] that you're referring to there, if you know?

[4] A: Dr. Sandler.

[5] Q: Thank you. Please continue.

[6] A: "No adverse effect during five days. Did [7] seem to be doing better. Day before suit received, [8] malpractice." It should be "Day before received [9] malpractice suit."

[10] Q: Day before what?

[11] A: Before he committed suicide. Then it [12] goes "Jumped off bridge. He had some suicidal [13] thinking, no plan and no attempts. Really denied [14] intent. He was quite resistant to meds. Was [15] hard-driving type A attorney with compulsive [16] traits. Day started, didn't feel at all suicidal, [17] didn't want to go." I think that meant didn't want [18] to go on medication. "He had discussed adverse [19] reactions with patient. Had open relationship with [20] his wife, who was very psychologically minded."

[21] Q: Dr. Teicher –

[22] MR. GREENWALD: And the "he" in that [23] sentence meaning?

[24] THE WITNESS: Michael Rosenbloom.

[1] MS. GUSSACK: Thank you, Attorney [2] Greenwald.

[3] BY MS. GUSSACK:

[4] Q: Dr. Teicher, did Dr. Sandler tell you [5] what adverse reactions he had discussed with the [6] patient?

[7] A: Yes, he did.

[8] Q: Can you tell us?

[9] A: I am not entirely clear on all he [10] enumerated at the time. I think he enumerated [11] anxiety, sleep disturbance, nausea.

[12] Q: Is that your recollection thinking back [13] to what Dr. Sandler told you or is that something [14] you read in transcripts since this conversation?

[15] A: No, that's my recollection trying to [16] think back to the phone conversation.

[17] Q: Now, sir, at the time that you wrote your [18] opinion of April 1991, which I will put before you [19] in a little bit, did you have in mind this [20] conversation that you had had with Dr. Sandler?

[21] A: Yes.

[22] Q: So at the time that you wrote that [23] opinion you had Dr. Sandler's records, the police [24] report that you referred to previously, and your

[1] knowledge of this conversation with Dr. Sandler as [2] reflected in Exhibit 9?

[3] A: Correct.

[4] Q: Have you ever spoken with Ms. Greer?

[5] A: Yes, I have.

[6] Q: When did you do that?

[7] A: I believe I spoke with Ms. Greer shortly [8] before I wrote my initial opinion.

[9] Q: Your initial opinion meaning in April [10] 1991?

[11] A: Yes.

[12] Q: And what did you speak with her about?

[13] A: I spoke with her about her recollections [14] about Michael Rosenbloom and the changes that she [15] had observed in the last several months before the [16] suicide.

[17] Q: And what did she tell you?

[18] A: As best I recollect she told me that he [19] was depressed, that he was sad, that he was under [20] considerable stress, that he wasn't happy. I asked [21] if there were any thoughts or indications about [22] suicide or that he had wanted to kill himself, stop [23] living, and she said no. She said that he loved [24] his new adopted son, that they were just in the

[1] process of renovating a house, that they were [2] really looking forward to the future and that they [3] were thinking about the future. That the day that [4] he committed suicide she had absolutely no hint and [5] was completely taken by surprise. That from her [6] knowledge of him, he was a very responsible man [7] with a lot of obligations and would just not have [8] left her with a new baby.

[9] Q: Now, sir, at the time that you had this [10] conversation with Ms. Greer you had already [11] reviewed Dr. Sandler's records?

[12] A: I believe so.

[13] Q: So was it surprising to you, sir, that [14] Ms. Greer didn't know about her husband's suicidal [15] ideation although you knew that it had appeared in [16] Dr. Sandler's record?

[17] MR. GREENWALD: Objection.

[18] A: It was not surprising.

[19] Q: Patients don't always tell their family [20] members about their feelings of suicidality, [21] Right?

[22] A: Correct.

[23] Q: In fact, patients frequently don't tell [24] family and friends about their feelings of

[1] suicidality?

[2] A: Patients often do. What you find is some [3] patients do and some patients don't. I wouldn't [4] want to say the majority do this or the majority do [5] that. Most patients who commit suicide, from what [6] I understand, do inform people. But it also is not [7] uncommon for patients not to inform people.

[8] Q: Sir, was there anyone else in that [9] conversation, participating in the conversation [10] that you had with Ms. Greer?

[11] A: No.

[12] Q: Have you spoken with her since that time [13] that you referred to shortly before your expert [14] opinion in April '91?

[15] A: No, not to my recollection.

[16] Q: Let me go back to the conversation that [17] you had with Dr. Sandler when he asked you whether [18] you could see an effect from Prozac in such a short [19] period of time and you said that you had [20] information at that time of an event within three [21] days. Is that right?

[22] A: Yes.

[23] Q: Who were you referring to?

[24] A: One of the patients in the case report

[1] series we had published.

[2] Q: By simply referring to the patient number [3] in your article, do you know which patient you're [4] referring to?

[5] A: I would have to look through it. I have [6] a copy here. (Pause)

[7] No, I'm sorry. The cases here are [8] onset of twelve to fifteen days. The three-day [9] framework must be another case I had been provided [10] some information

about.

Q: None of the six patients reported on in your 1990 article have onset of any symptoms related to the use of fluoxetine within three days. Correct?

A: That's not true. They did not develop by our observation obsessive suicidal preoccupation. They had other symptoms.

Q: And what other symptoms?

A: (Pause) They're not described in the report.

MS. GUSSACK: Sir, when you say in the report, why don't we mark now as Exhibit 10 the 1990 article entitled Emergence Of Intense Suicidal Preoccupation During Fluoxetine Treatment.

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(Teicher Deposition Exhibit 10 marked for identification.)

BY MS. GUSSACK:

Q: So the patient to which you were referring when you spoke with Dr. Sandler about an onset within three days, were you referring to an onset of obsessive preoccupation with suicide?

A: Or some suicidal activity.

Q: Or some suicidal activity?

A: Yes.

Q: You don't know which right now?

A: No.

Q: And this patient that's not included in your report, Teicher 10, where would you have received information about this patient? Was it someone you treated?

A: No.

Q: Where did you get the information?

A: From a colleague.

Q: A colleague at McLean?

A: No, I don't think so.

Q: Who was the colleague?

A: To the best of my recollection, the colleague was Tom Wehr at NIMH.

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Q: Dr. Teicher, do patients who are depressed and prescribed medication always take their medication?

A: No.

Q: What is the incidence or percentage of patients who are noncompliant in taking antidepressant medication? Do you know?

A: Completely or partially?

Q: Let's start with completely.

A: I don't know.

Q: Partially?

A: 30 percent.

Q: As you said, Doctor, Mr. Rosenbloom was very resistant to taking medications. Correct?

A: Yes.

Q: What do you understand was his reason for being resistant to taking medication?

A: It would be a sign of weakness.

Q: Now, sir, you would agree, wouldn't you, that many patients have a tremendous reluctance to talk about their suicidality?

A: Correct.

MR. GREENWALD: Objection.

BY MS. GUSSACK:

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Q: And some patients may feel very guilty, very ashamed that they have suicidal feelings?

A: Yes.

Q: And that would cause them not to share that with their family or friends?

A: Yes.

Q: Have you ever published on the patient that Dr. Wehr from NIMH reported to you?

A: No, I haven't.

Q: So classifying this kind of piece of information as, what, an unpublished case report? That's the bucket we would put that in?

A: Yes.

Q: Did Dr. Wehr send you any records on this patient who had experienced some symptoms after three days?

A: No.

Q: And you don't know what symptoms they experienced after three days?

A: This was a person who developed an intense desire to cut themself and felt suicidal.

Q: Do you know anything else about the patient?

A: He actually had treated this patient over

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a long period of time and this was a patient who in his experience developed the suicidal response to Prozac both initially and on subsequent rechallenge. And that's the case he described to me.

Q: He described this to you over the phone?

A: Described it to me in person.

Q: Do you know anything about whether the patient had any other conditions for which he was being treated?

MR. GREENWALD: Objection.

A: I don't know what other – I know depression was the major condition.

Q: What about personality disorders?

A: Not as far as I am aware.

Q: Any neurologic abnormalities?

A: Not as far as I know.

Q: Other medications he was taking?

A: Prozac was the main – was the medication.

Q: Was there any other medication?

A: Not that I am aware of. Not as I recollect.

Q: Any history of suicidality in that

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patient?

A: No.

Q: And this is all information that you received from Dr. Wehr?

A: Yes.

Q: How do you spell Wehr?

A: W-e-h-r.

Q: Sir, have you spoken with Dr. Alan Brown with regard to this case?

A: No, I have not.

Q: What about Dr. Eth?

A: Yes.

Q: When did you do that?

A: I spoke with Dr. Eth on two occasions. One was – I'm rusty on dates – I believe in May of 1996 and it was in conjunction with a meeting that I was attending, I believe at the American Psychiatric Association, and I met for lunch with Dr. Eth and Attorney Greenwald and we discussed the case as a whole.

Q: What do you mean by that?

A: I don't think we spent very much time discussing Mr. Rosenbloom. I think we discussed more the voluminous amounts of material that we had

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to review.

Q: Did you discuss your impressions upon your review of any of that material?

A: We talked about the BGA data and how we were all surprised by the BGA data.

Q: When you say BGA data, what are you referring to?

A: The information that is in these records that indicates that the BGA, the German equivalent of the Food and Drug Administration, had initially disapproved Prozac and had, among other things, pointed out a lack of

efficacy and high incidence [13] of suicide attempts during the trial period.

[14] Q: What else did you discuss with Dr. Eth in [15] your May meeting?

[16] MR. GREENWALD: Objection. Main [17] meeting?

[18] MS. GUSSACK: May meeting.

[19] MR. GREENWALD: Oh, May meeting. I m [20] sorry.

[21] A: The other thing I discussed with Dr. Eth [22] was the fact that I had received a call from the [23] chairman of my department, Dr. Joseph Coyle, [24] shortly before that meeting and Dr. Coyle had asked

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[1] me to come to his office at the earliest point in [2] time that I could to meet with him. And Dr. Coyle [3] brought me into his office and had one of his [4] colleagues from down the hall join us in his [5] office. He said –

[6] Q: Who was that?

[7] A: I don't recall his name. Hadn't met him [8] before. He said that he wanted to have this [9] meeting witnessed so there'd be no confusion as to [10] what was being discussed.

[11] He told me that he had heard that [12] I had agreed to serve as an expert in one of the [13] Prozac litigation cases and that he wanted to [14] express his concern. He said that psychiatrists [15] who were on faculty of Harvard Medical School and [16] who are on faculty of McLean Hospital are prominent [17] individuals who are likely to be called as expert [18] witnesses; and for the reputation of the department [19] and the hospital, he wants to make sure that people [20] who are testifying are testifying based on science [21] as opposed to anecdote or conjecture; and that from [22] his understanding of the literature he could [23] certainly understand why I published the original [24] series of case reports but it was his impression,

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[1] not being an expert in this particular area, that [2] the scientific evidence that had arisen since was [3] not supportive of the hypothesis that Prozac [4] induced suicidal ideation.

[5] At that point I discussed with him [6] the published material on Prozac, referring to [7] Dr. Fischer's studies, referring to my 1993 drug [8] safety paper, referring to the Fava and Rosenbaum [9] work. And he then concluded that, okay, there was [10] substantial scientific basis for your opinion and [11] that it was okay to testify. And when I discussed [12] it with Dr. Eth he indicated that he too had [13] received a call from I believe the chairman of his [14] department at UCLA.

[15] Q: Who is the chairman there?

[16] A: I don't know.

[17] Q: And what had Dr. Eth been told?

[18] A: I think it was a – I don't recall what [19] he said.

[20] Q: What did you think the significance was [21] of being called by Dr. Coyle?

[22] A: I found it –

[23] MR. GREENWALD: Objection.

[24] A: I found it to be very curious. I would

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[1] be very surprised if Dr. Coyle had called anybody [2] else in who's ever done forensic testimony even in [3] cases such as allegations of child sexual abuse, [4] repressed memories, steroids and psychosis, any of [5] the other things that a number of people at McLean [6] provide expert testimony in. I suspect that this [7] is probably one of the only times, if ever, that [8] he's done this before, and wondered where he had [9] gained the information and why he was pursuing it.

[10] Q: And did you ask him?

[11] A: No.

[12] Q: Did Dr. Coyle write you about the subject [13] matter of your conversation with him?

[14] A: No, he did not.

[15] Q: What is Dr. Coyle an expert in?

[16] A: Dr. Coyle is one of the world's foremost [17] authorities on brain neurotransmitter systems, [18] particularly excitatory amino acids, development of [19] the brain in general. He's a very prominent [20] neuroscientist who had been president at the [21] Society for Neuroscientists. He has also done some [22] research in child psychiatry.

[23] Q: Are you a member of the American Society [24] of Neuroscientists?

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[1] A: Society for Neuroscientists.

[2] Q: You are a member of that society?

[3] A: Yes.

[4] Q: Did Dr. Coyle tell you that it was his [5] opinion that there was no basis in science to [6] support the views that you were expressing in this [7] case?

[8] MR. GREENWALD: Objection.

[9] A: Dr. Coyle had said that he had heard; he [10] had not reviewed the material. And I had the [11] distinct impression that the person who had called [12] him to tell him that I was testifying had told him [13] that there was no scientific basis. When I started [14] explaining the scientific basis he pretty quickly [15] called the conversation off and said that it was [16] fine for me to continue.

[17] Q: And who is it that you believe called [18] Dr. Coyle?

[19] A: I don't know.

[20] Q: Now, sir, Dr. Coyle is the chairman [21] of the psychiatric department at Harvard?

[22] A: Yes.

[23] Q: And you are on the faculty there?

[24] A: Yes.

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[1] Q: You teach at Harvard?

[2] A: Yes.

[3] Q: What do you teach?

[4] A: I teach a lot of different things. My [5] main responsibility for teaching is to mentor [6] postdoctoral fellows and I presently have three [7] postdoctoral fellows in my laboratory. Harvard [8] postdoctoral fellows. I also supervise and teach [9] residents, PGY 2 and PGY 3 residents, and I provide [10] generally one lecture per quarter for the Harvard [11] medical students.

[12] Q: The postdoctoral fellows in your lab are [13] research scientist fellows?

[14] A: Yes.

[15] Q: And your supervision of residents is in [16] psychiatry?

[17] A: Yes.

[18] Q: Any particular area?

[19] A: Psychopharmacology.

[20] Q: What are your lectures on a quarterly [21] basis about?

[22] A: I lecture to the medical students on [23] anxiety disorders. I also lecture the residents on [24] borderline personality disorder, dissociative

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[1] disorders, effects of childhood abuse. Have been [2] lecturing to the residents on attention deficit [3] hyperactivity disorder and childhood depression.

[4] Q: You said that in your conversation with [5] Dr. Coyle you mentioned Dr. Fava and Rosenbaum's [6] work?

[7] A: Yes.

[8] Q: Dr. Rosenbaum is a colleague of yours at [9] Harvard?

[10] A: Yes.

[11] Q: A well-respected psychopharmacologist?

[12] A: Yes.

[13] Q: An excellent clinician?

[14] A: Yes.

[15] MR. GREENWALD: I object.

[16] BY MS. GUSSACK:

[17] Q: And you were referring to their published [18] paper on fluoxetine compared to tricyclics?

[19] A: Yes.

[20] Q: And what were you referring to

from[21] Dr. Fischer?

[22] A: His postmarketing surveillance data.

[23] Q: You also said you mentioned your 1993 [24] drug safety article. Correct?

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[1] A: Yes.

[2] Q: Did you mention any other science to [3] Dr. Coyle?

[4] A: I think that was it.

[5] Q: Now, you said you spoke with Dr. Eth on [6] two occasions and you have described one was in May [7] of this year.

[8] A: Correct.

[9] Q: When was the other?

[10] A: There was also a meeting of the New York [11] Academy of Science, they had a special conference [12] on post-traumatic stress disorder that was in [13] September of 1996. Dr. Eth and I were both in [14] attendance and we spent maybe two to five minutes [15] in the hallway at one of the breaks saying hi.

[16] Q: Have you told me now everything you can [17] recall about the conversation you had with Dr. Eth [18] in May of 1996 about this case, I think you said [19] overall was how you described it?

[20] A: Yes.

[21] Q: You've now told me everything you can [22] recall?

[23] A: That I can recall, yes.

[24] Q: Did you discuss with Dr. Eth the other

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[1] experts who had been identified by Attorney [2] Greenwald in this matter?

[3] A: I don't think we discussed all of the [4] experts. I think one of them was mentioned.

[5] Q: Who was that?

[6] A: Charlie Nemeroff.

[7] Q: And what did you discuss about Charlie [8] Nemeroff?

[9] A: That we both know him.

[10] Q: And what about him?

[11] A: He is prominent, well-respected.

[12] Q: You are a member of the American College [13] of Neuropsychopharmacologists. Correct?

[14] A: No, I am not.

[15] Q: Oh, you're not. Do you have any [16] affiliation with the organization?

[17] A: Well, I usually attend their meetings and [18] I won one of their awards.

[19] Q: Is there a reason you're not a member?

[20] A: I've never applied for membership.

[21] Q: I see. Is that where you know [22] Dr. Nemeroff from?

[23] A: I've met Dr. Nemeroff a couple of times.[24] I met him once at that meeting. I've met him at

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[1] Society for New Science meetings. I've been on [2] grant committees that have reviewed his work.

[3] Q: And a prominent psychopharmacologist?

[4] A: Yes.

[5] Q: Well-regarded in the field?

[6] A: Yes.

[7] Q: Have you ever spoken with Dr. Lord, sir?

[8] A: No.

[9] Q: Have you spoken with Dr. Cole about this [10] case since the initial discussion you had with him [11] after you had been contacted by Attorney Greenwald?

[12] A: I did not have a discussion with him [13] after I was contacted by Mr. Greenwald.

[14] Q: I don't mean to mischaracterize your [15] testimony, sir. I thought you told me you spoke [16] with Dr. Cole and spoke with him about the case.

[17] A: No, no.

[18] MR. GREENWALD: Objection. You asked [19] him whether or not he had, after he'd spoken with [20] me, talked with Dr. Cole and he said he had not [21] talked with Dr. Cole.

[22] BY MS. GUSSACK:

[23] Q: I think I misunderstood you. You told me [24] you spoke with Attorney Greenwald about Dr. Cole?

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[1] A: Correct.

[2] MR. GREENWALD: That's exactly what [3] he said.

[4] MS. GUSSACK: Thank you. Appreciate [5] the clarification.

[6] BY MS. GUSSACK:

[7] Q: Have you ever spoken with Dr. Cole about [8] this case?

[9] A: Yes.

[10] Q: And when was that?

[11] A: There was a meeting that took place in my [12] office with Dr. Cole, myself and Attorney Steve [13] Pavsner and during that period of time we met [14] together to put together our statement.

[15] Q: Expert report?

[16] A: Expert report.

[17] Q: And did you actually draft the report [18] while Dr. Cole and Attorney Pavsner were in your [19] office?

[20] A: Dr. Cole and I dictated it to Attorney [21] Pavsner, who had a laptop on his lap and typed [22] away.

[23] Q: I see. And were you planning on [24] preparing a joint report?

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[1] A: Yes.

[2] Q: Who did most of the dictating to Attorney [3] Pavsner?

[4] A: I believe it was a mutual effort.

[5] Q: What was the process by which you [6] generated the report? Attorney Pavsner typed it [7] into his laptop computer and then what happened?

[8] A: Then he sent us copies and we reviewed [9] them individually.

[10] Q: Did you make changes in the copy he sent [11] you?

[12] A: Some minor changes, yes.

[13] Q: Editorial changes?

[14] A: Editorial? Meaning?

[15] Q: Grammatical; stylistic. What kind of [16] changes?

[17] A: They were mostly rephrasing some [18] sentences to be more scientifically accurate.

[19] Q: So, sir, do you have the original draft [20] that Attorney Pavsner sent you in the folder that [21] you brought with you today?

[22] A: Probably.

[23] Q: And do you have a copy of the notes that [24] you made on the draft?

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[1] A: It's likely that they're here.

[2] Q: Then you sent your copy with the notes on [3] it back to Attorney Pavsner?

[4] A: I'm trying to remember if I did that or [5] if – I know he had also sent a disk and we may [6] have made the changes directly on it and sent him [7] back the final version.

[8] Q: So he sent you a computer disk with what [9] he had typed when he met with you?

[10] A: Yes.

[11] Q: And you believe you made changes directly [12] on the disk?

[13] A: Right, printed them out, yes.

[14] Q: So you believe you have both the original [15] hardcopy version of the report and your revisions [16] to it?

[17] A: Yes.

[18] Q: And that would be in the folder that [19] you've brought with you today?

[20] A: Yes.

[21] Q: What was the process, if you know, that [22] Dr. Cole followed with respect to his report?

[23] A: I don't know.

[24] Q: Now, sir, do you assume that your

report

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[1] is identical to Dr. Cole's?

[2] A: No.

[3] Q: In what way is it different?

[4] A: I just don't assume. I haven't read [5] Dr. Cole's.

[6] (A woman entered the room.)

[7] Q: Did you discuss with Dr. Cole any [8] revisions that you were making to your report?

[9] A: No. I haven't discussed it with Dr. Cole [10] at all.

[11] Q: So the last time that you and Dr. Cole –

[12] MR. GREENWALD: I'm sorry. Could you [13] tell us who this person is?

[14] MS. GUSSACK: As soon as I finish my [15] question, yes.

[16] BY MS. GUSSACK:

[17] Q: So the last time that you spoke with [18] Dr. Cole about your report was in the course of [19] preparing the report with Attorney Pavsner in your [20] office?

[21] A: Yes.

[22] MR. GREENWALD: Off the record.

[23] (Discussion off the record.)

[24] BY MS. GUSSACK:

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[1] Q: Dr. Teicher, I have had marked as Exhibit [2] 3 a C.V. dated July '95. Do you have a C.V. that [3] is more current than that?

[4] A: Yes, I do.

[5] Q: Do you have it with you?

[6] A: Yes, I do.

[7] MS. GUSSACK: Let's have marked as [8] Exhibit 11 the October '96 C.V. of Dr. Teicher.

[9] (Teicher Deposition Exhibit 11 marked [10] for identification.)

[11] BY MS. GUSSACK:

[12] Q: Dr. Teicher, are there any additions on [13] this C.V. that relate to Prozac from the C.V. that [14] I have had marked as Teicher 2?

[15] MS. GUSSACK: This is an extra copy [16] of it. Why don't you use that to testify from and [17] then when we're done, we can make other copies of [18] it.

[19] MS. GUSSACK: I'm sorry. Teicher 3. [20] I misspoke.

[21] MR. GREENWALD: Wait a second now. [22] You're asking him differences between 3 and 11?

[23] MS. GUSSACK: Yes.

[24] MR. GREENWALD: Okay.

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[1] A: I would guess that one significant [2] difference was that reference 74 of the original [3] papers in the '95 which was in press has come out [4] and it's now listed as reference 73.

[5] Q: What is the title, sir?

[6] A: It is Development Of An Animal Model Of [7] Fluoxetine-Induced Akathisia.

[8] It appears that specifically [9] regarding Prozac that's the only difference.

[10] Q: What about any additions on your current [11] C.V. with respect to SSRIs generally?

[12] A: That would be it too.

[13] Q: Excuse me?

[14] A: No other additions with regard to SSRIs.

[15] Q: What about any additions with respect to [16] the treatment of depression?

[17] A: Yes, there are.

[18] In the 1995 C.V., reference 72 had [19] Cortisol Regulation In Post-Traumatic Stress [20] Disorder: A Chronobiological Analysis. When that [21] was revised and accepted in Biological Psychiatry, [22] it came out in Biological Psychiatry and also [23] included major depression, so the title is now [24] Cortisol Regulation In Post-Traumatic Stress

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[1] Disorder And Major Depression: A Chronobiological [2] Analysis.

[3] The article Motor Activity And [4] Severity Of Depression In Hospitalized Prepubertal [5] Children has appeared. The reference 78 that was

[6] A: J. Allen, A Controlled Trial Of Light Therapy [7] For The Treatment Of Pediatric Seasonal Affective [8] Disorder, is now in press in the Journal of The [9] American Academy of Child and Adolescent [10] Psychiatry.

[11] The article that was 84 in the 1995 [12] C.V. on Circadian Rest-Activity Rhythms In Seasonal [13] Affective Disorder, which was submitted to the [14] Archives of General Psychiatry, is now in press in [15] the Archives of General Psychiatry as reference 80.

[16] Unlisted in 1995 was an article on [17] Circadian Rest-Activity Disturbances In Children [18] With Seasonal Affective Disorder, which is now in [19] press in the Journal of The American Academy of [20] Child and Adolescent Psychiatry.

[21] Q: Doctor, is that a particular area of [22] interest that you have?

[23] A: Seasonal depression?

[24] Q: Yes.

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[1] A: Yes.

[2] Q: And child psychiatry as well?

[3] A: Yes.

[4] Q: Are you board-certified in child [5] psychiatry?

[6] A: Adolescent, not child.

[7] Q: Adolescent psychiatry?

[8] A: Yes.

[9] Q: And circadian rhythms, that is another [10] area of interest?

[11] A: Yes.

[12] Q: And in basic research in looking at those [13] issues? Is that what you spend time doing?

[14] A: Well, research in that area is clinical [15] research.

[16] Q: Do you do any basic research in that [17] area?

[18] A: Yes, I do. I do basic research but that [19] research is clinical research.

[20] Q: What are your areas of basic research?

[21] A: Basic research areas are in receptor [22] development, generally monoamine receptors, [23] particularly dopamine.

[24] Q: Anything else?

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[1] A: We look at dopamine receptors and we also [2] look at serotonin receptors and seratonin [3] transmission receptors.

[4] Q: And who is "we"?

[5] A: My lab group. I am the head of the [6] laboratory; Dr. Andersen is an instructor in the [7] laboratory also.

[8] Q: My question really about your C.V. was is [9] there anything new, not now whether it has been now [10] formally published or submitted in manuscript or [11] the like, but is there anything new in your most [12] current C.V. related to the treatment of [13] depression?

[14] A: We submitted a work on Hemispheric EEG [15] Asymmetries In Seasonal Depression Before And After [16] Light Therapy and also presented that data and our [17] functional MRI data on seasonal depression, which [18] hadn't been previously...

[19] Q: What percentage of your time do you spend [20] in the research?

[21] A: 40 percent.

[22] Q: What percentage [illegible] would you [23] say accounts for the teaching responsibilities that you have previously described?

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[1] A: That's tied in with the laboratory time.

[2] Q: That is part of the 40 percent?

[3] A: What I enumerated before in terms of [4] teaching is because a lot of my teaching is [5] mentoring postdoctoral

fellows and the postdoctoral [6] fellows are involved in the research so the [7] mentoring centers on the research. So they're part [8] and parcel of that same 40 percent.

[9] Q: What do you spend the other 60 percent of [10] your time doing?

[11] A: Forty percent is basic research which is [12] in a basic laboratory looking at brain development [13] and these receptor systems. I guess another [14] 40 percent of my time is clinical research and the [15] main focus is on locomotor activity, circadian [16] rhythms, seasonal depression, attention deficit [17] disorder, and childhood abuse.

[18] Q: Do you maintain a private clinical [19] practice?

[20] A: Yes, I do.

[21] Q: How many patients are currently being [22] seen in your private practice?

[23] A: My average billing for a month would [24] involve forty patients.

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[1] Q: Now, are those patients that you see [2] through the McLean clinic?

[3] A: No, they are private practice.

[4] Q: So they come to see you?

[5] A: Yes.

[6] Q: They are ongoing patients of yours?

[7] A: Yes.

[8] Q: And of those forty patients how many of [9] them suffer from major depression?

[10] A: Probably thirty.

[11] Q: Are any of them taking Prozac, sir?

[12] A: Yes.

[13] Q: How many?

[14] A: Two or three.

[15] Q: You have prescribed Prozac to your [16] patient population since it first became available, [17] haven't you?

[18] A: Yes.

[19] Q: You have prescribed it for yourself?

[20] MR. GREENWALD: Objection.

[21] A: I took it on one or two occasions.

[22] Q: Do you mean one or two days?

[23] A: Yes.

[24] Q: And then stopped it?

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[1] A: Yes.

[2] Q: Because why?

[3] A: Developed arthralgia.

[4] Q: What indications do you use Prozac for, [5] sir?

[6] A: What indications?

[7] Q: Yes.

[8] A: Depression, panic disorder.

[9] Q: Anything else?

[10] A: OCD. That's about it.

[11] Q: And have you used it continuously since [12] it was first available to you?

[13] A: Used it or prescribed it?

[14] Q: Prescribed it.

[15] A: Yes.

[16] Q: Are there certain patients, sir, for whom [17] you do not prescribe Prozac?

[18] A: The way that I treat patients is I follow [19] a procedure of informed consent in which I discuss [20] with the patient their diagnosis and their [21] prognosis and their recommendations for treatment, [22] and I enumerate the options so that in discussing a [23] patient's options I would include, where it's [24] indicated, you know Prozac is one of the options.

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[1] I would also indicate many of the [2] other antidepressants or other modes of therapy and [3] talk therapy, all of the approved, recommended, [4] appropriate modes of treatment. And I would [5] discuss with the patient the pros and cons, risks [6] and benefits of the different treatments and work [7] with the patient to reach a decision. And largely [8] the choice of the drug reflects the patient's wish.

[9] Q: Sir, of the forty patients that you are [10] presently seeing in your private practice, how many [11] of them are you administering talk therapy to?

[12] A: All of them get some.

[13] Q: What's "some"?

[14] A: Whenever I see them for a session, part [15] of the session is talk therapy.

[16] Q: How much of the session, what percentage [17] of the time that you spend with them?

[18] A: That depends on the patient.

[19] Q: What does it range from?

[20] A: It ranges from twenty minutes to an hour.

[21] Q: And of these forty patients how many are [22] you seeing on a regular basis to monitor their [23] medications and make adjustments in their [24] medication treatment?

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[1] A: I would say that the vast majority are on [2] medication and that's part of their treatment. For [3] some it is a major part. For some it is a minor [4] part.

[5] Q: Which percentage is it a major part for [6] of the forty we're talking about?

[7] A: Probably about a third.

[8] Q: You are licensed to practice medicine in [9] Massachusetts?

[10] A: Yes.

[11] Q: Anywhere else?

[12] A: No.

[13] Q: Has your license ever been suspended?

[14] A: No.

[15] Q: Have your privileges ever been [16] restricted?

[17] A: No.

[18] Q: You are not trained as a neurologist?

[19] A: No. I am not.

[20] Q: You are not an expert in epidemiology, [21] are you?

[22] MR. GREENWALD: Objection. What do [23] you mean by expert?

[24] MS. GUSSACK: What I asked.

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[1] BY MS. GUSSACK:

[2] Q: Are you an expert in epidemiology?

[3] MR. GREENWALD: Same objection.

[4] A: I would say no, I am not.

[5] Q: And are you an expert in suicidology?

[6] A: Expert in suicide, yes.

[7] Q: In the study of suicide?

[8] A: Yes.

[9] Q: You recognize the field of suicidology?

[10] A: Yes.

[11] Q: Who would you say were leaders in that [12] field?

[13] A: Jan Fawcett.

[14] Q: Anyone else, sir?

[15] A: Cynthia Pfeffer.

[16] Q: And you believe that you are one of their [17] peers in the study of suicide?

[18] A: Yes.

[19] MR. GREENWALD: Objection.

[20] BY MS. GUSSACK:

[21] Q: Are you a member of the American [22] Association of Suicidology?

[23] A: No.

[24] Q: Do you have any training in

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[1] biostatistics?

[2] A: Yes.

[3] Q: What is it?

[4] A: In the course of my Ph.D. I have [5] extensive training in statistics.

[6] Q: Now, sir, in your 1990 article that has [7] been marked as Exhibit 10 you have an incidence [8] rate that you have defined. Correct?

[9] A: Yes.

[10] Q: And do you have a confidence

interval [11] identified in there?

[12] A: Yes.

[13] Q: Did any statistician assist you in [14] arriving at that incidence rate?

[15] A: No.

[16] Q: Or confidence interval?

[17] A: No.

[18] Q: Did you do any statistical analysis to [19] derive that incidence rate?

[20] A: Yes, I did.

[21] Q: Has that statistical analysis been [22] produced to us in the course of the response to the [23] subpoena?

[24] A: Yes, it has.

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[1] Q: Can you, sir, referring to the folder you [2] brought with you, identify the initial draft report [3] that you prepared by dictating to Attorney Pavsner [4] and the document evidencing your changes to it?

[5] MR. GREENWALD: I am going to object, [6] not to him doing that, but only because I thought [7] he said that he was sent a disk and he had the disk [8] typed out at his office.

[9] MS. GUSSACK: I believe the testimony [10] was that he dictated with Dr. Cole his expert [11] report to Attorney Pavsner, who sat there with his [12] laptop. That he subsequently received from [13] Attorney Pavsner a disk which he believed contained [14] a draft, printed it out in hard copy, made [15] additions and revisions to the draft report on his [16] computer but also maintained a hard copy of those [17] revisions.

[18] MR. GREENWALD: I don't remember, but [19] I'm not sure he testified that he printed it out [20] and made copies. I don't know whether he said that [21] or he made changes on the computer. I don't know. [22] He would obviously know the answer to that.

[23] THE WITNESS: Yes, here it is.

[24] (Pause)

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[1] MR. GREENWALD: As I understand the [2] question, she wants to know the report that was [3] submitted to Ely Lilly that was part of your what's [4] called 26(a) statement that was dictated to [5] Attorney Pavsner. That's what the question is.

[6] THE WITNESS: Okay.

[7] MR. GREENWALD: She's asking whether [8] or not you have a draft of this report that you [9] made changes on. Isn't that what you're asking [10] him?

[11] MS. GUSSACK: I believe that was it.

[12] MR. GREENWALD: That's the question. [13] This is not – This is your affidavit. This is [14] not what she's asking you for.

[15] BY MS. GUSSACK:

[16] Q: Dr. Teicher, just to clarify, you [17] understood earlier, didn't you, when I asked you [18] about the process by which your expert report was [19] prepared and you described sitting in your office [20] with Dr. Cole and dictating to Attorney Pavsner, [21] who had his laptop out and was typing what you [22] said, that we were referring to the expert report [23] at that time. Correct?

[24] A: I'm clearer on that now.

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[1] Q: Well, is that in fact what happened? You [2] were talking about the expert report.

[3] A: Will you give me a couple of minutes to [4] try to figure this out?

[5] Q: Yes. But let me just distinguish your [6] other testimony. You also testified that you [7] prepared a letter which you sent to Attorney [8] Pavsner from which he generated your affidavit. So [9] to me we're talking about two totally different [10] pieces of paper.

[11] A: Yes.

[12] Q: One, you have described a process where [13] you wrote a letter to Attorney Pavsner and he [14] turned it into an affidavit. The other, we're [15] talking about a meeting you had in which you [16] dictated a report to Mr. Pavsner.

[17] A: Right. And I need to make sure that [18] affidavits and reports are going in the right [19] direction.

[20] Q: Take your time.

[21] MR. GREENWALD: What she's asking for [22] is a draft of this report, if there is one, where [23] you dictated with Dr. Cole in the presence of [24] Attorney Pavsner.

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[1] (Discussion off the record.)

[2] A: I wonder if I can clarify this. I was [3] confused about the report and the affidavit. The [4] affidavit was the one that I was sent a disk and a [5] hard copy and made changes. The report was the one [6] that was dictated in the office with Mr. Pavsner [7] taking notes on the laptop. What happened with [8] that in terms of revision was he read it to me over [9] the phone and I made changes over the phone and [10] then he sent the final report. I don't have a [11] draft of that one.

[12] Q: He didn't give you a draft from his [13] laptop before he left your office?

[14] A: No.

[15] Q: Well, sir, which document was it that you [16] sent Mr. Pavsner a letter about from which he [17] generated a document?

[18] A: The letter that I sent him was for the [19] response to the motion to compel.

[20] Q: Can you pull from your file now those [21] documents? I would like to see the document that [22] you sent Mr. Pavsner from which he prepared the [23] response to the motion to compel, any documents [24] relating to your affidavit and any documents

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[1] relating to your expert report. Then we can [2] identify them accordingly.

[3] MR. GREENWALD: Can we hold this till [4] after lunch so I can have a chance to look through [5] this? It's already 12:20. We'll just keep [6] everything in the file and we can –

[7] MS. GUSSACK: Sure. We can come [8] back to that then right after lunch.

[9] BY MS. GUSSACK:

[10] Q: Doctor, in order to talk about your 1990 [11] article with you, I feel like I need you to clarify [12] some terms with me because I suspect that I'm not [13] understanding them as you might have meant them.

[14] A: Okay.

[15] Q: In your article, Exhibit 10, sir, you use [16] the term, I believe, de novo suicidal thoughts.

[17] A: Yes.

[18] Q: Can you tell me what you mean by that?

[19] A: It means new.

[20] Q: And when you say it means new, do you [21] mean to convey that a patient who has de novo [22] suicidal thoughts had no suicidal thoughts [23] previously?

[24] A: No.

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[1] Q: What do you mean?

[2] A: I mean that at the time, say at the start [3] of observation, there were no suicidal thoughts; [4] then at a subsequent point in time suicidal [5] thoughts emerged would be de novo suicidal thoughts [6] even if months, years, decades earlier the patient [7] had had suicidal thoughts. So they're not the [8] first in their lifetime but they are the first in [9] this time period.

[10] Q: Now, Doctor, you would agree with me that [11] depression as a disease waxes and wanes. Correct?

[12] A: Correct.

[13] Q: So you can have a patient who had [14] suicidal thoughts whose depression improves and in [15] the course of their disease their depression may [16] worsen and their suicidal thinking may return. [17] Correct?

[18] A: Yes.

[19] Q: And you would agree that suicidal

[20] thinking is a symptom of depression?

[21] A: Among other things, but yes.

[22] Q: It is a diagnostic criteria for [23] depression, isn't it?

[24] A: Part of the diagnostic criteria.

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[1] Q: What percentage of depressed patients [2] have suicidal thinking?

[3] A: 40 percent or so.

[4] Q: Not as many as 80 percent?

[5] A: Well, that depends on whether you look at [6] the whole picture or whether you look at a slice in [7] time. So the point incidence of suicidal ideation [8] may be 40 percent. The morbid risk of suicidal [9] ideation would be closer to 80 percent.

[10] Q: And what point in time are you looking at [11] when you take a slice and say it is 40 percent?

[12] A: If at any moment you surveyed somebody [13] who was in the middle of a major depression, you [14] would find that about 40 percent of them had [15] suicidal thinking.

[16] Q: And over the lifetime of their depressive [17] disease, as many as 80 percent experience suicidal [18] ideation?

[19] A: Right.

[20] Q: And somewhere between 40 and 60 percent [21] over the lifetime of a depressed person's disease [22] may attempt suicide?

[23] A: That seems a bit high.

[24] Q: Do you have any data that contradicts

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[1] that?

[2] A: It's much higher than my clinical [3] experience.

[4] Q: And you treat very seriously ill patients [5] at McLean, don't you?

[6] A: Yes.

[7] Q: And seriously ill patients meaning [8] psychiatrically seriously ill patients. Correct?

[9] A: Yes.

[10] Q: And those are the highest risk for [11] suicide, aren't they?

[12] A: Yes.

[13] Q: What is chronically suicidal?

[14] A: It refers to a state of real persistent [15] feelings and thoughts about suicide.

[16] Q: When you say real persistent do you mean [17] day to day to day they're feeling suicidal?

[18] A: Yes.

[19] Q: So that they are more often suicidal than [20] not?

A: Right.

[22] Q: What is mild suicidal ideation?

[23] A: Passive thoughts of suicide with no [24] intent or no desire. Basically fleeting thoughts.

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[1] Q: Can you give me an example of a fleeting [2] thought?

[3] A: Sure. Somebody's had a rough day at [4] work, they're driving home, they see a bridge, they [5] think for half a second what it would be like, you [6] know, would it solve their problems to drive into [7] the bridge; they immediately dismiss it, go home [8] and give it no further thought.

[9] Q: So mild and passive are the same kind of [10] ideation to you?

[11] A: Passive specifically means with no [12] intent.

[13] Q: What does no intent mean?

[14] A: That the person does not wish they were [15] dead; the person does not feel that they would be [16] better off if they weren't alive. They have the [17] thought but there is really no desire to act on it.

[18] Q: Now, Doctor, do you know about a [19] patient's intent from any source other than the [20] patient?

[21] A: Mostly you know from the patient. There [22] are other clues.

[23] Q: What are the other clues?

[24] A: Depends on what the patient is doing.

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[1] For instance, a patient who intends to commit [2] suicide may put their affairs in order. A patient [3] who intends to commit suicide may be giving away [4] possessions and valuables. A patient who intends [5] to commit suicide may be leaving important clues. [6] So you can sometimes tell from their behavior that [7] their intention is serious.

[8] Q: What clues would that be other than what [9] you've described?

[10] A: They'll make passing comments to people. [11] They may go out and purchase a gun. They may [12] stockpile and hoard medications.

[13] Q: Sir, do patients commit suicide who have [14] not previously expressed an intent?

[15] A: Yes.

[16] Q: Do patients commit suicide without giving [17] clues about their intent to commit suicide?

[18] A: On occasion, yes.

[19] Q: What are mild suicidal gestures?

[20] A: A mild suicidal gesture is often a [21] nonserious self-destructive act that if it were [22] more serious could be associated with suicide. [23] A very mild, say, scratching of the wrist [24] superficial cuts with a then expectation of

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[1] attention, support, help, assistance. That would [2] be a suicidal gesture.

[3] Q: If a patient that you were treating with [4] depression has a history of mild suicidal gestures, [5] do you watch that patient more closely for being at [6] risk for suicide?

[7] A: Yes.

[8] Q: Is there a difference between self-[9] destructive thoughts and passive suicidal ideation?

[10] A: Yes.

[11] Q: What is the difference?

[12] A: A self-destructive thought may not be [13] suicidal. A self-destructive thought may be a [14] person who wants to, say, burn themselves with a [15] cigarette. They may want to hurt themselves in [16] some way but clearly not to commit suicide but to [17] feel pain.

[18] Q: Do self-destructive thoughts put you as [19] the clinician on notice that there is a risk of [20] suicide in the patient?

[21] A: Yes.

[22] Q: So even though it is not necessarily [23] intended to be a life-ending act but more one [24] designed to elicit pain, that puts you on notice

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[1] that the patient may be at risk for suicide?

[2] A: It means it may be progressing in that [3] direction, yes.

[4] Q: And active suicidality is what?

[5] A: Somebody who has intent, a plan, strong [6] wish.

[7] Q: How is that different than chronically [8] suicidal?

[9] A: There are patients who are chronically [10] suicidal but aren't active in their intent. A [11] patient, for instance, can think about committing [12] suicide every day when she wakes up and struggle [13] with feelings of suicide, decide very clearly that [14] she's committed to live, she's committed to working [15] and treatment and that she would have no intention [16] and no plan to commit suicide. So that person [17] could be chronically suicidal but not active in [18] their intent.

[19] If it changed and they then felt that [20] they were going to commit suicide, that suicide was [21] inevitable, that they really wanted to be dead, [22] that would then become active.

[23] Q: So someone who is actively suicidal is [24] someone who is literally on the brink of attempting

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or committing suicide?

A: It doesn't have to be that way. There are patients who are actively suicidal who really want to be dead, who have the intent to be dead, but they also could have a reasonably long time frame. I have had patients who will be actively suicidal, who want to be dead, who will say, have a goal that if they're not better by six months, by a year, they'll commit suicide. And so they can really be actively thinking about suicide but they also can be deferring it. They can give the medication a chance or something like that.

Q: I see. What is intermittent suicidal ideation?

A: Intermittent means that it occurs sporadically. So a patient currently in a depressive episode may have suicidal thoughts once a week, twice a week, and on the other days not. So probably less likely than more.

Q: Any patient who presents with a history of being chronically suicidal or intermittent suicidal thoughts or mild suicide gestures are all patients at increased risk for suicide. Correct?

A: Yes.

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Q: Even a patient with passive suicidal ideation you would say was at increased risk for suicide?

A: Compared to somebody with no suicidal thoughts or compared to somebody who was completely normal, yes.

Q: How would you describe Michael Rosenbloom's suicidality in the last month of his life prior to when he was prescribed Prozac?

MR. GREENWALD: Objection to the form of the question.

A: Passive and intermittent.

Q: So by passive you mean no intent or plan?

A: Right.

Q: And intermittent, meaning that it sort of waxed and waned from day to day?

A: Yes. Well, in his case even less frequently than that; present on rare occasions.

Q: And what is the evidence that you are relying on when you say present on rare occasions?

A: Dr. Sandler's notes and my conversation with Dr. Sandler.

Q: How many times, do you know, does Dr. Sandler refer to Mr. Rosenbloom's suicide

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ideation in his notes?

A: I would have to count.

Q: I will put the records before you in a minute because I have some specific questions for you.

A: I could even look at my notes on his records. It might be in there.

MS. GUSSACK: Tell you what. Can we have marked as Exhibit 12 Dr. Teicher's handwritten notes and miscellaneous documents contained in his folder.

MR. GREENWALD: This is the light blue folder, for the record.

(Teicher Deposition Exhibit 12 marked for identification.)

BY MS. GUSSACK:

Q: Handing you what has been marked as Exhibit 12, sir, can you identify for me the notes you took of Dr. Sandler's records?

A: These are my notes of Dr. Sandler's treatment notes.

MS. GUSSACK: Can we have them marked as 12-A through E, five pages.

(Teicher Deposition Exhibits 12-A

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through 12-E marked for identification.)

BY MS. GUSSACK:

Q: Doctor, just showing you what's been marked as Exhibit 12-A, there is a notation in the left-hand corner I think of October 25. Is that right?

A: Yes.

Q: Are these notes that you made October 25th of this month?

A: Yes.

Q: And that refers to the 12-A through E?

A: Yes.

Q: Could you direct my attention, sir, to the place where you believe you've made notes about Dr. Sandler's records of suicidal ideation?

A: (Pause) Well, there's one on May 31.

Q: And what is your note for that?

A: My note for that whole session: Claims sleep is normal now but otherwise has many symptoms of depression; feeling depressed, low self-esteem, feeling weak, defensive; feels unworthy of Joan's support, though this is variable; high anxiety; thoughts of being street person; thoughts of suicide, though low intensity; difficulties in

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concentrating, very tense; five-pound weight loss, decreased appetite. Primary concern is with Texas lawsuit including his rage at client Phil who he feels set him up and now denies. Unable to effectively process the anger, as he is dependent on this client. Will see this client over next week. He is accommodating to weekly sessions and further evaluation of medications.

Then on 6/4 there is mention of suicidal feelings and specifically there, suicidal feelings pursued and are mild and low risk now.

That's all I see in my notes.

Q: Doctor, had Michael Rosenbloom been your patient, when would you have first prescribed an antidepressant for him?

MR. GREENWALD: Objection.

A: Probably around the same time that Dr. Sandler did. Maybe a little bit – Probably more likely at the time when Dr. Sandler started first broaching the topic.

Q: There are several times where Dr. Sandler mentions the possibility of using antidepressants but the patient is resistant. Correct?

A: Correct.

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Q: And you believe at one of those earlier times several weeks before he actually prescribes?

A: Well, I think I would have also broached the topic; and again, it is the patient's choice.

Q: Doctor, referring back to 7-C, your billing record, it reflects that as of today, October 29, you've spent four hours on this case?

A: Yes.

Q: There's commitment for you, 5:20 to 5:40 this morning. What were you doing at that time?

A: Trying to get all this stuff organized and trying to prepare that –

Q: List of materials reviewed?

A: – list of materials reviewed, and trying to put together the billing sheet.

Q: And, sir, this record, Teicher 7-C, also reflects that, on October [redacted], which was yesterday, [redacted] entry labeled "7:00 o'clock to 10: meet." Were you meeting with Attorney Greenwald?

A: Yes.

Q: You had dinner with him?

A: Yes.

Q: Doctor, what did you discuss with Attorney Greenwald last night for which you are

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billing him three and a half hours of

time?

MR. GREENWALD: Objection. First of all, he didn't say he was going to bill me three and a half hours for dinner. Second of all –

MS. GUSSACK: C refers to three and a half hours.

MR. GREENWALD: Yeah, but that doesn't mean he's necessarily going to send me a bill for that. Maybe he is; I don't know.

BY MS. GUSSACK:

Q: The document is labeled "Greer billing at $400 an hour." But aside from whether the bill actually issues, this document reflects a three-and-a-half-hour meeting with Attorney Greenwald. Can you tell me what you discussed?

A: Well, we first discussed where we were going to go eat and decided that we would go to Legal Seafood. Then we discussed how we were going to get to Legal Seafood, and we walked – we were horrible at it. We had to ask two people for instructions, but we finally got there, and then there was a long wait so we discussed whether we were going to wait or not; and although it was about a half hour, we chose to wait. Then we sat

at a bench nearby and discussed the upcoming deposition.

I'm trying to think about what we specifically discussed. Basically he said "Relax, answer the questions honestly. Make sure that you understand the question." He told me an anecdote about an individual he had recently done a deposition with and after they broke for lunch he asked the person if he'd discussed the deposition with counsel and he said yes and told him he didn't understand a single question he had asked him. So he encouraged me to make sure I understand what you're asking.

Talked a lot about his daughter being in law school for the first year and how she has no life and she's going to Georgetown.

MR. GREENWALD: Don't put that on the record.

MS. GUSSACK: I'm not going to show it to her.

BY MS. GUSSACK:

Q: Other discussions with respect to the case, sir?

A: Basically Attorney Greenwald asked me a

number of questions and they seemed be questions that struck me as they re points of clarification about things that had gone on in Dr. Eth's deposition.

Q: Such as what?

A: We discussed Dr. Eth's statement that he was not an expert in psychopharmacology and I expressed that when I had read it, that I was surprised: that I would have considered somebody who was a board-certified psychiatrist who had conducted clinical trials in psychopharmacology to be by rights an expert in psychopharmacology. And then I mentioned to him that I was surprised that in Dr. Cole's deposition, that Dr. Cole did not state that he was an expert on ecothesia when I would consider Dr. Cole to be one of the foremost authorities on ecothesia.

So we discussed that and had a general discussion about what one would construe as an expert in the legal sense versus how academics view themselves and came to the conclusion that when academics are asked if they're an expert, they basically interpret it to mean are they an authority as opposed to whether they're an expert.

And it seemed like that was a significant part of it.

Q: What other points of clarification did you discuss with Attorney Greenwald from Dr. Eth's deposition?

A: Well, we talked about the BGA data and I'm not exactly sure what the connection was, but I mentioned that I had run a statistical analysis on the BGA data and that the difference between number of suicide actions on Prozac versus placebo was significant and mentioned that point. I also mentioned that I had gone through all of the voluminous adverse reports that were available uncoded, looking to see when they had replied to the BGA, and indicated that on August 31st of 1986 there were sixty-two suicidal actions on fluoxetine, that that was an underestimate; that there were more. That there were in fact at least sixty-nine suicidal actions. And so discussed that there was some underreporting that appeared to be going on.

Q: When did you perform your statistical analysis?

A: This morning. No, I performed one this

morning, performed one yesterday.

Q: What did you perform a statistical analysis of this morning?

A: There was the 1986 data that I performed this morning, which was the fluoxetine safety update 6/20/86.

Q: Is that a document you've generated, sir?

A: Yes.

Q: Leave it; we'll get to it. Is that folder labeled that you're referring to?

A: Yes, Exhibit 12.

Q: That is the folder labeled Exhibit 12?

A: Yes.

Q: What statistical analysis had you performed the morning before or the day before I think you said?

A: That's the one I performed today. The one I performed the day before was on the BGA data.

Q: Sir, you are not an authority as academics use the term in foreign regulatory labeling requirements, are you?

A: No.

Q: Have you ever consulted with any foreign regulatory agency on labeling requirements for any

pharmaceutical?

A: No.

Q: Do you know what the labeling history was with respect to fluoxetine in Germany?

A: Oh, I've seen many documents on it.

Q: Lilly documents, sir?

A: Yes.

Q: Provided to you by plaintiff's counsel?

A: Yes.

Q: Have you ever consulted with FDA on labeling issues?

A: No. Well –

Q: I am familiar with your role as a consultant to PDAC. Is that what you're wanting to offer?

A: Right. And I guess part of that was, one of the concerns was product labeling.

Q: Aside from that?

A: No.

Q: What else did you discuss with Attorney Greenwald about Dr. Eth's testimony other than what you've described?

A: I think that was it for Dr. Eth's testimony.

Q: What else did you discuss with Attorney Greenwald about the Rosenbloom case?

A: I don't think we discussed the Rosenbloom case particularly at all.

We did discuss more [5] about the deposition, if you want to consider that [6] part of it.

[7] Q: Other than pointers on how to be deposed, [8] did you discuss issues related to Prozac such as [9] BGA but other than BGA issues or with respect to [10] Mr. Rosenbloom?

[11] A: Yes, I did discuss or we did discuss an [12] e-mail from Leigh Thompson that was discussing the [13] 5 milligram strength Prozac in which Leigh Thompson [14] indicated that the data was massaged to make it [15] look like the 5 milligrams was not as effective [16] while 5 milligrams actually had a faster onset and [17] didn't differ in terms of final endpoint versus 20 [18] milligrams. Discussed that, and discussed my [19] impression that it was very important that they [20] maintain that illusion in terms of rapid approval [21] of Prozac.

[22] Q: First of all, sir, when you say "they," [23] who are you referring to?

[24] A: Lilly.

[1] Q: And I don't understand your comment. It [2] was important to Lilly to maintain what?

[3] A: That illusion that the 5 milligrams was [4] much less effective than the 20 milligrams.

[5] Q: For rapid approval?

[6] A: Yes.

[7] Q: Rapid approval of what?

[8] A: Of Prozac by the FDA.

[9] Q: What do you mean by that statement, sir?

[10] A: What I mean is that when a drug becomes [11] available clinically you want to know the lowest [12] effective dose. You want to know the optimal [13] effective dose as best you can in the course of a [14] clinical trial, and a drug company will do [15] dose-seeking finding studies where they test [16] patients on a variety of doses to establish a [17] therapeutic range for the medication. And they [18] generally want to find in doing this a dose that is [19] subtherapeutic. That way they can give good [20] guidance as to what the appropriate dosage is.

[21] They also want to conduct the [22] majority of their tests at the best therapeutic [23] dose or at the safest, lowest, safest, most [24] effective dose. And if they were showing that 5

[1] milligrams was actually equivalent to or better [2] than 20 milligrams, that would put them in the [3] position of having to do further testing of doses [4] even lower than 5 milligrams and more data on [5] low-dose range since the majority of their studies [6] were at greater than 20 milligrams.

[7] Q: That is the explanation for why it is [8] essential for Lilly to maintain the illusion of –

[9] A: That the 5 milligrams is not effective.

[10] Q: I see. Now, Doctor, have you reviewed [11] Lilly's clinical trial data regarding the low-dose [12] study?

[13] A: No.

[14] Q: Have you reviewed the final reports of [15] the low-dose studies?

[16] A: No, I have not.

[17] Q: Have you reviewed the final reports of [18] the fixed-dose studies?

[19] A: Which final reports?

[20] Q: Clinical trial final reports submitted to [21] FDA.

[22] MR. GREENWALD: I am going to object [23] only because I'm not sure. Are you talking about [24] all of the trials that were done by Lilly?

[1] MS. GUSSACK: No, the fixed-dose [2] clinical trial final report submitted to FDA.

[3] MR. GREENWALD: You're talking about [4] all the fixed-dose studies?

[5] MS. GUSSACK: The fixed-dose final, [6] I'm asking the doctor whether he has reviewed that [7] data.

[8] MR. GREENWALD: The reason for my [9] objection is, as you know, Lilly consistently [10] during the MDL argued against producing all their [11] data, and in fact Judge Dillon in his order [12] indicated that the plaintiffs would not get all of [13] the data. And the plaintiffs only got, as [14] I recall, four pivotal studies.

[15] So I just want to be clear that when [16] questions are asked about reviewing, they may [17] relate to things that Lilly fought not to provide [18] during the MDL. And in fact at one of the hearings [19] before the judge we were told by Lilly's counsel [20] that it is unnecessary to see everything; that no [21] one does a sampling or a survey; that in fact they [22] are done by doing some spot, random checks. And [23] that was argued to the court, that that's the way [24] it should be done.

[1] So I just want to be clear when you [2] ask for information to be seen that we're not [3] talking about things that Lilly fought against [4] providing.

[5] BY MS. GUSSACK:

[6] Q: Doctor, have you reviewed the final [7] report of the clinical trial regarding the fixed- [8] dose study that Lilly submitted to the FDA?

[9] A: No, I have not.

[10] Q: Have you –

[11] MR. GREENWALD: Perhaps if you have a [12] copy of that, the doctor would be happy to take a [13] look at it.

[14] BY MS. GUSSACK:

[15] Q: Doctor, have you reviewed the seventeen [16] clinical trials from which data was presented at [17] the Psychopharmacology Drug Advisory Committee [18] meeting that Lilly provided?

[19] A: I reviewed the material that was [20] presented to the people who were [21] on the drug [22] advisory panel.

[22] Q: What material was that?

[23] A: It's a brown folder. Is that it?

[24] Q: You brought it with you today?

[1] A: Yes.

[2] MR. GREENWALD: Maybe we could find [3] it at lunch.

[4] A: And I carefully reviewed the med analysis [5] which Beasley had published at that time, which [6] I guess involved the seventeen studies.

[7] Q: What data did you review from which you [8] performed your statistical analysis of this [9] morning?

[10] A: There should be a folder that has a lot [11] of red paper clips that we produced this morning.

[12] MR. GREENWALD: Red paper clips?

[13] MS. GUSSACK: This requires us to [14] look through the documents you've brought?

[15] THE WITNESS: Yes.

[16] MS. GUSSACK: All right, I'll suspend [17] the question for the moment until we get a chance [18] to look through during the lunch break for some [19] organizational purposes.

[20] BY MS. GUSSACK:

[21] Q: Doctor, has there been any particular [22] data that you have wanted to see that you have [23] requested from Attorney Greenwald?

[24] A: Yes.

[1] Q: And what is that?

[2] A: I had asked if I could get all of the [3] data from the Beasley med analysis and spoke with, [4] I guess, the keeper of the records from the [5] multidistrict litigation.

[6] Q: Who is that?

[7] A: It was Nancy – oh, I can't remember her [8] last name.

[9] Q: When did you do that, sir?

[10] A: About a week ago.

[11] Q: And when did you speak with Mr. Greenwald [12] about asking for the

clinical trial data?

A: Within the last two weeks.

Q: What else have you asked Mr. Greenwald for?

A: I asked if we could get a computerized database with all the data.

Q: And he told you what?

A: What he told me was that Lilly had not made that available and indicated that it would only run on software that was available within the company and that one could not export it.

Q: What did Nancy, the keeper of the MDL documents, tell you?

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A: That the vast majority of data that would go into the Beasley med analysis is redacted and not unmasked and that you can't find out the true incidence of suicide attempts in that data; that you can't track it.

Q: Did you make any effort to do so?

MR. GREENWALD: I am going to object again because Lilly filed a motion for a protective order in the MDL with respect to providing any of the computerized data. In fact, at the first hearing that we had Lilly's counsel got up and told the judge that Lilly may not have any computerized data. At which time I asked the judge if we could have however they do it, whether they write it in a logbook and take it off a shelf when they get information or if they have it computerized.

Lilly's counsel, which I believe was Mr. Stanley but I'm not sure if it was Mr. Stanley, but that firm, indicated to the judge at that hearing that they didn't know, something to the effect that Lilly wasn't that forward of a company in computers. And the judge ordered them to check.

Subsequent to that they filed a motion for protective order with respect to any of

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the computerized material, arguing that the folks in the MDL even if they got it wouldn't be able to understand it and wouldn't be able to support it and didn't have the ability to do that. That material was never provided by Lilly. And if you want, although I'm sure you have it, there are a number of orders that were passed in the MDL with regard to that.

So my objection is that I think it is inconsistent to ask an expert if he has seen things that you have refused to provide. That's my objection, but go on.

MS. GUSSACK: Can you read back the question, please.

(The reporter read the question.)

BY MS. GUSSACK:

Q: Did you make any effort to review the data that Nancy told you she had to determine whether you could track the patients?

A: No. She told me it was impossible.

Q: My question is, did you make any effort to do so yourself?

A: No. Well, actually, I did the next best thing. I went and tracked the data that I had that

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was not coded or unmasked and I tracked that to check on the accuracy of their statement to the BGA about the incidence. So I didn't have that data to check but I checked on the accuracy of the data that they were submitting.

Q: You checked on the accuracy of data that you believed was submitted to the BGA. Is that what you're saying?

A: Yes.

Q: Sir, have you ever made a Freedom of Information Act request to FDA for any data related to Prozac?

A: No.

Q: Did you discuss with Mr. Greenwald last evening when you met your consulting generally in Prozac litigation?

A: No.

Q: Are you presently involved in any other case involving Prozac?

A: No.

Q: Doctor, are you presently conducting any clinical trials for any pharmaceutical company?

MR. GREENWALD: I'm sorry. I missed the question.

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BY MS. GUSSACK:

Q: Are you presently conducting any clinical trials for any pharmaceutical company?

A: No.

Q: Have you ever done so?

A: Yes.

Q: For whom?

A: I conducted a trial of thioridazine in borderline personality disorder for, oh, boy, I think it's Hoffmann-LaRoche.

Q: Sounds like Sandoz to me.

A: You're right.

Q: Okay. Any others, sir?

A: Can you repeat the question?

Q: Have you ever performed a clinical trial for any pharmaceutical company other than the one that you're just mentioned about Sandoz and thioridazine? Have you been involved in any other clinical trial?

A: I tested light devices for light therapy companies but they're not pharmaceutical companies.

Q: And when you were looking at thioridazine you were evaluating safety and efficacy for Sandoz?

A: Yes.

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Q: Did you draft the protocol in that clinical trial?

A: Yes.

Q: Who else participated in that?

A: Dr. Cole and Dr. Schatzberg.

Q: You used the Hamilton depression rating scale in that trial?

A: Yes, I believe so.

Q: What is Sepracor, sir?

A: Sepracor is a chemical manufacturing company.

Q: What is your involvement with them?

A: I have done some basic research for them regarding the enantiomers of fluoxetine.

Q: Can you explain what the enantiomers of fluoxetine are?

A: Fluoxetine is a racemic mixture. It means that there are left-handed and right-handed crystal forms of fluoxetine. They are what we call stereoisomers. And Prozac is marketed as a racemic, that is, D and L, dextro and levo, although it is accurately designated R and S fluoxetine. And Sepracor has a method and I guess patent rights or some kind of production rights to

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manufacture the enantiomers of fluoxetine and they were in the process, they had applied for a use patent for the S-enantiomer and they wanted me to evaluate in animals the pharmacological actions of the S-enantiomer and the R-enantiomer of fluoxetine.

Q: Have you performed any animal research with fluoxetine?

A: Yes.

Q: Now, you mentioned the addition to your C.V.; I forget the title of the article.

A: Development Of An Animal Model Of Fluoxetine-Induced Akathisia.

Q: Is that the research you're referring to? Is that the basic research you're doing involving fluoxetine that you've been involved in?

A: That was part of it. We have done a number of other studies on brain

metabolism, [19] receptor binding, pharmacokinetics.

[20] Q: That is rat research, basically?

[21] A: Yes.

[22] MS. GUSSACK: Off the record.

[23] (Discussion off the record.)

[24] BY MS. GUSSACK:

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[1] Q: Doctor, Attorney Greenwald has put before [2] you some papers with red paper clips. Is this the [3] data that you believe you referred to in conducting [4] your statistical analysis?

[5] A: Yes.

[6] MS. GUSSACK: I think now would be a [7] good time to break.

[8] (Luncheon recess at 1:12 p.m.)

[9] AFTERNOON SESSION

[10] 2:20 p.m.

[11] BY MS. GUSSACK:

[12] Q: Doctor, I have marked as Teicher 13 a [13] booklet labeled Psychopharmacological Drugs [14] Advisory Committee, September 20, 1991, and I am [15] just asking you: Are these the materials that you [16] stated previously you reviewed from PDAC when you [17] said that you reviewed the materials that were sent [18] to the attendees at the meeting?

[19] A: I understand the question. These are [20] part of the material I reviewed. I seem to recall [21] that maybe there was some more information that was [22] part of this, another booklet.

[23] Q: Another booklet that looked like the one [24] you're holding?

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[1] A: Yes. I know it's not in the boxes. I [2] don't know where it is.

[3] Q: What kind of material did that booklet [4] have in it, if you recall?

[5] A: It had more drug company data. I mean, [6] there was both data that I believe was from Lilly [7] and there was data that I believe was on trazodone [8] from, I think, Mead Johnson. So there was more [9] tables and data.

[10] Q: I have had marked as Exhibit 12-F a [11] handwritten note from your folder of handwritten [12] notes that we previously marked as Teicher 12. [13] This document has at the top the notation "2:45 to [14] 9:45, October 13," and I am putting it before you [15] and I would point out that your billing record has [16] an entry of seven hours for October 13. Are those [17] notes made by you on October 13?

[18] A: I believe so, yes.

[19] Q: And did you in fact spend twelve hours on [20] October 13 reviewing materials?

[21] A: 2:45 to 9:45 is seven hours.

[22] Q: What did I say?

[23] MR. GREENWALD: You said twelve.

[24] MS. GUSSACK: I meant seven hours.

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[1] Excuse me.

[2] BY MS. GUSSACK:

[3] Q: But, Doctor, you did in fact spend seven [4] hours on October 13?

[5] A: Yes.

[6] Q: Doctor, can you tell me, the notes that [7] have been marked as 12-F, are those notes of a [8] telephone conversation that you had with somebody?

[9] A: No. These are notes that I made to [10] myself while I was in the process of reading [11] depositions.

[12] Q: And do you recall on October 13 whose [13] depositions you were reviewing?

[14] A: I think I reviewed a number of them on [15] that date. It looks like from the notes, and this [16] is an extrapolation from the notes, that Dr. Cole's [17] deposition and Dr. Johnstone's deposition and maybe [18] part of Dr. Eth's deposition.

[19] Q: Now, sir, did you take any of your [20] handwritten notes with you to dinner last night [21] when you met with Mr. Greenwald?

[22] A: I did bring the blue books. They were in [23] my computer pouch.

[24] Q: And the blue books refer to what?

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[1] Teicher 12?

[2] A: Yes.

[3] MR. GREENWALD: I think that goes in [4] the blue book, the exhibit you just stuck in the [5] file.

[6] MS. GUSSACK: Thank you.

[7] BY MS. GUSSACK:

[8] Q: And another blue book?

[9] A: Yeah, which has miscellaneous.

[10] MS. GUSSACK: Why don't we have that [11] marked now as Teicher 15.

[12] MR. GREENWALD: Off the record a [13] second.

[14] (Discussion off the record.)

[15] (Teicher Deposition Exhibit 15 marked [16] for identification.)

[17] BY MS. GUSSACK:

[18] Q: Dr. Teicher, you said that you took [19] Teicher 12 and Teicher 15 with you to dinner last [20] night, and what else?

[21] A: What I was saying is they were both in my [22] computer case which I brought with me because [23] I didn't want to leave it in the car.

[24] MR. GREENWALD: I'm sorry. Was the

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[1] first thing in the second blue book the deposition [2] notice?

[3] MS. GUSSACK: Yes.

[4] MR. GREENWALD: I just want to make a [5] note of that. Thank you.

[6] BY MS. GUSSACK:

[7] Q: And, Dr. Teicher, do you have any data, [8] notes or information on any computer disk with [9] regard to this case?

[10] MR. GREENWALD: Objection. I don't [11] understand the question.

[12] BY MS. GUSSACK:

[13] Q: Do you have a computer disk that contains [14] notes or –

[15] MR. GREENWALD: I'm sorry. I didn't [16] know whose computer disk you were referring to.

[17] A: There are probably some numbers I used to [18] do the statistics and I made the graphs on [19] computer. They're not on the floppy disk. On my [20] hard drive.

[21] Q: Have you printed out hard copies of what [22] is on there?

[23] A: Yes.

[24] Q: And you have brought those with you

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[1] today?

[2] A: Yes.

[3] Q: Do you have any floppy disks of [4] information data relating to this case or to Prozac [5] generally?

[6] A: No.

[7] Q: Were the items that are contained in [8] Teicher 15, which are the miscellaneous collection [9] of documents, ones that you specifically selected [10] to review with Mr. Greenwald last night?

[11] A: No, not at all. And I'm not actually [12] sure that those were the documents that were in the [13] blue folder last night. I'm sure it's gotten [14] rearranged this morning when I was going over [15] material.

[16] Q: Do you recall specific documents that [17] were reviewed last night with Mr. Greenwald?

[18] A: We didn't review any documents last [19] night.

[20] Q: When you met with Mr. Greenwald last [21] night, did you discuss your prior testimony in the [22] criminal matters that you mentioned today?

[23] A: Last night?

[24] Q: Yes.

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[1] A: No.

[2] Q: Did you discuss your testimony [3]

the[3] Falk case?

[4] A: No.

[5] Q: Did you discuss your malpractice suit?

[6] A: No.

[7] Q: Have you been approached by any other [8] plaintiff's counsel with regard [9] a Prozac case?

[10] MR. GREENWALD: Objection.

[11] A: Yes.

[12] Q: And have you agreed to testify in any [13] Prozac case other than this one?

[14] A: No, absolutely not.

[15] Q: Do you have any intention to do so?

[16] MR. GREENWALD: Objection.

[17] A: No.

[18] Q: And, sir, is that because you don't find [19] the particular case that you were approached on to [20] be meritorious?

[21] MR. GREENWALD: Objection. I don't [22] really think that it is appropriate to ask him [23] about other cases that he may or may not have [24] looked at. I certainly don't know what he's looked [25] at, but I think it is inappropriate to ask this

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[1] witness because that information in another case [2] would certainly not be discoverable if, for [3] example, he looked at a case and determined he was [4] not going to testify in it. That would not be [5] discoverable information in another case, so I just [6] think it is an inappropriate question.

[7] MS. GUSSACK: Andy, the line that [8] I worked out with Steve in this regard previously [9] was that, without identifying the case or counsel, [10] the general subject and general reasons therefor [11] are not problematic. And while I don't necessarily [12] agree with your objection or Steve's, I think for [13] these purposes that's the scope of my question.

[14] MR. GREENWALD: I just think it is [15] inappropriate to get into specifics.

[16] BY MS. GUSSACK:

[17] Q: Sir, why is it that you have not agreed [18] to get involved in other litigation?

[19] A: It's not how I want to spend my time.

[20] Q: Do you have any other experience than [21] what you have previously described as an expert in [22] litigation?

[23] A: There's one case that I don't think [24] you've gotten that I had agreed to testify in, it's

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[1] not a Prozac case, and I think it's [2] probably in one [3] of those blue books.

[4] (Pause)

[5] It's somewhere here. The name I can [6] remember. It's John Acosta versus the State of [7] California. It's a criminal case.

[8] Q: And what is the issue in that case?

[9] A: It's another psychotropic drug and it was [10] some criminal behavior that took place on it. It's [11] not an SSRI. It's not an antidepressant.

[12] Q: Doctor, I guess I anticipated you. [13] Teicher Exhibit 14 –

[14] A: Oh, there it is.

[15] Q: – is documents labeled Notice Of [16] Deposition, and I see at the bottom a reference to [17] the Acosta case that you just mentioned.

[18] A: Yes.

[19] Q: So does Teicher Exhibit 14 fully detail [20] those cases in which you have acted as an expert or [21] consultant in litigation?

[22] A: As you spelled out the questions in the [23] notice of deposition, there's a four-year time [24] frame on some of these, that's true.

[25] Q: You have "Fentress case, question mark" [26] on Teicher 14?

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[1] A: Yes.

[2] Q: Were you retained as an expert in the [3] Fentress case?

[4] A: Yes, I was.

[5] Q: And you reviewed medical records in that [6] case?

[7] A: Yes.

[8] Q: And did you provide an opinion in that [9] case?

[10] A: Yes, I did.

[11] Q: A written opinion?

[12] A: Yes, I did.

[13] Q: And what was your opinion?

[14] MR. GREENWALD: Objection. If he was [15] a witness who was not called to testify, then [16] I think whatever opinions he had in the Fentress [17] case are not discoverable.

[18] MS. GUSSACK: I don't believe that's [19] true. And in the context of this case I am [20] entitled to find out what opinions he came to with [21] regard to Prozac in other litigation.

[22] MR. GREENWALD: I don't think you are [23] entitled necessarily to find out about a witness, [24] an expert who was retained and not used in

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[1] litigation as to what his opinions were in another [2] case. But if you want, let's put that aside and [3] we'll think about it and you can come back to it. [4] We can talk about it at a break or something.

[5] MS. GUSSACK: Let's mark this [6] Exhibit 16.

[7] (Teicher Deposition Exhibit 16 marked [8] for identification.)

[9] BY MS. GUSSACK:

[10] Q: Doctor, I put before you what has been [11] identified as Teicher 16. Would you confirm for me [12] that these are copies of slides for presentations [13] you've made regarding your article, The Emergence [14] Of Intense Suicidal Preoccupation During Fluoxetine [15] Treatment?

[16] A: Yes, they appear to be.

[17] Q: You have made presentations with regard [18] to your findings from your 1990 article, correct, [19] to your colleagues at McLean?

[20] A: Yes.

[21] Q: And did you make a presentation to the [22] ACMP?

[23] A: Yes.

[24] Q: Where else have you done that, sir?

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[1] A: The American Suicide Foundation.

[2] Q: Where else?

[3] A: I think I gave two at McLean; one was to [4] the manic-depressive and depressive association. [5] It's a patient support group, actually, patient [6] advocate group. I think that's it.

[7] Q: Have you always used the Teicher 16 set [8] of slides in making those presentations?

[9] A: As far as I can tell. This seems to be [10] pretty much all of the slides that I had made. [11] I don't know that I necessarily used every one in [12] every talk.

[13] Q: Sir, let me direct your attention to page [14] MHT000644 of Teicher 16. Are you there?

[15] A: Yes.

[16] Q: And at the bottom half of the page where [17] it says "Prozac and self-mutilation, TW patient," [18] is that Dr. Wehr's patient that you referred to [19] this morning?

[20] A: Yes.

[21] Q: Can you tell me where in that description [22] it describes that after three days' use of Prozac [23] the patient developed symptoms regarding [24] suicidality?

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[1] A: It doesn't say that.

[2] Q: Now, sir, that summary does say, [3] however, [3] that the patient was on [4] fluoxetine with a good [4] antidepressant [5] response at 80 milligrams a day. [5] Correct?

[6] A: Yes.

[7] Q: And that the patient was in fact

started [8] on Prozac at a subsequent time and did well for [9] another four months and then relapsed into –

[10] A: No, no, after treatment with Prozac, [11] decided to go off medication, did well another four [12] months off medication.

[13] Q: And then after four months, restarted the [14] Prozac?

[15] A: Right.

[16] Q: And that was at 80 milligrams over one to [17] two weeks, sir. Correct?

[18] A: Yes.

[19] Q: So that would be inconsistent with [20] somebody experiencing symptoms at three days?

[21] A: It occurred within the first two weeks [22] but it doesn't sound like that was three days.

[23] Q: Can I direct your attention to MHT000647 [24] of Teicher 16. You see at the top of that page

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[1] where it says "Prozac and aggression towards [2] others, Joseph Wesbecker"?

[3] A: Yes.

[4] Q: Mr. Wesbecker was the individual involved [5] whose action was at the center of the Fentress [6] case. Is that right?

[7] A: Yes.

[8] Q: Did you in your slide presentation [9] identify to the groups to which you presented that [10] you had been consulted as an expert in the [11] Wesbecker case?

[12] A: I don't think I made any mention of being [13] consulted as an expert.

[14] Q: Did you think that was relevant, sir?

[15] A: No, I don't think it was relevant.

[16] Q: You had obtained information about [17] Mr. Wesbecker from plaintiff's counsel in that [18] case. Correct?

[19] A: Yes.

[20] Q: And that would have been at the time [21] Mr. Finz?

[22] A: Yes.

[23] Q: That was not your first contact with [24] Mr. Finz, was it, sir?

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[1] A: Which?

[2] Q: When he provided you information about [3] Wesbecker.

[4] A: It may well have been. I can't

[5] Q: Can I direct your attention to MHT000643 [6] of Teicher 16, and you see the entry regarding [7] Rhonda Hala?

[8] A: Yes.

[9] Q: Is the information that is presented here [10] obtained from plaintiff's counsel in that case?

[11] A: I spoke with Rhonda Hala directly.

[12] Q: Did you also speak with her counsel?

[13] A: I think at the time that I got the [14] material I had talked with her directly and I later [15] received material. But I can't recall. My guess [16] is that actually I received material on Wesbecker [17] before I got the Rhonda Hala material.

[18] Q: So your first contact with Mr. Finz--

[19] MR. GREENWALD: Excuse me. Is there [20] another copy of that I could have? I thought you [21] had three copies.

[22] MS. GUSSACK: Yes. I handed you one. [23] Didn't I?

[24] MR. GREENWALD: No.

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[1] (Discussion off the record.)

[2] BY MS. GUSSACK:

[3] Q: Sir, when did you first have contact with [4] Mr. Finz?

[5] A: Mr. Finz called me on the phone and I had [6] contact with him probably sometime late in the [7] course of 1990, I would guess. I really can't give [8] you an exact date. The first contact was about [9] Wesbecker and it was not about Hala at all.

[10] Q: So Mr. Finz represented Wesbecker and you [11] spoke with him with regard to that matter?

[12] A: Yes.

[13] Q: And then he also represented Ms. Hala and [14] you spoke with him about her case as well. [15] Correct?

[16] A: Yes.

[17] Q: I am going to renew my question of [18] earlier, which is: What is the opinion that you [19] offered Mr. Finz with respect to your evaluation of [20] the records pertaining to Joseph Wesbecker?

[21] MR. GREENWALD: Same objection. [22] I thought we were going to talk about that at a [23] break?

[24] MS. GUSSACK: Off the record.

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[1] (Discussion off the record.)

[2] BY MS. GUSSACK:

[3] Q: Dr. Teicher, referring to Teicher 16, [4] page 000644, who provided you the information about [5] the case that you have described as the Michigan [6] case?

[7] A: If I recall, that was both a letter and a [8] phone conversation and that was the patient's [9] family.

[10] Q: The patient's family member?

[11] A: Yes.

[12] Q: And the same question as to 000645, the [13] Connecticut case on the next page, who provided you [14] information about that case?

[15] A: I honestly don't recall.

[16] Q: You don't recall? Is that what you said, [17] sir?

[18] A: Yes.

[19] Q: And, sir, the MHT case on the bottom of [20] 000645, is that one of your patients, sir?

[21] A: Yes.

[22] Q: Is this a patient that you have published [23] on anywhere?

[24] A: No.

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[1] Q: Have you ever in any of the presentations [2] you've made to any of the groups that you have [3] described this afternoon ever presented Michael [4] Rosenbloom's case?

[5] A: No.

[6] Q: Doctor, let me return to something we [7] were discussing this morning, which is the sources [8] of information on which you can assess a patient's [9] suicidality. You had told me you largely have to [10] rely on the patient and then there are some clues [11] as well.

[12] A: Yes.

[13] Q: Do you in the course of treating patients [14] ever administer any scales to them, tests?

[15] A: Sure.

[16] Q: What do you use?

[17] A: I use a whole variety of them. But one [18] of the ones I use most is the Kellner symptom [19] questionnaire, which is a 92-item self-report [20] inventory. When it is a matter of suicide I tend [21] to use the suicide ideation questionnaire, that [22] being Reynolds.

[23] Q: Excuse me?

[24] A: Reynolds is the author of that. And

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[1] there are adult versions and adolescent and child [2] versions. I use the Hamilton, and I use the [3] structured interview guide for the Hamilton with [4] the eight-item addendum most of the time. I use [5] the mania rating scale. I use structured [6] diagnostic interviews, the DISC and the Kiddie [7] SADS. I use a number of rating scales that I've [8] created. I use the limbic system checklist 33.

[9] Q: Do you use the Hopkins symptom checklist?

[10] A: Rarely. I have used it in research [11] studies. I think the Kellner questionnaire is [12] better.

[13] Q: But, if I understand you, some of these [14] scales are ones that you administer and some are [15] ones that the patient self-reports?

[16] A: Self-reports, yes.

[17] Q: But you would agree, sir, that there is [18] no objective measure that one can use? You can't [19] look at someone's blood cells and –

[20] A: For suicide?

[21] Q: Yes, for suicide.

[22] A: Right.

[23] Q: So you have to rely on your clinical [24] judgment and the information that you elicit from

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[1] the patient directly and through the use of those [2] kinds of questionnaires and scales?

[3] A: Yes.

[4] Q: And you recognize that there are risk [5] factors that put somebody at greater risk for [6] suicide?

[7] A: Yes.

[8] Q: And you evaluate those risk factors when [9] you evaluate the patient for suicidality?

[10] A: Yes.

[11] Q: Now, can we agree that, for instance, [12] borderline personalities are at greater risk for [13] suicide?

[14] A: Yes.

[15] Q: Patients with epilepsy are at greater [16] risk?

[17] A: Yes.

[18] Q: Patients with history of child abuse are [19] at greater risk for suicide?

[20] A: For attempts.

[21] Q: For attempts?

[22] A: For attempts, yes.

[23] Q: History of suicide attempts in the family [24] put you at greater risk for suicide yourself?

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[1] A: History of completed suicide in the [2] family.

[3] Q: What about attempted suicide?

[4] A: I am not aware of the data.

[5] Q: You are not familiar with that data?

[6] A: Right.

[7] Q: But if there is such data you would find [8] that of interest in evaluating the risk?

[9] A: Sure.

[10] Q: We have already talked about obviously [11] patients with depression are at greater risk for [12] suicide.

[13] A: Yes.

[14] Q: And in fact patients with depression are [15] at greater risk than with other psychiatric [16] disorders, aren't they?

[17] A: That is not actually completely [18] e. For instance, Dr. Fawcett has found that panic [19] attacks are an equal long-term risk and greater [20] short-term risk for suicide, and that has been [21] confirmed by I believe Weisman's study and also it [22] is consistent with Beck's observations.

[23] Q: I thought Dr. Fawcett said that depressed [24] patients with anxiety are at greatest short-term

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[1] risk.

[2] A: Well, yeah, but if you want to compare [3] depression alone versus panic attacks alone, then [4] panic attacks are a greater short-term risk than [5] depression alone.

[6] Q: But certainly patients with depression [7] with anxiety are at greater risk than just patients [8] with depression for suicide?

[9] A: If you have depression plus anxiety [10] you're at greater risk than if you have depression [11] alone. How that compares with panic attacks [12] I don't know, but panic attacks are a major [13] factor. That's all less than dysphoric mania.

[14] Q: Are patients with multiple personality [15] disorders at greater risk for suicide than just [16] patients who are depressed?

[17] A: They're certainly at high risk for [18] suicide attempts. I'm not sure what the data is on [19] completed suicide in multiple personality disorder.

[20] Q: Patients with alcohol abuse problems or [21] drug abuse problems are also at increased risk for [22] suicide?

[23] A: Yes.

[24] Q: Now, Doctor, what about simply life

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[1] stressors? As opposed to what we've been [2] describing, people who have suffered financial [3] reversals or depressed individuals who have [4] suffered financial reversals are at greater risk [5] for suicide?

[6] MR. GREENWALD: Objection. What do [7] you mean by financial reversals?

[8] MS. GUSSACK: Financial problems.

[9] A: Stress increases risk. To the extent [10] that one of these is perceived as stress it can [11] increase risk. Loss increases risk.

[12] Q: Feelings of loss?

[13] A: Yes.

[14] Q: Feelings of hopelessness increase risk?

[15] A: Yes.

[16] Q: I think you used the phrase in your 1990 [17] article feelings of abandonment or concerns about [18] abandonment?

[19] A: Yes.

[20] Q: What were you referring to?

[21] A: That's interpersonal: rejection, loss of [22] social support, divorce, break-up of the marriage.

[23] Q: What about change in job status, loss of [24] job? Would that be a loss that –

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[1] MR. GREENWALD: Objection. Hold on.

[2] MS. GUSSACK: Can I finish my [3] question before you object?

[4] MR. GREENWALD: Sure. But it's two [5] questions.

[6] MS. GUSSACK: Then I'll know which [7] part you object to.

[8] MR. GREENWALD: Absolutely. [9] Wait until she asks the question. [10] You weren't finished with your [11] question and I was going to object because it's [12] actually two questions and not one.

[13] MS. GUSSACK: I will break it down.

[14] MR. GREENWALD: So I wouldn't know [15] which one was being answered, because there are two [16] questions.

[17] MS. GUSSACK: Can you read me the [18] beginning of the last question?

[19] (The reporter read the question.)

[20] BY MS. GUSSACK:

[21] Q: Would change in job status be a kind of [22] stressor that could increase the risk for suicide?

[23] MR. GREENWALD: Objection to the form [24] of the question.

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[1] A: It could be.

[2] Q: And would loss of a job be a stressor [3] that would increase the risk for suicide?

[4] MR. GREENWALD: Objection. Would or [5] could?

[6] A: It could.

[7] Q: It could be?

[8] A: Yes.

[9] Q: Now, Doctor, is it true that patients who [10] have been unresponsive to prior treatment for [11] depression are also at greater risk for suicide?

[12] MR. GREENWALD: Objection.

[13] A: Yes.

[14] Q: What is a tertiary care facility?

[15] A: A tertiary care facility is basically a [16] medical institution that treats patients who have [17] generally failed to do well at more of the [18] first-line community resources.

[19] Q: McLean is a tertiary care facility?

[20] A: Yes.

[21] Q: Doctor, is it true that people with

[22] abnormal EEGs are more susceptible to the effects [23] of medication?

[24] A: They can be depending on the medication.

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[1] Q: Psychoactive medications? Are they more [2] susceptible to the effects of psychoactive [3] medications?

[4] A: They can be. There are some medications [5] that lower seizure threshold. There are some [6] medications that raise seizure threshold. Drugs [7] that lower seizure threshold they would probably [8] respond to more sensitively and more adversely.

[9] Q: Are you familiar with Dr. Blumenthal's [10] risk factors for suicide?

[11] A: Dr. Blumenthal?

[12] Q: Yes, Susan Blumenthal.

[13] A: Oh. I am familiar with some of the [14] things she's written. I'm not sure what list [15] you're referring to.

[16] Q: Dr. Teicher, can you tell me how sort of [17] chronologically you developed the idea of reporting [18] on the patients that were the subject of your 1990 [19] article? Who is the first patient that you saw [20] that you thought you were seeing some kind of [21] response to Prozac?

[22] A: Could I see the article?

[23] Q: Exhibit 10 is the article.

[24] A: (Pause) I am not absolutely certain.

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[1] Case 4 and case 5 were started on Prozac by me at [2] approximately the same time and I'm not sure which [3] one I recognized it in first.

[4] Q: Which is the patient that you [5] rechallenged with clomipramine and observed [6] suicidal ideation?

[7] A: That would be case 2.

[8] Q: And have you brought with you today the [9] notes on each of these patients that you had [10] produced in response to the subpoena?

[11] A: No, I have not. I didn't bring the stuff [12] I already sent you.

[13] MS. GUSSACK: Off the record.

[14] (Discussion off the record.)

[15] BY MS. GUSSACK:

[16] Q: So, Doctor, what period of time did you [17] treat patients 4 and 5 that you observed this [18] response? What I mean is what year?

[19] A: Oh. This was shortly after Prozac came [20] on the market, so that would be '89, '88.

[21] Q: From –

[22] A: Yeah, '88.

[23] Q: From your affidavit submitted in this [24] case, here's what I understand; and I want you to

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[1] tell me if I have this wrong. Of the six patients [2] you report on in your 1990 article, patient number [3] 1 was Dr. Cole's patient?

[4] A: Correct.

[5] Q: And of the remaining five, patient number [6] 3 was an inpatient at McLean Hospital?

[7] A: Yes.

[8] Q: Was that patient your patient?

[9] A: No.

[10] Q: Who was the attending physician or [11] admitting physician at McLean responsible for that [12] patient?

[13] A: I don't recall.

[14] MR. GREENWALD: Objection.

[15] A: I don't recall.

[16] Q: How did you become aware of patient [17] number 3 and their course?

[18] A: Dr. Cole was in charge of the [19] psychopharmacology service at McLean and they do [20] all the inpatient consultations on medication, and [21] that patient was brought to Dr. Cole's attention, [22] who is the psychopharmacology consultation service, [23] and then Dr. Cole brought it to my attention.

[24] Q: And my understanding further from

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[1] materials you have produced in this case is that [2] the incidence rate that you have in your article [3] reflects six patients but not patient number 3. [4] Correct?

[5] A: Correct.

[6] Q: Who is the sixth patient?

[7] A: There's a patient that we didn't include [8] in the paper.

[9] Q: Have you published on that patient [10] anywhere?

[11] A: No.

[12] Q: Do you have notes reflecting the course [13] of that patient's situation?

[14] A: That was included in what you received.

[15] Q: How would we know which patient that [16] was? Were they given a number or identifying [17] information?

[18] A: I think in some way it's marked not [19] included case or case not included.

[20] Q: And, sir, why did you not include that [21] patient in your 1990 article?

[22] A: Six was enough I thought for a case [23] report series. There is a word limit on articles [24] and it didn't add anything new to the other cases.

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[1] Q: That patient was more complicated than [2] your other patients?

[3] A: Oh, they're all –

[4] MR. GREENWALD: Objection. I don't [5] believe he said that.

[6] BY MS. GUSSACK:

[7] Q: Was the patient more complicated?

[8] A: No. I mean, these patients, it's hard to [9] get that much more complicated.

[10] Q: The six that you report on were quite [11] complicated?

[12] A: Yes, quite complicated.

[13] Q: And you don't report on this seventh [14] patient, for lack of a better term right now, in [15] your 1993 article?

[16] A: No.

[17] Q: Now, in your 1993 article you do in fact [18] comment on Rhonda Hala?

[19] A: Yes.

[20] Q: And another patient with chronic fatigue [21] syndrome. Right?

[22] A: Yes.

[23] Q: And that patient with chronic fatigue [24] syndrome is also the patient you've mentioned in

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[1] your expert report here issued in this case? Would [2] you like to see your expert report?

[3] A: Sure. (Pause) Yes.

[4] Q: Doctor, what material did you review to [5] come up with the summaries that are presented in [6] your case reports?

[7] A: These were the patient notes and patient [8] records.

[9] Q: Now, when you say patient notes, what are [10] you referring to?

[11] A: Well, actually, let me be real specific. [12] For case 2, case 4, case 5 and case 6 what was [13] reviewed was my individual process notes on the [14] patients plus, particularly for case 6, there were [15] some additional notes made by one of my coauthors, [16] Carol Glod.

[17] Q: What is Glod's title?

[18] A: Her current title?

[19] Q: Yes.

[20] A: She is assistant professor of nursing at [21] Northeastern University and lecturer on psychiatry, [22] Harvard Medical School.

[23] Q: So she's a nurse?

[24] A: Clinical nurse specialist, yes.

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[1] Q: And, I'm sorry. Specifically with [2] respect to patient number 6 what did you do with [3] Glod?

[4] A: She had some additional notes.

[5] Q: She had additional notes?

[6] A: Yes.

[7] Q: She had seen patient number 6 without you [8] present?

[9] A: I was out of town, yes.

[10] Q: She only saw patient number 6 without you [11] present on one occasion or talked with patient [12] number 6?

[13] A: No, she had seen patient number 6 I think [14] a couple of times, probably two or three, when [15] I was not available, and she had a number of phone [16] conversations with the patient when I was not [17] available. And in specific the action that we [18] describe, she handled part of that. She did part [19] of the crisis intervention.

[20] Q: What are process notes?

[21] A: Process notes are notes that are taken in [22] the process of conducting psychotherapy. In my [23] hands, process notes are largely verbatim [24] indications of what the patient is saying in the

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[1] course of the therapy session.

[2] Q: Forgive my reducing this to basic [3] terminology. When you say in the course of [4] psychotherapy, you're talking about talk therapy?

[5] A: Yes. But –

[6] Q: The patient is not on the couch?

[7] A: The patient is not on the couch: face to [8] face. But that can be part of the pharmacotherapy [9] also.

[10] Q: So that you could see a patient, monitor [11] their medications, talk to them for ten or fifteen [12] minutes and send them on their way and that would [13] also be contained in the process note?

[14] A: I would never see a patient that short. [15] My minimum sessions have generally been half an [16] hour.

[17] Q: Just so I understand you, sir, your [18] process notes are your handwritten notes of [19] interviews? And when I say interview, I mean your [20] talk therapy with the patient.

[21] A: Yes.

[22] Q: And in your process notes you are [23] basically verbatim taking down what they're saying [24] to you as best you can?

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[1] A: Yes.

[2] Q: Without knowing shorthand or using your [3] own shorthand, I take it?

[4] A: Yes.

[5] Q: Just so it is clear, you have not [6] produced any of those process notes with respect to [7] any of these patients. Correct?

[8] A: Correct.

[9] Q: What other notes do you have with respect [10] to these patients that you referred to in [11] summarizing them in your 1990 article?

[12] A: That would largely be the main source of [13] my information. I do use rating scales during the [14] course of treatment, so if they completed rating [15] scales there would be rating scales. During the [16] course of treatment I'll send them for laboratory [17] evaluations. There will be laboratory slips. [18] I will write prescriptions. There'll be [19] prescription sheets on patients.

[20] Occasionally for a patient I'll need [21] to write a report or a referral note or some kind [22] of thing and that might be in the chart. Some of [23] these patients had hospitalizations and during the [24] course of their hospitalization there would be

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[1] hospital records produced.

[2] Q: Right now we are really just talking [3] about 2, 4, 5 and 6, because those were your [4] patients. Right?

[5] A: Correct.

[6] Q: And your affidavit, which I am going to [7] have marked as Exhibit 17, refers to process notes [8] in paragraph 7. Is that right? You call them [9] near-verbatim psychotherapy process notes.

[10] A: Yes.

[11] Q: So now you have described those for me. [12] Right?

[13] A: Well, you had asked the generality about [14] what psychotherapy notes are, and that was [15] accurately what psychotherapy notes are. When I'm [16] referring to the psychotherapy notes on this set of [17] patients it should be noted that all of those [18] patients were being seen for intensive [19] psychotherapy along with medications, so these were [20] not half-hour sessions. These were hour sessions [21] and these were very much psychotherapy intermixed [22] with some medication management.

[23] Q: Thank you for that clarification.

[24] Now, in paragraph 6 of Teicher 17 you

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[1] say you have thousands of pages of clinical [2] records. Are clinical records different than [3] process notes?

[4] A: Clinical records are the process notes [5] plus the lab reports, plus the rating scales, plus [6] the prescription sheets.

[7] Q: For instance, in your 1990 article you [8] used the Hamilton depression rating scale on some [9] of those patients. Correct?

[10] A: Yes. There's Hamilton data on case 1. [11] And correct me if I'm wrong, but I'm only seeing [12] Hamilton data on case 1.

[13] Q: I think it is on more than just one but [14] I don't have my copy of the article with me.

[15] A: Oh, yes, there's Hamilton data on case 2.

[16] Q: I think there is even another one. But [17] my question was: To the extent that you used the [18] Hamilton depression scale on these patients, that [19] would be contained in your clinical records?

[20] A: Yes.

[21] Q: And, sir, when you say lab evaluations, [22] patients 2, 4, 5 and 6, did they receive CAT scans [23] or MRIs? Point of clarification. I think it was [24] patient 6 as well as 1 and 2 that had the

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[1] Hamilton. Do you see that?

[2] A: Yes, I do. So I know that case 6 had a [3] CT scan and EEG studies. I am not aware at this [4] juncture of whether case 2 had. You said case 4?

[5] Q: Yes.

[6] A: I know case 4 had EEG studies and [7] I believe case 4 had a CT scan and that would – [8] No, I'm sure that case 5 had a CT scan. And I'm [9] pretty sure that case 4 did, yes.

[10] Q: So you have not produced any of those [11] laboratory evaluations in this case. Correct?

[12] A: Right. The question that comes up is, [13] I'm not sure they're my records. They may have [14] been obtained during hospitalizations and they [15] would be in the hospital records, not my records.

[16] Q: Which of patients 2, 4, 5 and 6 were [17] hospitalized during your care for them?

[18] A: Two was never hospitalized. Patients 4, [19] 5 and 6 were hospitalized during the period of time [20] that I've cared for them.

[21] Q: And were they hospitalized for reasons [22] having to do with risk of suicide?

[23] A: Yes.

[24] Q: You said yes?

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[1] A: Yes.

[2] Q: Now, Doctor, in preparing your case [3] reports you referred to your process notes, which [4] I now understand to be this larger universe which [5] contains all of these subpieces, the laboratory [6] evaluations and –

[7] A: No, no, the process notes are the process [8] notes. The clinical record –

[9] Q: I'm sorry, I misspoke. The clinical

[10] records. The clinical records include the process [11] notes, laboratory evaluations, hospitalization [12] records?

[13] A: No. I don't have the hospitalization [14] records in my clinical records.

[15] Q: Did you review the hospitalization [16] records for these patients when you put together [17] your summaries for your 1990 article?

[18] A: I believe only the discharge summary and [19] I don't believe – The discharge summary and [20] probably on case 6 also I drafted a conference [21] workup report.

[22] Q: What is that?

[23] A: As part of a hospitalization sometimes [24] patients will have a conference with multiple

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[1] professionals from different domains and the case [2] will be presented and experts will discuss the [3] case. And as part of that process on case 6, I had [4] written a presentation on the case to present to [5] the conference group. So that was in my clinical [6] records.

[7] Q: Now, you mentioned referral notes. Had [8] you referred patients 2, 4, 5 or 6 for referrals to [9] other psychiatrists?

[10] A: At various times these patients had had [11] consultations, yes.

[12] Q: And none of those referral notes have [13] been produced here in this case?

[14] A: No.

[15] Q: What information did you review on [16] patients 1 and 3 for purposes of describing them in [17] your 1990 article?

[18] A: I did not review the material in case 1 [19] and in case 3. Carol Glod, one of the coauthors on [20] the paper, reviewed the material on case 1 and [21] case 3. For case 1 she met with Dr. Cole and he [22] related his experience and made available his file [23] on the patient, which she went through. On case 3 [24] she reviewed the hospital records on the case.

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[1] Q: Did you ever review Dr. Cole's file on [2] patient number 1?

[3] A: No.

[4] Q: And you never reviewed the [5] hospitalization record for patient number 3?

[6] A: No.

[7] Q: Did you ever check Nurse Glod's work on [8] patients 1 or 3, her summaries extracting [9] information from those records?

[10] A: Dr. Cole checked case 1 against his [11] judgment to see if it was good and Dr. Cole was [12] also aware of case 3, because case 3 had been [13] reported back to him independently.

[14] Q: But did anybody check Nurse Glod's [15] summary of that patient against the raw source [16] material?

[17] A: No.

[18] Q: Now, sir, it is your position, isn't it, [19] that you have presented in these case reports all [20] of the relevant data on each of the patients so as [21] to allow clinicians reading your case reports to [22] evaluate or assess your information about exposure [23] to Prozac and the preoccupation with suicidality [24] that you described. Correct?

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[1] A: Yes.

[2] Q: Is there information that you reviewed in [3] your clinical records that you did not include in [4] your case reports because it was inconsistent with [5] your conclusion that Prozac was causing a [6] preoccupation with suicidal ideation?

[7] A: No. We were very accurate.

[8] Q: You strove to be very accurate?

[9] A: We strove to be accurate. I don't [10] believe anybody would accuse these of being simple [11] and straightforward.

[12] Q: Simple and straightforward patients?

[13] A: Or presentations in terms of there are [14] items of information that somebody could use to [15] say, well, these people have had previous suicidal [16] thoughts; these are not cases that are [17] unassailable.

[18] Q: In what way are they assailable?

[19] A: There are things that people can point to [20] in these cases to argue very differently than we [21] argued.

[22] Q: And could come to very different [23] conclusions. Correct?

[24] A: Yes.

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[1] Q: Based on information contained in the [2] case reports?

[3] A: In the case reports, yes.

[4] Q: What about information not contained in [5] the case reports?

[6] A: To my understanding and our goal was to [7] present the data in a very fair, accurate way, and [8] that anything that would be really germane one way [9] or the other was presented.

[10] Q: How long do you treat a patient with [11] Prozac before you can determine whether they are a [12] nonresponder to medication?

[13] A: Presently or in the past?

[14] Q: At the time that you wrote this article [15] in 1990.

[16] A: Well, at the time I wrote the article in [17] 1990 I gave them a very long time on the [18] medication, with the belief that eventually they [19] might respond, and proceeded for far longer than [20] I would currently proceed. In part, that was my [21] decision. In part, that was also the patient's [22] decision. They had had such expectations for [23] Prozac based on what other patients were telling [24] them, what some of the media excitement was about

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[1] Prozac, that they thought it was going to be the [2] wonder drug and that they would eventually respond [3] and that they wanted to give the medication an [4] absolute, total, complete trial, and so we [5] persisted long after. With what I know now, [6] I would've aborted the trial long before that.

[7] Q: Is that why you call these patients [8] optimistic and hopeful before starting on Prozac?

[9] A: That's a big part of it.

[10] Q: Because they were optimistic about the [11] possible effectiveness of the new medication [12] available to them?

[13] A: About Prozac, yes.

[14] Q: Had you told them things about Prozac [15] before you prescribed it, about its new and [16] different mode of action?

[17] A: As I mentioned before, when I talk to [18] patients about the option I do, educate them about [19] the treatment, the risks and the benefits. Largely [20] they had heard also about the medication and they [21] had had friends or people they knew who had gone on [22] the medication and had dramatic responses. So they [23] had heard some of the exciting success stories, [24] which motivated them.

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[1] Q: How long today do you try a patient on [2] Prozac before you determine that they are a [3] nonresponder?

[4] A: Well, it's a little bit of a complicated [5] question. I'll give you two scenarios.

[6] If the patient is having no response [7] to Prozac, sort of no positive response, no [8] negative response, they're basically taking the [9] medication and it doesn't seem to be doing [10] anything, I might give them four to six weeks to [11] assess efficacy. If they are taking the medication [12] and they're going in the wrong direction, they're [13] getting worse, I won't give them that long at all. [14] I might stop after two or three weeks.

[15] Q: What is evidence that they're going in [16] the wrong direction to you?

[17] A: Their depression is getting worse, [18] they're becoming more suicidal,

they're having [19] intense irritability, they can't sleep, and that we [20] can't minimize the side effects.

[21] Q: How long does it take to have a [22] clinically therapeutic response to Prozac?

[23] A: Generally it's about four weeks.

[24] Q: So if a patient is getting worse in the

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[1] first two weeks after starting Prozac, what do you [2] assume that is due to?

[3] A: It's due to side effects of the drug or [4] it's due to Prozac-induced worsening of their [5] condition.

[6] Q: What about the possibility of their own [7] depression worsening separate and apart from the [8] drug?

[9] A: It's a possibility. But in general with [10] these patients that I have been treating I know how [11] their illness fluctuates, and what I am looking for [12] that would make me believe that it's drug-induced [13] worsening or exacerbation is a change in degree or [14] direction that would be outside of the scope of [15] what we had previously observed.

[16] Q: Doctor, it is generally agreed, isn't it, [17] that only 70 percent of depressed patients who use [18] Prozac will have a therapeutic response. Is that [19] correct?

[20] A: Somewheres between 50 and 70, yes.

[21] Q: And that is true for other SSRIs as well, [22] isn't it?

[23] A: Correct.

[24] Q: Generally true for antidepressants, isn't

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[1] it?

[2] A: Yes.

[3] Q: So that there is according to you [4] somewhere between 30 and 50 percent of patients who [5] use antidepressants who will not benefit [6] therapeutically. Right?

[7] A: Right.

[8] Q: And their depression may in fact worsen [9] during that time because it is untreated. Right?

[10] A: Right. There are patients whose [11] depression stays the same; there are patients who [12] have a partial but rather unsatisfactory response; [13] and there are patients whose depression clearly [14] gets much worse.

[15] Q: So of 30 to 50 percent who are [16] nonresponders to, say, Prozac, is it your position [17] that they are all suffering adverse effects from [18] the drug?

[19] A: No.

Q: So what is it that you use to define who [21] is simply not a responder to the drug who may in [22] fact have their depression causing a deterioration [23] of their well-being and those who are suffering [24] adverse effects from the drug?

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[1] A: That is based on knowing the patient [2] well, knowing the course of their illness, knowing [3] the way their symptoms present, and then seeing how [4] they respond to the medication.

[5] For instance, take a patient with a [6] classic psychomotor-retarded anergic hyperphagic [7] depression. This is a patient who sleeps [8] excessively, usually has carbohydrate cravings, has [9] increased appetite, is gaining weight, has no [10] energy. And time and time again when they are [11] depressed, this is the way they manifest. You put [12] them on Prozac, they become agitated, they become [13] restless, they have insomnia; they lose their [14] appetite and they start losing weight. It's not [15] their depression, it's the drug. Their depression [16] has never been like that, never will be like that. [17] Stop the medication, they go back to being [18] hypersomnolent, psychomotor-retarded and [19] hyperphagic.

[20] Those are drug-induced side effects. [21] If you know your patients well, you can distinguish [22] them.

[23] Q: Now, sir, can you tell in advance of [24] prescribing Prozac for a depressed patient who is

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[1] going to be at risk for the problem that you have [2] described in your 1990 article of obsessive [3] preoccupation with suicidality?

[4] A: Not with any degree of certainty. There [5] are some factors that we identified as perhaps [6] related.

[7] Q: Possibilities?

[8] A: Yes.

[9] Q: These are your best speculations about [10] who might be at risk?

[11] A: Yes.

[12] Q: Doctor, is it your opinion that every [13] depressed patient who commits suicide while taking [14] Prozac has done so because of Prozac?

[15] A: No.

[16] Q: So there is some subset of people in your [17] view who take Prozac who go on to attempt or commit [18] suicide who are induced to do so by the drug, and [19] you cannot tell who those people are in advance of [20] their taking Prozac with any certainty?

[21] A: That's a complicated question. I think [22] if I understood it you were asking if there's a [23] group of patients who go on to commit suicide who [24] have taken Prozac and who I would believe Prozac

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[1] was responsible for the suicide who I could not [2] tell in advance before they started Prozac?

[3] Q: Yes.

[4] A: Yes.

[5] Q: It is generally accepted in psychiatric [6] circles, isn't it, that you can have a worsening of [7] depression while on antidepressant medication that [8] is unrelated to the antidepressant medication, [9] isn't it?

[10] A: Yes.

[11] Q: And turning to Michael Rosenbloom for a [12] moment, would you have expected him to show any [13] therapeutic response within five or six days on [14] medication?

[15] A: Not generally, no.

[16] Q: What is the evidence that you are relying [17] upon that Michael Rosenbloom in fact took five or [18] six days' worth of medication?

[19] A: The evidence was that I guess there were [20] five or six pills absent from the pill bottle; that [21] he indicated that he was going to take the [22] medication; that he told his doctor he would, he [23] told his wife that he would; and he seemed to be an [24] honest fellow.

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[1] Q: Dr. Teicher, what is your opinion as to [2] the deficiencies in Lilly's package labeling at the [3] time that Michael Rosenbloom was prescribed Prozac [4] in June of 1990?

[5] A: The first is, there should have been a [6] warning indicating that patients on the medication [7] may respond poorly and be at increased risk for [8] suicide attempts or development of suicidal [9] ideation. That there also should have been an [10] indication that 20 milligrams may be too large of [11] an initial dose for patients with significant [12] anxiety. And there should have been a warning that [13] the medication can produce agitation and [14] restlessness that may worsen the patient's clinical [15] condition and that in those cases they should [16] either discontinue the medication or use a sedative [17] along with Prozac.

[18] Q: Do you prescribe a sedative to patients [19] for whom you prescribe Prozac?

[20] A: If they experience any agitation or [21] restlessness or insomnia, yes.

[22] Q: So you would agree, I take it, based on [23] what you just described, that Michael Rosenbloom at [24] the time that he was first prescribed Prozac had

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significant anxiety?

A: Yes.

Q: Would you agree with me that that anxiety was caused by life stressors as we've referred to them?

A: It's hard to know what caused them. He certainly had anxiety and he certainly had life stressors.

Q: Well, let me withdraw the question, because it well could be that his depression caused his anxiety as well. Correct?

A: Right.

Q: Not just the stressors that he was experiencing?

A: Right.

Q: It's hard to know which. Or maybe both, right?

A: Yes.

Q: Okay. In the patients that you treated and reported on in your 1990 article, sir, you had them at doses way above 20 milligrams, didn't you?

A: Absolutely, yes.

Q: In fact, they were as high as 80 milligrams?

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A: Yes. There were some that were 20 to 40 and there were definitely some that went to 80.

Q: And you kept increasing their dose even though you were not seeing any therapeutic response?

A: Yes.

Q: Do you regret doing that?

A: Yes.

Q: Do you think it was a mistake to do that?

A: Yes.

Q: Doctor, after you reviewed the clinical records that you've described, you made I take it notes that were sort of the draft of your case reports?

A: Yes.

Q: Have you produced those notes to us?

A: You received those notes, yes.

MR. GREENWALD: Shall we take a short break?

MS. GUSSACK: Sure, if you'd like to.

(In recess 3:25 p.m. to 3:34 p.m.)

BY MS. GUSSACK:

Q: Doctor, turning to paragraph 8 of Exhibit 17, the affidavit, are there any documents that

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reflect the discussions and consent provided to you by your patients in reporting on them in your article?

A: No, they did not sign anything.

Q: Would the discussions that you had with them about reporting on them in your 1990 article be part of your process notes?

A: Possibly. Probably not. As I indicated with my process notes, they're verbatim descriptions or near-verbatim descriptions of what the patient says. I can take notes and listen but I can't take notes and talk, so anything that I've said to the patient there tends to be not much in the way of notation, nearly nothing.

Q: Do you have any medication charts for any of the patients reported on in the 1990 article?

A: I can't say with certainty. It's likely on some of the cases that I have one sheet of paper in the chart that would list medications and list when it was tried and the response they had, and I have it on a number of my patients. Whether I specifically have it on these I am not entirely sure.

Q: But somewhere you maintain a list of all

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the medications that the patients have been on over periods of time?

A: For a patient I have been seeing long- term who's been on multiple drugs I will often at some point review their chart and prepare such a list. Sometimes it is a separate list. Sometimes it is in the middle of a process note. If I've done it myself, if I've gone through the chart, it is usually on a separate sheet. If I am doing it with the patient, the patient has a good memory and we're working together on it, it would generally be in the process note.

Q: But as you prescribe medications for patients you make note of them in your process notes?

A: Yes.

Q: You don't keep a separate medication chart?

A: No.

Q: Now, sir, is it fair to say that you have provided all of the relevant information on these patients – and when I say these patients I guess for these purposes I'm talking about 2, 4, 5 and 6. Right?

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A: Yes.

Q: – from the patient's history and information reported to you and all of the information contained in your clinical records?

A: Yes.

Q: In evaluating the patients and summarizing them I think you told me you strove to be extremely accurate. But my question is: In evaluating what you believed you were observing in the patients, did you also consider the psychosocial stressors that they were experiencing as a possible explanation for their suicidality?

A: Yes.

Q: And it is true, sir, that the article refers to the emergence of intense suicidal preoccupation as a result of fluoxetine, not suicidal acts. Correct?

A: Correct.

Q: So you observed or learned of this intense suicidal ideation from the patients themselves?

A: Yes.

Q: Now, sir, how did you learn of it? Did the patients tell you?

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A: Eventually.

Q: What do you mean, "eventually"?

A: The patients did not, at least the patients that we're talking about, 2, 4, 5 and 6, the patients did not right away indicate that this was occurring as soon as it started. There was a lag. And -

Q: In all four of the patients?

A: Particularly true for patients 4 and 5.

Q: It is likely true that there was a lag time in between when they experienced this intense suicidal ideation and when they told you about it?

A: Yes.

Q: In patients 2 and 6, did they tell you as they were experiencing it?

A: Pretty much.

Q: And did their family members describe it to you at or around the time they were experiencing it?

A: Case 2 I think was living alone and did not have family members. Although he wasn't living with a family member but his elderly mother did call; she had become very concerned just from a phone conversation or a visit. And family members

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were aware in case 6.

Q: Now, were they aware from observing the patient, sir?

A: Yes.

Q: Both in patients 2 and 6?

A: Yes.

Q: Because this obsessive rumination that you described you say was intrusive, I take it that means it was evident in their thought or conduct?

A: No. But by intrusive psy-

chiatrically[11] I mean that the thought comes into your head even [12] though it is uninvited, you don't want it, you [13] might try to push it away; that it intrudes on your [14] consciousness.

[15] Q: Depressed patients do ruminate [16] obsessively about negative thoughts, don't they?

[17] A: Yeah, but there's a very big difference. [18] There is a difference between a rumination and an [19] obsessive thought. You ruminate about something [20] generally because you want to think about it. [21] You're depressed and you're bothered by what [22] happened at work and you can't get it out of your [23] mind and you're thinking about it and thinking [24] about it and rehashing it and thinking what you

[1] should have said, and it's an active, conscious [2] process. An intrusive thought is not something [3] you're ruminating about. It's a thought, bang, [4] makes itself felt, makes itself noticed. It's [5] present and you're not necessarily striving to [6] ruminate.

[7] Patients can have both, but I would [8] not use the word "ruminating" and "intrusive" [9] interchangeably.

[10] Q: None of the patients you report on had a [11] therapeutic response to fluoxetine. Correct?

[12] A: Right.

[13] Q: And you have not observed this obsessive [14] suicidal ideation in anybody who was in fact [15] therapeutically benefiting from the drug?

[16] A: I have not.

[17] Q: Other than these six patients, [18] I understand you have collected reports as you [19] described in your McLean slides of some other [20] patients that were reported to you either by a [21] patient or a family member or a colleague?

[22] A: Correct.

[23] Q: How many such reports do you have, sir? [24] (Pause) Some of them came from plaintiffs' lawyers

[1] too. Right?

[2] A: Right. I would be hard-pressed to say. [3] A lot of them were colleagues talking to me either [4] over the phone or at meetings, and for a period of [5] time I was pretty inundated with people discussing [6] cases with me. There may have been fifty or sixty [7] but I didn't take notes on the vast majority of [8] them so I have relatively little recollection for [9] them.

[10] Q: Well, sir, didn't you testify at some [11] point that you were collecting case [12] reports for a [12] databank to be used in litigation?

[13] MR. GREENWALD: Objection. Are you [14] talking about here in this deposition?

[15] MS. GUSSACK: No, not today.

[16] BY MS. GUSSACK:

[17] Q: Previously haven't you testified that you [18] were collecting cases?

[19] A: For a databank to be used in litigation? [20] Not to my knowledge. If you can find it, I never [21] had that intention. I mean, for a period of time [22] I was collecting cases to understand the [23] phenomenon. I was trying to better get an idea of [24] what patients were at risk, what factors were

[1] involved, but never for the purpose of litigation.

[2] Q: Patient number 3 was not Dr. Cole's [3] patient although he was responsible for –

[4] A: It was a request to Dr. Cole for [5] consultation on the patient and evaluation.

[6] Q: Okay. Did you ever discuss with the [7] physician who was responsible for patient number 3 [8] your view that their increased suicidal ideation [9] was attributable to Prozac?

[10] A: I personally did not. I believe Dr. Cole [11] did, but I did not.

[12] Q: Have you ever discussed with physicians [13] who saw the patients whom you reported on their [14] view that these patients had not had a response to [15] Prozac?

[16] MR. GREENWALD: Objection.

[17] BY MS. GUSSACK:

[18] Q: Do you understand my question?

[19] A: No.

[20] MR. GREENWALD: I think it is a [21] little convoluted.

[22] BY MS. GUSSACK:

[23] Q: Patients 2, 4, 5 and 6 have been seen by [24] other psychiatrists on occasion, haven't they?

[1] A: Yes.

[2] Q: Have any of the psychiatrists who have [3] ever treated patients 2, 4, 5 or 6 ever told you [4] that they disagree with your view that those [5] patients experienced an intensified suicidal [6] ideation as a result of taking Prozac?

[7] A: Not specifically, no.

[8] Q: Now, sir, you have acknowledged in [9] I guess a follow-up letter to the editor that five [10] of your six patients had limbic system neurologic [11] abnormalities. Correct?

[12] A: Yes.

[13] Q: What efforts if any did you make to rule [14] out the role of limbic system abnormalities as an [15] explanation for the effect you thought you were [16] seeing attributable to Prozac?

[17] A: The hypothesis that we rendered was that [18] it may have been an interaction between Prozac and [19] the limbic system abnormalities. It wasn't the [20] limbic system abnormalities per se as the sole [21] cause. We never postulated that. We were [22] suggesting they might have a special vulnerability [23] to the drug.

[24] Q: How many depressed patients have limbic

[1] system abnormalities?

[2] A: Nobody knows.

[3] Q: Anybody's guess?

[4] A: I have no idea.

[5] Q: So is it your hypothesis as a result of [6] your 1990 article that those patients with limbic [7] system abnormalities may have a heightened [8] susceptibility to the effects of Prozac?

[9] A: It is one of the possibilities that we [10] raised in the letter to the editor. Or in the [11] response to the letter to the editor.

[12] Q: One possible explanation for what you [13] were observing in your six patients?

[14] A: Yes.

[15] Q: Do you know whether Mr. Rosenbloom had [16] any abnormal EEGs?

[17] A: I have no information on it.

[18] Q: You don't know whether he had any limbic [19] system disorder?

[20] A: As far as I know there was no evaluation [21] made.

[22] Q: Did you look at the cerebral spinal fluid [23] of any of your six patients to determine if they [24] were serotonergically atypical?

[1] A: No, I did not.

[2] Q: Doctor, in arriving at your incidence [3] rate you compared your six patients against I think [4] 170 patients seen at McLean who had been treated [5] with Prozac. Is that right?

[6] A: I compared the six outpatients that [7] Dr. Cole and I together had seen who we believed [8] developed obsessive preoccupation with suicide [9] while on Prozac with the denominator of the number [10] of outpatients that Dr. Cole and I together had [11] treated with Prozac.

[12] Q: Where did you get the information on [13] those 170 patients? How did you put together [14] whether they had

been -

A: I counted the patients that I treated and I asked Dr. Cole to count the number of patients that he treated.

Q: And what did you look to to determine the evidence of prescription of fluoxetine for those patients?

A: Records that it had been prescribed.

Q: Would those be in your process notes?

A: Yes.

Q: Did you personally look at Dr. Cole's

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records?

A: No. No.

Q: He contributed his number?

A: Yes.

Q: So this isn't truly an incidence rate, would you say?

A: Sure it is.

Q: Why? Epidemiologically how do you define an incidence rate, sir?

MR. GREENWALD: Wait a minute. We have two questions pending. Which question are you asking?

BY MS. GUSSACK:

Q: Epidemiologically how do you define an incidence rate? I think he already answered the earlier question.

A: The number of cases observed at a particular point in time.

Q: Over a defined period of time?

A: Yes.

Q: When you take out the phenomenon that you are looking at?

A: No. That's not the definition of incidence rate at all.

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Q: I see. And other than the six patients that you report on in the case series, there were none others that you knew of in the 170 in your denominator?

A: Right.

Q: How many of those 170 patients, were they all treatment-refractory patients?

A: No.

Q: So did you make any comparison between the six that appear in your case reports versus the type of patients that were represented by the 170?

A: No.

Q: Do you know whether they were similar?

A: Some were. Some weren't.

Q: Was Mr. Rosenbloom treatment-refractory?

A: This was his first psychotropic medication. Well, this was his first antidepressant trial. I guess he had received a little bit of Dalmane. And he did not come into the Prozac trial treatment-refractory. You may judge from his response to Prozac that he was refractory to it.

Q: He had not had a history of being treatment-refractory?

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A: Right.

Q: He was not taking any other psychotropic medications, was he, sir?

A: No.

Q: At the time he was prescribed Prozac. Right?

A: Right.

Q: Did he have any other co-morbid diagnoses other than depression at the time he was prescribed Prozac?

A: His major diagnosis was adjustment disorder with depressed and anxious mood.

Q: That was in 1984. Correct?

A: Yes. And that basically I believe was the diagnosis that Sandler was following through most of the time he treated him, and then I guess toward the end Dr. Sandler concluded he had developed a major depressive disorder.

Q: Now, sir, it is true, isn't it, that a major depressive disorder as a diagnosis would be sufficient in and of itself to explain Michael Rosenbloom's suicide?

MR. GREENWALD: Objection to the form of the question.

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A: Is that a specific question or is that a theoretical question?

Q: It is theoretical only in that I am asking you to assume that Mr. Rosenbloom did not take Prozac. Would his major depressive disorder be a sufficient explanation for his suicide?

MR. GREENWALD: Objection. I've lost you.

A: I can't answer that because I believe that if he had not taken Prozac he would not have committed suicide.

Q: And on what do you base that, sir?

A: By my clinical impression and experience he was modestly depressed; he was not severely depressed. I hardly have a patient in my current practice who is less depressed who's under active treatment. He is unlike any mild to moderate depressed patient that I've treated, because none of them have gone on to even attempt suicide. From his profile, in terms of the severity of his depression, even granted that he had substantial psychosocial stressors, I would not have in any case predicted, believed, imagined that he would have gone on to commit suicide.

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Q: Sir, can you always predict who is going to commit suicide?

A: No.

Q: Patients with mild depression commit suicide, don't they?

A: Psychiatrists are poor at predicting suicide, but you overpredict; you don't underpredict. We overpredict. So we are much more likely to think that patients will commit suicide than that they will. This would not have been a case that I believe any credible psychiatrist would have predicted would have committed suicide and I do not believe this kind of case goes on to commit suicide.

Q: Patients with mild depression commit suicide, don't they, sir?

A: Patients without depression commit suicide.

Q: Well, let's answer my questions before we get to your comments. Do patients with mild depression commit suicide?

MR. GREENWALD: Objection. He has a right to explain his answer.

MS. GUSSACK: No, there wasn't an

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answer. That's my concern.

BY MS. GUSSACK:

Q: Do patients with mild depression commit suicide, sir?

A: Not due to the depression.

Q: Excuse me?

A: Not due to the depression.

Q: And what is it that you rely on to make that statement?

A: My clinical experience.

Q: Do you have any data to support that, any published literature that you are referring to?

A: The published literature on suicide and depression indicates that the vast majority of patients who have committed suicide with depression had had multiple episodes, had been treatment- refractory, had not done well on an antidepressant, and in many instances had concomitant substance abuse. I am not aware of any case descriptions of mildly depressed patients going on to commit suicide.

Q: That describes your patient pop-

ulation,[23] doesn't it, sir, multiple histories of suicidal [24] attempts or history of depression, alcohol or

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[1] substance abuse? What you just described that [2] describes the patients you treat?

[3] A: A number of the patients I treat, yes.

[4] Q: Treatment-refractory, difficult, complex [5] patients. Right?

[6] A: I also treat some pretty healthy, high- [7] functioning multimillion dollar executives who [8] aren't like that.

[9] Q: Is financial success insurance against [10] suffering from depression?

[11] A: No, no, no, not at all. I was saying if [12] you are functioning at a very high level you are [13] generally not terribly depressed. By the time that [14] your depression is really severe a lot of patients [15] are unable to work, they're disabled.

[16] Q: Was Mr. Rosenbloom functioning very well, [17] sir?

[18] A: He had been functioning at a high level [19] through most of his life. He had been quite [20] accomplished. And from what I understand he was [21] doing reasonably well until shortly before his [22] death.

[23] Q: Let's talk about the two or three or four [24] months before – What about the year that his

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[1] secretary said that he was depressed for? You are [2] familiar with that testimony now, aren't you, sir?

[3] A: I read her testimony.

[4] Q: Since you submitted your expert report in [5] this case you've read it?

[6] A: Yes.

[7] Q: In the past two weeks you've read it?

[8] A: Right.

[9] Q: She said he was depressed for a year [10] prior to his death. Right?

[11] A: You will have to show me that part.

[12] Q: You don't recall the part where she says [13] Michael told me that he had been depressed for a [14] year? Because it is in your notes on Gale [15] Stieler's transcript.

[16] A: I would like to see it again.

[17] Q: Sure. In the several months before he [18] committed suicide, sir, it is your opinion that [19] Michael Rosenbloom was functioning at a high level?

[20] A: I think he was productive; he was [21] working. I think he was not as [22] productive as he had hoped to be, but sounded like he was [23] generating lots of billable hours and doing [24] credible work from what I understand. It seemed

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[1] like toward the very end that his concentration was [2] impaired and his work efficacy had really fallen by [3] the wayside. But that was very shortly before the [4] suicide.

[5] Q: Nondepressed people commit suicide. [6] Correct?

[7] A: Yes.

[8] Q: Mildly depressed people commit suicide?

[9] A: Yes.

[10] Q: Moderately depressed people commit [11] suicide?

[12] A: Yes.

[13] Q: Patients with major depression that's [14] worsening commit suicide. Correct?

[15] A: Yes.

[16] Q: You can't predict who will commit [17] suicide, can you?

[18] MR. GREENWALD: Objection.

[19] BY MS. GUSSACK:

[20] Q: Can you, sir?

[21] A: Again, psychiatrists overpredict.

[22] Q: Can you predict who will commit suicide? [23] With reasonable medical certainty are you able to [24] predict which patients will commit suicide?

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[1] A: We can indicate which patients are at [2] high risk.

[3] Q: Yes, and we've talked about those risk [4] factors today. Right?

[5] A: So that if you're talking about [6] prediction in terms of a probabilistic statement [7] you can start attaching some probability. I've [8] seen a number of patients who were high-probability [9] suicides, and we are asked to do that. We are [10] asked in terms of filling out involuntary [11] commitment papers, to indicate that a patient is at [12] substantial risk for harming themselves or others.

[13] So it is part of the job to be able [14] to render that prediction. I think we all have to [15] acknowledge that we err on the side of caution and [16] we overpredict. But, yes, we do that as part of [17] our job.

[18] Q: Can you predict with reasonable medical [19] certainty who will commit suicide?

[20] A: Sometimes.

[21] Q: Sometimes. Not all the time, though?

[22] A: Again, we overpredict.

[23] Q: But you cannot do it all the time, can [24] you? It's a simple yes or no question.

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[1] MR. GREENWALD: You mean every single [2] time? Is that your question?

[3] MS. GUSSACK: That's my question.

[4] BY MS. GUSSACK:

[5] Q: Every single time, sir?

[6] A: No, we can't do it all the time. We [7] can't do it with a hundred percent accuracy.

[8] Q: And I take it you've been surprised on [9] occasion in your own experience hearing about [10] patients of yours or others who have gone on to [11] commit suicide that you didn't expect to?

[12] MR. GREENWALD: Objection.

[13] A: In my own practice? No.

[14] Q: In others' that you've heard about?

[15] MR. GREENWALD: I am going to object [16] to the question.

[17] BY MS. GUSSACK:

[18] Q: Doctor, unless you're about to tell me [19] that you are a soothsayer, I am having a hard time [20] figuring out how you are the only person so far [21] I've heard say that they are able to predict with [22] certainty who is going to commit suicide and you [23] never get surprised. So my question is –

[24] MR. GREENWALD: Objection. He never

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[1] said that.

[2] MS. GUSSACK: I didn't say he did say [3] that. I said unless he's about to tell me that, my [4] question is:

[5] BY MS. GUSSACK:

[6] Q: Aren't you surprised and aren't you aware [7] that there are psychiatrists who are surprised by [8] patients who commit suicide because you are not [9] able to predict with certainty in advance who will [10] and who won't?

[11] MR. GREENWALD: Objection.

[12] A: And I am trying to explain to you that [13] the situation is not the way you perceive it. The [14] situation is that we are definitely not a hundred [15] percent accurate when it comes to predicting [16] suicide. But we overestimate. So we estimate that [17] patients A, B and C are at risk for committing [18] suicide, and patients A, B and C don't commit [19] suicide.

[20] Q: You're talking in populations generally?

[21] A: Right. So that we are basically saying [22] that we might identify fifty patients at risk for [23] committing suicide when only three of them may [24] commit suicide. But we identified the three

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[1] patients who are likely to commit suicide. We just [2] identified a whole lot more that never went on to [3] commit suicide.

[4] Q: Let me refer you to page 31 of the [5] deposition of Gale Stieler in which the question [6] was:

[7] "So approximately a year before he [8] died he told you he was depressed?

[9] "Answer: It would have been at least [10] a year. I don't remember an exact date."

[11] Do you remember that testimony, sir?

[12] MR. GREENWALD: Hold on. I am going [13] to object to the question. Your question that this [14] was predicated on was that he told her he'd been [15] depressed for a year. That's what you asked. That [16] is not what the question says. The question that [17] I believe you read says that he told her over a [18] year ago he was depressed. Unless I'm misreading [19] it. It doesn't indicate that he said he was [20] depressed for a year.

[21] BY MS. GUSSACK:

[22] Q: Doctor, you see the question on page 31? [23] Or is it page 34?

[24] A: I do. "So approximately a year before he

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[1] died he told you he was depressed?

[2] "It would have been at least a [3] year. I don't remember."

[4] Which I guess is the point that [5] Attorney Greenwald is making, that she said that he [6] was depressed a year before he died, at least a [7] year before he died.

[8] Q: And, sir, are you familiar with –

[9] MR. GREENWALD: Excuse me. Can [10] I just ask you one question? Somewhere on this [11] table was a copy of her deposition.

[12] MS. GUSSACK: Whose deposition?

[13] MR. GREENWALD: Gale Stieler's.

[14] A: And if I recall the deposition, I think [15] it's important to make clear that she distinguished [16] between what one would say was clinically depressed [17] versus what one would say was depressed in their [18] language. So I think that we have to be very [19] careful as to how we're using the term.

[20] Q: Page 34:

[21] "Question: So it was a depression [22] that had gone on for a year as far as you were [23] concerned?

[24] "Answer: Yes."

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[1] MR. GREENWALD: I'm sorry. I just [2] found it. Can I just follow you?

[3] MS. GUSSACK: Page 34, lines 2, 3, 4.

[4] A: I remember that. I also remember that [5] she was couching it, I thought it was her [6] deposition, that she was couching it that this was [7] lay terminology for depression, meaning the patient [8] was sad. Doesn't mean the patient was clinically [9] depressed.

[10] Q: Well, sir, is Joan Greer a psychiatrist?

[11] A: No.

[12] Q: But you have relied on her testimony for [13] information about Mr. Rosenbloom, haven't you?

[14] A: I did not rely on her diagnosis.

[15] Q: I didn't ask if you're relying on her [16] diagnosis or anyone else's. I'm not asking you [17] about a diagnosis; I'm asking you about a [18] description. Are you familiar with the testimony [19] by Gale Stieler in which she says Mr. Rosenbloom [20] was depressed for a year prior to his death?

[21] A: Yes.

[22] Q: Now, you are familiar with Joan Greer's [23] testimony, aren't you, in which she described how [24] her husband was not functioning very well? Aren't

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[1] you?

[2] A: Yes.

[3] Q: He wasn't able to concentrate at work? [4] Right?

[5] A: I didn't think that Joan testified about [6] his capacity at work.

[7] MR. GREENWALD: Can you refer me to [8] where you're talking about?

[9] BY MS. GUSSACK:

[10] Q: Do you recall her testimony where she [11] said he didn't have any energy, he felt lethargic, [12] he felt burnt out, weary?

[13] A: Right. But I didn't think she was [14] observing him at work.

[15] Q: What about Dr. Sandler's records and [16] description of how Mr. Rosenbloom was functioning [17] professionally? Was that significant to you? Was [18] that somebody you could rely on?

[19] A: Yes.

[20] Q: So his notes observing a patient that he [21] had seen for six years are valuable to you, aren't [22] they?

[23] A: Yes.

[24] Q: You never saw Mr. Rosenbloom, did you?

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[1] A: No.

[2] Q: And Dr. Sandler is a psychiatrist, [3] Right?

[4] A: Yes.

[5] Q: So he is competent to offer these [6] impressions and diagnoses of the individual?

[7] A: Yes, certainly.

[8] Q: So when he says "multiple crises [9] emerging, depression worsening," and [10] I'm referring to his entries of April 1990, May 1990 and June [11] 1991, you are familiar with those?

[12] A: Yes. Those are the ones I agree is [13] when he was depressed.

[14] Q: And major depression. Correct?

[15] A: Yes.

[16] Q: Not mild depression?

[17] A: As far as it was mild major depression.

[18] Q: I see. And you are familiar with his [19] notations of suicide feelings which you have [20] previously described. Now, sir, when you wrote [21] your report on January 5, 1996, you had at that [22] time – in this case, right?

[23] A: Yes.

[24] Q: You at that time had reviewed

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[1] Dr. Sandler's records?

[2] A: Yes.

[3] Q: The police report?

[4] A: Yes.

[5] Q: You had had a conversation with [6] Dr. Sandler about the patient?

[7] A: Yes.

[8] Q: And had read the transcripts of [9] Mr. Rosenbloom's first wife, her husband, and his [10] adult son Seth. Right?

[11] A: I believe so, yes.

[12] Q: You did not have Joan Greer's deposition [13] testimony?

[14] A: I do not think so, no.

[15] MR. GREENWALD: I am going to object. [16] He testified that he talked with her on the [17] telephone.

[18] THE WITNESS: I did talk with her.

[19] BY MS. GUSSACK:

[20] Q: And you've told us what she described to [21] you.

[22] A: Yes.

[23] Q: And – Andy, you had asked for the [24] citation – page 163 of Joan Greer's testimony

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[1] where she says, quote, "He was having a hard time [2] focusing on his work." Does that refresh your [3] recollection, sir?

[4] A: Can I see it in context?

[5] MR. GREENWALD: We don't know that he [6] has a problem with his recollection.

[7] MS. GUSSACK: Well, I think he said [8]

he didn't recall.

MR. GREENWALD: Page 163?

MS. GUSSACK: Yes.

MR. GREENWALD: All right, give me a minute.

BY MS. GUSSACK:

Q: You see where he was having a hard time focusing on his work, he felt very tired and burnt out? That's the context.

A: Yes. I see that, and I think it is useful to put it in its appropriate context.

MR. GREENWALD: I would also just like the record to reflect that this deposition was taken subsequent to the report.

MS. GUSSACK: Thank you. That's exactly right.

BY MS. GUSSACK:

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Q: So, sir, at the time that you issued your report you did not have the information that is contained in Joan Greer's deposition testimony taken after the date of your report. Right?

A: Correct.

Q: And you had not reviewed at the time that you wrote your report Ken Keane's deposition testimony. Correct?

A: Correct.

Q: Have you since read it?

A: Yes.

Q: Barry Ruden's deposition testimony, had you read that before you issued your report? I mean Paul Ruden.

A: I did not read that before I issued my report now.

Q: Have you read it now?

A: No.

Q: Barry Friedman's deposition, had you read that before you wrote your report?

MR. GREENWALD: Objection. Counsel, you know that none of those depositions were taken prior to that time.

BY MS. GUSSACK:

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Q: Prior to your report you did not have the benefit of Barry Friedman's deposition testimony. Right?

A: Right.

MR. GREENWALD: Objection. It wasn't taken.

BY MS. GUSSACK:

Q: Have you read it since?

A: No.

Q: And Ms. Stieler's deposition transcript you've just read in the past two weeks. Right?

A: Yes.

Q: Is it in the past month from plaintiff's counsel or through reading the deposition testimony that you learned about the additional substantial psychosocial stressors that Mr. Rosenbloom was experiencing prior to his death?

MR. GREENWALD: Objection. What substantial stressors are you referring to in your question?

BY MS. GUSSACK:

Q: Can you answer, Dr. Teicher?

A: A lot of them were enumerated in Dr. Sandler's notes and they were enumerated to me

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in Dr. Sandler's phone conversation, so I wasn't surprised by those psychosocial stressors.

Q: You were surprised by the fact that his former business partners were telling him that he was going to be responsible for the hundred- thousand-dollar deductible on the insurance covering the malpractice claim. Right?

MR. GREENWALD: Objection.

BY MS. GUSSACK:

Q: That was news to you since you wrote your report?

A: Yes.

Q: And you –

A: Well, actually, I'm not certain about that. Because I think Mr. Pavsner provided information that that was also a problem.

Q: At the time that you wrote your report?

A: I'm sort of recalling that.

MR. GREENWALD: Doctor, you can look at your notes if you would like to.

MS. GUSSACK: Sure.

BY MS. GUSSACK:

Q: Would it be helpful to look at your notes?

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A: I don't think it would tell me.

MR. GREENWALD: You can look at Dr. Sandler's notes.

MS. GUSSACK: I don't believe that's in Dr. Sandler's notes.

MR. GREENWALD: I think there is a separate exhibit, Doctor, that was marked, your notes from Dr. Sandler's notes. Isn't that right?

MS. GUSSACK: 12-A through F.

MR. GREENWALD: That's 12-A through E. They're handwritten and they should be on the table someplace.

(Discussion off the record.)

BY MS. GUSSACK:

Q: Doctor, on review of Dr. Sandler's records which are before you, is there some reference that you wanted to point to about knowledge about this meeting in which Mr. Rosenbloom's former partners told him that he was on the hook for a hundred-thousand-dollar deductible for the insurance?

A: It is not in his notes. What I'm saying is, I don't have a detailed record or any record of –

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MR. GREENWALD: Wait a minute. Wait a minute. I think I found them. Aha! They were stuck in this pile of stuff that's here on the table. I'm going to put all these in the center of the table. Okay? These are the marked exhibits that I have found here.

THE WITNESS: And do you have the note that I had from the phone conversation with Sandler?

MS. CRAWFORD: It should be number 8.

MR. GREENWALD: I have the exhibits here now. That was an exhibit, I believe.

(Pause)

MS. CRAWFORD: Number 9.

(Pause)

BY MS. GUSSACK:

Q: You have Exhibit 9 before you, Doctor, your notes of your conversation with Dr. Sandler. Is there something you wanted to point to there?

A: No.

Q: So there is no reference in either your notes Exhibit 9 or in Dr. Sandler's notes of treatment that refers to that –

A: Hundred-thousand deductible that they

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were asking –

Q: The deductible under the insurance coverage for the malpractice claim?

A: Yes.

Q: Now, Doctor, have the synopses, the detailed synopses that you refer to in your affidavit, been checked against the source material for patients 2, 4, 5 and 6?

A: They were derived from the source material.

Q: And verified for accuracy?

A: The way they were derived was –

Let me [13] get this straight. For the four patients that were [14] in my practice we derived them in two ways. The [15] first was that I had my clinical impressions, which [16] I put down, and then Carol Glod, my associate, went [17] through the chart and independently got charts for [18] those four patients, all the data on dates, so that [19] the source was double-checked in terms of this time [20] between the start of that medication, this time and [21] that, and when there was any question we went over [22] it together and looked at prescriptions and looked [23] at all of these things to get the time course for [24] when symptoms emerged and things like that.

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[1] MS. GUSSACK: Exhibit No. 18.

[2] MR. GREENWALD: What is it?

[3] MS. GUSSACK: It is Dr. Teicher's [4] drafts of case reports responsive to paragraph 17 [5] of the subpoena served upon him.

[6] (Teicher Deposition Exhibit 18 marked [7] for identification.)

[8] BY MS. GUSSACK:

[9] Q: Doctor, so am I right this is your [10] collection of the drafts of the case reports that [11] you produced in response to paragraph 17 of the [12] subpoena that was served upon you by Lilly. [13] Correct?

[14] A: Yes.

[15] Q: These represent the write-ups of the [16] patients that you reported on in your 1990 article?

[17] A: Yes.

[18] Q: Turning to Teicher 18, for instance, page [19] 648, there are handwritten notations there, sir, on [20] a document that has your name typed at the top. [21] Are those handwritten notations Carol Glod's?

[22] A: Yes. I would believe so. Yes, they must [23] be.

[24] Q: And as you look through the first ten or

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[1] so pages where you see additional handwritten [2] notations both in chart form and in narrative form, [3] would those notations also be from Carol Glod?

[4] A: Yes.

[5] Q: So that is part of the process that you [6] were just describing in which she took notes which [7] you worked with –

[8] A: She went over the charts and made sure [9] all the dates were accurate.

[10] Q: And then the written materials, sir, the [11] typed material, starting at page 656 throughout, [12] for instance, is that your work product, sir?

[13] A: Some of it is hers. For instance, case [14] 3, if I recall – where's the article? -- case 3 [15] was the hospitalized case in which she reviewed the [16] records, so these are her notes.

[17] Q: So if it was with respect to case number [18] 1 or case number 3, the typewritten entries would [19] have been of Carol Glod's authorship?

[20] A: Yes.

[21] Q: And if they refer to patients 2, 4, 5 and [22] 6, the typewritten portions are yours?

[23] A: Probably.

[24] Q: Well, sir, if they are not yours, whose

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[1] would they be?

[2] A: They are largely mine, but there may be [3] sentences, paragraphs, lines in here that Carol put [4] on.

[5] Q: And to the extent that patient numbers [6] have been put in next to these entries, they are [7] your attempt to correlate these descriptions with [8] the patient numbers reported on the 1990 article?

[9] A: Yes.

[10] Q: And they are accurately identified in [11] here, in Teicher 18?

[12] A: I believe so. I think Carol wrote them [13] in.

[14] Q: Excuse me?

[15] A: Carol wrote them in. I imagine she's [16] accurate.

[17] Q: So everywhere we see a handwritten case [18] number we can assume that it refers to that patient [19] number in your 1990 article?

[20] A: Yes, that's true.

[21] Q: And as you've told us before, if it says [22] patient number 7 not included, that's the patient [23] that was not included in your 1990 article?

[24] A: Correct.

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[1] Q: Referring to Exhibit 10, Doctor, your [2] 1990 article, on page 209 you state that no patient [3] was actively suicidal at the time fluoxetine [4] treatment began. Is that correct?

[5] A: Yes.

[6] Q: And from your testimony today [7] I understand that now to mean that none of these [8] patients had any actual plan or intent or present [9] concerns about suicide. Right?

[10] A: No. What it meant was that at the time [11] that they were started on medication, at that [12] moment the patient did not have an active intent to [13] die at that time.

[14] Q: Well, sir, would it have been significant [15] if they had had that active intent to die the day [16] before they were started on medication?

[17] A: Sure, that would be significant.

[18] Q: And that would be something you [19] would report. Right?

[20] A: I believe so, yes.

[21] Q: And if it was within a week or two [22] weeks that they had been actively suicidal, you would [23] have reported that?

[24] A: Certainly within a week. And I would

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[1] have tried to have given a clear and accurate [2] impression of what their suicidal status was prior [3] to starting medication and in the relevant period [4] before.

[5] Q: Is it your opinion that Prozac induces [6] suicidal thought where none exists at the time that [7] the drug is administered?

[8] A: I actually clarified that in one of the [9] letters to the editor, one of the responses to the [10] letters to the editor. Are you familiar with that [11] one?

[12] Q: What is your clarification?

[13] A: The clarification was that fluoxetine did [14] not in our opinion cause the thought to spring out [15] of whole air; that patients, particularly depressed [16] patients but sometimes even non-depressed patients, [17] have random fleeting thoughts of suicide; and that [18] on Prozac, what we believe happened is that these [19] fleeting, not terribly consequential thoughts of [20] suicide could become obsessions. They could [21] ruminate about them. They could become more [22] intrusive. So that what it did was, it took a sort [23] of low-level event and made it a high-intensity [24] event.

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[1] Q: Is that letter to the editor the same one [2] in which you said that you don't believe there is a [3] direct link between Prozac and akathisia and [4] suicidality?

[5] A: I would have to read it.

[6] Q: Do you remember saying that in a letter [7] to the editor?

[8] A: I don't think it was so straightforward [9] as that. What I recall was that –

[10] MR. GREENWALD: Let me object and say [11] that if you have it, Nina, why don't you show it to [12] Dr. Teicher and then we can talk about the exact [13] language and what it means rather than everybody [14] trying to guess what it says.

[15] BY MS. GUSSACK:

[16] Q: Sir, do you recall stating "We do not [17] believe that there is a direct

causal relation [18] between this change in motor tension and the [19] emergence of suicidal thoughts or impulses"?

[20] A: That was in the six patients that we [21] described. What I believe is that was a response [22] to a letter to the editor in which that was [23] suggested, and what we went on to say was that in [24] some of the cases that we had seen it did not

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[1] appear that they were suffering from akathisia. So [2] akathisia did not appear to be the entire answer. [3] That there were some patients who developed [4] obsessive preoccupation with suicide who were not [5] akathisic. So we did not say that it is a one- [6] to-one correspondence between akathisia and [7] suicidal preoccupation.

[8] Q: So akathisia is not a necessary [9] prerequisite to the phenomenon that you described [10] in your 1990 article?

[11] A: Yes, that would be correct.

[12] Q: And, sir, is it your opinion that your [13] six patients had fleeting suicidal thoughts that [14] were inconsequential at the time they started on [15] medication?

[16] A: I would have to go through each case, but [17] that's probably true.

[18] Q: And is that how you would describe [19] Michael Rosenbloom in the six weeks or so before he [20] was prescribed Prozac?

[21] A: Pretty much.

[22] Q: What is that based on, sir?

[23] A: Dr. Sandler's notes.

[24] Q: In 1990 when you prescribed Prozac for

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[1] your patients, you say in your 1990 article at page [2] 210 that "We have told them that this medication [3] does not always work, that some patients feel [4] worse, and that a few have developed suicidal [5] thoughts. They are instructed to call if they [6] develop side effects or feel worse." Is that [7] correct?

[8] A: Yes.

[9] Q: And you believe that is the kind of [10] information that Lilly should have provided [11] clinicians in the product labeling?

[12] MR. GREENWALD: Wait a second. I'm [13] going to object only for this reason. Earlier on [14] in the day you asked him the same question and [15] Dr. Teicher testified as to four things that he [16] believed were deficient with respect to the package [17] warnings.

[18] MS. GUSSACK: Excuse me, Andy?

[19] MR. GREENWALD: I am not going to [20] read them. I'm just saying he has already [21] testified to this.

[22] MS. GUSSACK: You're right, it's the [23] same subject matter, but it's a different question. [24] All right?

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[1] BY MS. GUSSACK:

[2] Q: And I am interested in whether this [3] description that you have on page 210 of the 1990 [4] article in your opinion is the kind of information [5] that Lilly should have provided clinicians in its [6] package insert.

[7] A: That's one of the things they should have [8] provided, yes.

[9] Q: And you would agree, sir, wouldn't you, [10] that what a clinician tells his patient is a matter [11] of clinical judgment by the physician?

[12] A: Correct.

[13] Q: So you recognize that the package insert [14] is not a set of requirements dictating how [15] physicians should practice medicine. Right?

[16] A: Correct.

[17] Q: I believe five out of six of the patients [18] you report on in your case series in fact called or [19] reported that they were feeling worse on [20] medication. Correct?

[21] MR. GREENWALD: Let's just take a [22] minute to let him review.

[23] (Discussion off the record.)

[24] MS. GUSSACK: Mark this as the next

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[1] exhibit, please.

[2] (Teicher Deposition Exhibit 19 marked [3] for identification.)

[4] MR. GREENWALD: Maybe you could read [5] the question back.

[6] (The reporter read back as follows:

[7] "Question: I believe five out of six [8] of the patients you report on in your case [9] series in fact called or reported that they [10] were feeling worse on medication. Correct?")

[11] A: Okay, called or reported. I was looking [12] to see how many called because I didn't think five [13] out of six called. Yes, that's true.

[14] Q: They reported they were feeling worse on [15] medication. Is that correct?

[16] A: Yes.

[17] Q: Doctor, when you first observed patients [18] 4 and 5 and their reactions to fluoxetine, did you [19] discuss with any of your colleagues what you had [20] observed with respect to Prozac?

[21] A: Yes.

[22] Q: Who did you talk to?

[23] A: Dr. Cole.

[24] Q: Is that when he contributed patient

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[1] number 1 to you?

[2] A: Yes.

[3] Q: And then how did you get 2, 3 and [4] 6? How or did that chronology occur?

[5] A: Three came later because that was a [6] consultation; Dr. Cole brought it to our attention. [7] All of the cases, 2, 4, 5 and 6, were in my [8] practice and were started on Prozac shortly after [9] the drug had become available and were in many [10] instances patients who had been on other [11] treatments. Some of those were patients whom I had [12] tapered off of monoamine oxidase inhibitors to put [13] on Prozac, so this was sort of occurring over [14] roughly the same time frame.

[15] Q: These patients that you report on were [16] complex, difficult, complicated patients, not the [17] run-of-the-mill patient that takes Prozac. Right?

[18] MR. GREENWALD: Objection. How would [19] he know who the run-of-the-mill patient is who [20] takes Prozac?

[21] BY MS. GUSSACK:

[22] Q: Sir?

[23] A: They are complicated patients and not [24] your average or typical depressed patient.

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[1] Q: Not the typical patient who takes [2] Prozac. Right?

[3] MR. GREENWALD: Objection. How would [4] he know?

[5] BY MS. GUSSACK:

[6] Q: Doctor, shall I quote you on your [7] testimony in the Ransom criminal case, where you [8] say that "The patients we reported on were the kind [9] of patients that one sees in a practice in a [10] center. These are difficult, complicated patients, [11] not the usual patient taking the medication." [12] That's an accurate quote. Right?

[13] A: Right. That was many years ago.

[14] Q: That was your quote in 1991 in the Ransom [15] criminal trial. Right?

[16] A: Right. You know, Prozac is widely used. [17] Many of the patients are complicated; many of the [18] patients aren't complicated. I would guess, but [19] it's really only a guess, that these rare, [20] complicated patients are less prevalent than the [21] more simple patients, and so the majority of [22] patients taking Prozac are going to be simpler [23] cases.

[24] Q: Doctor, you said I believe at the PDAC

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[1] hearing, didn't you, that you didn't think your [2] patients would have found their way into the Lilly [3] clinical trials?

A: Correct.

Q: Would Michael Rosenbloom have found his way into a Lilly clinical trial? Would he have satisfied the inclusion criteria?

A: Probably.

Q: Probably?

A: Yeah.

Q: Now, sir, when you prepared your draft of this report did you send it to colleagues for comment and review?

A: Yes.

Q: Who did you send it to?

A: Professor Baldessarini.

Q: Anyone else?

A: No.

Q: And did you submit it anywhere other than the American Journal of Psychiatry?

A: No.

Q: Why did you pick the American Journal of Psychiatry to submit it to?

A: It's probably the most read clinical

journal in psychiatry and they publish case report series.

Q: And not all journals do that, do they?

A: Some don't. Some do.

Q: Because it is not highly valued as a form of scientific data?

MR. GREENWALD: Objection.

A: It is valued as a form of clinical data. There are some journals that are more scientific and want more controlled trial data.

Q: Doctor, your case reports are at the bottom of the ladder of scientific validity in terms of scientific data used to assess causation, aren't they?

MR. GREENWALD: Objection.

A: At the bottom? No.

Q: When you testified under oath, sir, in the Ransom case, you said:

"The type of report as the one in the American Journal of Psychiatry is at the bottom insofar as scientific accuracy and validity. Is that correct?

"Answer: Yes."

MR. GREENWALD: I'm sorry. Could you

show him what you're reading from, please?

MS. GUSSACK: Certainly.

BY MS. GUSSACK:

Q: Was that correct?

MR. GREENWALD: Can we just wait a second until he takes a look at what you're reading from?

(Transcript handed to the deponent by Ms. Gussack.)

Q: Lines 21 to 25.

MR. GREENWALD: You may want to read the whole page, Doctor.

A: From what I understand here, and I'm not sure if I was confused about the question, we're discussing the letters to the editor. This is all a discussion about letters to the editor, and I tried to make it clear to the attorney who was questioning me that that's true for letters to the editor. My report wasn't a letter to the editor. So there is confusion about what the nature was.

At the bottom of the rung of scientific inquiry I would suggest that there are single cases that are submitted as letters to the editor, that a case report series is higher than a

single case that is a letter to the editor.

Q: A rung above the bottom rung?

A: Yes.

Q: Thank you, sir.

MR. GREENWALD: Do we have an extra copy of this if you're going to ask him questions about it?

MS. GUSSACK: No, I don't. But if I use it again, I will provide it.

MR. GREENWALD: Well, may I make a request?

BY MS. GUSSACK:

Q: Doctor, Teicher Exhibit 19 has been marked, which is Ross Baldessarini, M.D. comments responsive to item number 24 of the subpoena that was served by Lilly. Correct, sir?

A: Yes.

Q: This is the set of comments that you received from Dr. Baldessarini after you provided him with your draft article prior to submission to the American Journal of Psychiatry?

A: Yes.

Q: And that is Exhibit 19?

A: Right.

Q: And, sir, did you prepare the typed draft that you submitted to Dr. Baldessarini?

A: Yes, I think so.

Q: And this typed draft that you prepared was intended to be an accurate description of the patients you were reporting on. Correct?

A: Yes.

Q: And you sent it to Dr. Baldessarini shortly before you submitted it to the American Journal of Psychiatry. Correct?

A: Yes.

Q: So it was almost a final draft?

MR. GREENWALD: Objection.

BY MS. GUSSACK:

Q: Isn't that right?

A: I would – I'm not sure how far along in the process it was. But temporally it was short. I guess they received it January 17 and I sent it to Professor Baldessarini on approximately December 14, so it was about a month.

Q: What is Dr. Baldessarini's area of expertise?

A: He is an expert on psychopharmacology and depression.

Q: And you were interested in his views on the article?

A: Yes.

Q: Was there a particular area of interest that you wanted his input on?

A: No. I value all his opinions.

Q: Did you have a conversation with Dr. Baldessarini before you sent it to him about the article?

A: Yes, I did.

Q: What did you tell him?

A: I don't have a specific recollection. I imagine I told him that I had --

MR. GREENWALD: Objection. Don't guess. If you know what you told him, that's what she wants to know, but she doesn't want you to guess.

A: I imagine I asked him if he'd read it.

Q: Did you describe to him what it was about, what the article was about that you were sending him?

A: I don't have a specific recollection of the conversation.

Q: At the time that you sent this to

Dr. Baldessarini had you made your presentation to your colleagues at McLean?

A: No.

Q: So first you got back the comments from Dr. Baldessarini and then later in time you made a presentation to your colleagues at McLean?

A: I believe that's the case.

Q: And you made your presentation at McLean prior to publication of the article or after?

A: I think it was after publication.

Q: Prior to submitting your article for publication, did you call Lilly and tell them that you had some interesting patients who had experienced some

unusual reaction to Prozac?

A: Carol Glod called Lilly and indicated that we had some patients who became suicidal and asked them what data they had on suicide and Prozac.

Q: Who did Ms. Glod speak to?

A: She's currently Dr. Glod, but I'm not sure who she spoke to. She was told, and I asked her recently what she was told, she said that she was told that there have been some cases that have been reported to Lilly. Unfortunately,

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they said that they don't code the items by suicidal ideation; that it would be coded by worsening of depression and that they could not pull out those cases and that there would be literally thousands of cases that they would have or something like that that were worsening depression cases. Or hundreds of cases. It would be a massive amount of material.

Q: Doctor, you know that Dr. Beasley's article in the British Medical Journal searched for all comments about suicidal ideation and didn't just rely on worsening of depression as a code. Right?

A: At the time when we called we were told that they could not do that. We were told that they were only categorized, that their only descriptor term was worsening of depression.

Q: Can you answer my question about the BMJ article?

A: What about it?

Q: You are aware that the information reported by Dr. Beasley in the BMJ article does not rely upon a code, it relies upon review of all the case report forms and all information provided by

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the clinical investigators?

A: Yes.

Q: You know that?

A: Yes.

Q: Turning your attention to Exhibit 19, are the handwritten comments on Exhibit 19 Dr. Baldessarini's?

A: Yes.

Q: After you received these comments from Dr. Baldessarini did you discuss them? Did you discuss Dr. Baldessarini's handwritten comments with him when you received them?

A: I discussed his impressions. I did not specifically go over his handwritten comments.

Q: On page 000916 of Exhibit 19, sir, where there is a chart of Eli Lilly's stock peaking in 1988 and plummeting in 1989, what did you understand Dr. Baldessarini to mean by that handwritten notation?

A: I took that as a Dr. Baldessarini joke.

Q: And what was the joke, sir?

A: That after this article came out that there would be a drop in sales of Prozac.

Q: And was that funny to you?

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A: I thought it was, because I thought that the article would never cause something like that to happen.

Q: Now, sir, at the top of Exhibit 19 can you tell me what it says? It's hard to read at the very top there. Do you know what that says?

A: I can't ready the very top. I see "go for it," parenthesis, AJP, exclamation point, close parenthesis.

Q: What did you understand that note to mean, sir?

A: It meant send it to the American Journal of Psychiatry.

Q: That would be a good placement for this article. Correct?

A: Right.

Q: And "go for it" meaning that you thought you had an interesting set of observations here?

A: Right.

Q: Surprising set of observations. Correct?

MR. GREENWALD: Objection. Surprising to whom?

MS. GUSSACK: Surprising to Dr. Teicher since that's the language he used in

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the article.

BY MS. GUSSACK:

Q: Was it a surprising set of observations to you, sir?

A: Sure. But I'm not sure that Dr. Baldessarini's comment "go for it" meant that Dr. Baldessarini thought they were surprising. I think basically from knowing Dr. Baldessarini for now fifteen years, I would probably suspect that he would use the word "interesting."

Q: What is the other handwritten notation in the right-hand corner of Exhibit 19?

A: There is "rule out," or R/O, "pseudobipolarity, rule out akathisia as contributor."

Q: What did you understand Dr. Baldessarini to mean by those notations?

A: What he is basically suggesting that we look into, think about more is the possibility that these patients may be more manic-depressive than unipolar depression and that maybe fluoxetine has induced a manic state and that that might be part of the explanation. And the other one is that maybe fluoxetine has induced akathisia and that the

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exacerbation in their condition, the emergence of suicidal behavior is a consequence of akathisia.

Q: After you received Dr. Baldessarini's comments did you or anyone go back and re-review the patient histories or your clinical records?

A: I don't recall going back over and reviewing the clinical records. What I do recall doing was speaking to Dr. Cole more about akathisia. And in particular I was asking again whether he felt that akathisia occurred in what was case 1 in the paper.

Q: Anything else?

A: Not that I recall.

Q: Now, in the draft that you sent Dr. Baldessarini seven patients are included. Correct?

A: Right.

Q: One of them drops out, the 40-year-old woman, patient 6. Right?

A: 30-year-old woman, patient 6?

Q: 40-year-old.

A: Case 6? In which one?

Q: In the draft that you sent to Dr. Baldessarini.

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A: This one has case 6 as a 30-year-old woman. Are there two case 6's? Case 5, Ms. E is a 40-year-old woman.

Q: I'm sorry, case 5, a 40-year-old woman with major depression, late luteal phase dysphoric disorder. You don't end up including that patient in your final report, do you?

A: No, I didn't.

Q: Now, at the time that you sent the draft to Dr. Baldessarini you thought that patient was similar enough to include in your case series. Correct?

A: Similar enough to include in this draft of the case series, yes.

Q: This is practically a final draft before you sent it to the American journal. Right?

MR. GREENWALD: Objection.

A: It's a draft. It is really not the final draft.

Q: Well, no, apparently not. And you pulled this patient out because why?

[22] A: This patient had an unusual response to [23] potentiation with methylphenidate, which really [24] caused the syndrome to remit, and so it is more

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[1] ambiguous.

[2] Q: The patient's reaction, patient number [3] 5's reaction was more ambiguous and could not be [4] attributed to the use of Prozac?

[5] A: The response to methylphenidate in this [6] case caused her to have a therapeutic response [7] while on fluoxetine, so I think it is more [8] ambiguous.

[9] Q: Well, she didn't have what you were [10] describing as the intense suicidal preoccupation as [11] a result of fluoxetine?

[12] A: What we described was that she over the [13] next two weeks – At week six suicidal ideation [14] and panic attacks emerged. Over the next two weeks [15] she experienced increasing suicidality, intense [16] homicidal and violent dreams, dissociation and [17] suspiciousness. Then methylphenidate was added to [18] her regime and she had enhanced work performance, [19] concentration and mood, and that at a [20] methylphenidate dose of 10 milligrams her symptoms [21] remitted, cognition improved, and her suicidal [22] thoughts and violent dreams abated.

[23] Q: So she didn't fit the pattern of what you [24] were describing in the other six patients?

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[1] A: Well, I'm not sure. I think we gave her [2] a challenge with another drug which may have [3] reversed some of the effects of fluoxetine. It [4] would have been much clearer had we not done that [5] and had we stopped the medication. But this was [6] ambiguous.

[7] Q: Let me direct your attention to page 927 [8] of Exhibit 19, sir, the bottom paragraph. Are you [9] there?

[10] A: Yes, mm-hmm.

[11] Q: I ask you to refer to the sentence [12] "Second, all but one patient" – and I'm reading [13] under Dr. Baldessarini's writings to get to the [14] original draft that you submitted to him –

[15] "Second, all but one patient, case 1, developed [16] intense fatigue or abulia on fluoxetine and two [17] patients eventually developed hypersomnia, cases 4 [18] and 7." Right?

[19] A: Yes.

[20] Q: So, Doctor, this was striking to you, [21] wasn't it, because you were expecting these [22] patients to become activated on fluoxetine and [23] instead they were becoming sedated?

[24] A: Yes.

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[1] Q: And hypersomnia means what?

[2] A: Increased sleep.

[3] Q: "More typically patients with depression [4] find fluoxetine to be stimulating and frequent [5] side-effect complaints include nervousness and [6] insomnia." But that is not in fact what you were [7] reporting in this draft to Dr. Baldessarini. [8] Correct?

[9] A: What do you mean?

[10] Q: You just said the patients developed [11] intense fatigue abulia, hypersomnia. They were [12] not stimulated, right?

[13] A: Right. So that is consistent with what [14] I wrote, yes.

[15] Q: Now, it was the patients who were [16] extremely sedated who experienced the so-called [17] suicidal ideation. Right?

[18] A: Yes.

[19] Q: Not the extremely activated patients?

[20] A: Correct.

[21] Q: Sir, does the word akathisia appear in [22] this draft that you sent to Dr. Baldessarini [23] anyplace except on page 9 where you use the word [24] akathisia to reference the fact that you reduced

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[1] neuroleptics to treat the akathisia?

[2] A: I wouldn't know. Do you want me to sit [3] here and read it?

[4] Q: Well, sir, do you recall when you [5] submitted the draft to Dr. Baldessarini that you [6] were commenting on the finding of akathisia induced [7] by fluoxetine in any of the patients?

[8] A: This was seven and a half years ago. [9] I don't exactly remember what I wrote in this [10] draft. I haven't seen it or read it again to this [11] moment. So I don't know if I have the word [12] akathisia in here.

[13] Q: Well, Doctor, I am going to ask you [14] tonight to tell me whether akathisia appears in [15] that article anywhere other than on page 9 as I've [16] just described to you. So we don't have to take [17] the time now but we can address it tomorrow after [18] you have had a chance to look.

[19] A: Okay.

[20] Q: Could you turn to page 929 of Exhibit 19? [21] And in this case you say, first full paragraph, you [22] say "It is always difficult to know with certainty [23] whether untoward effects that emerge during [24] pharmacological treatment are a consequence of the

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[1] drug." Correct?

[2] A: Yes.

[3] Q: Particularly so when the symptoms that [4] you are observing may be symptoms of the underlying [5] disease. Correct?

[6] A: Yes.

[7] Q: That makes it particularly troublesome?

[8] A: Yes.

[9] Q: And you go on to say in that paragraph [10] that "Second, it is possible that suicidal thoughts [11] emerged for reasons unrelated to fluoxetine [12] treatment, e.g., loss or abandonment, and we are [13] linking two common events whose simultaneous [14] occurrence was merely coincidental." Correct, sir?

[15] MR. GREENWALD: Your question is, is [16] that what it says?

[17] MS. GUSSACK: Yes.

[18] A: That's what it says.

[19] MR. GREENWALD: The document speaks [20] for itself. What it says is what it says.

[21] BY MS. GUSSACK:

[22] Q: You see where I'm referring, Doctor?

[23] A: Yes.

[24] Q: So it was important to you at the time

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[1] that you prepared this draft to evaluate the [2] significance or contribution of what you call loss [3] or abandonment as possible factors precipitating [4] suicidality. Correct?

[5] A: Correct.

[6] Q: Now, can you tell me, sir, what [7] Dr. Baldessarini's handwritten comment in the [8] right-hand margin is next to "loss or abandonment"?

[9] A: It says "Does not fit story well and [10] seems a forced straw man."

[11] Q: What did you understand from that [12] comment?

[13] A: What one would mean by a straw man is an [14] argument that one sets up merely to knock down; [15] that had this been in Dr. Baldessarini's opinion a [16] powerful argument, there would have been some [17] evidence of it in the cases. So he thinks that we [18] were essentially putting this point in but that we [19] didn't really believe this to be true or that the [20] cases didn't provide this kind of evidence, so that [21] we are – I guess he felt we were being overly [22] cautious in putting this in, something like that.

[23] Q: You go on to state, sir, that "However, [24] we are unaware of any changes in the life

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[1] circumstances of these patients during treatment. [2] No one lost a job, had a

relationship end, or [3] learned that they had a terminal illness." [4] Correct?

[5] A: Yes.

[6] Q: All of those would be significant life [7] stressors that could increase the risk for [8] suicidality. Correct?

[9] A: Yes.

[10] Q: You in fact looked for those kinds of [11] stressors in each of your patients –

[12] A: Correct.

[13] Q: – to evaluate the role that they might [14] play in increasing the patient's suicidality?

[15] A: Yes.

[16] Q: And it was your view at the time that you [17] published this draft that such stressors were [18] absent from each of the patients' lives?

[19] A: Yes.

[20] MR. GREENWALD: I am going to object [21] because the draft wasn't published.

[22] MS. GUSSACK: Prepared.

[23] MR. GREENWALD: Okay, I'll accept [24] that.

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[1] BY MS. GUSSACK:

[2] Q: You go on to say "It was also very [3] striking that no patient was able to articulate a [4] concrete reason for why they felt suicidal. [5] Instead they indicated that these thoughts were [6] there for no apparent reason." Correct?

[7] A: Yes.

[8] Q: And, sir, in your experience with these [9] patients had you had occasions on which they told [10] you that they had felt suicidal previous to [11] starting fluoxetine?

[12] A: There were occasions when these patients [13] had had previous suicidal thoughts, yes.

[14] Q: And were they able to tell you why they [15] were having suicidal thoughts?

[16] A: In general, yes.

[17] Q: What do you mean by "in general"?

[18] A: Either they were able to tell me or we [19] were able to figure it out in the course of [20] therapy.

[21] Q: I see. And some of those cases would be [22] simply because their depression was worsening, they [23] felt more suicidal?

[24] A: No. In the patients that I was reporting

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[1] here and it is true for many patients, there's not [2] any kind of simple straightforward correlation [3] between suicidal ideation and depressive severity. [4] You can have a patient who is roughly the same [5] level of depression on week one as they are on week [6] two but they may be suicidal on week two. And they [7] may be suicidal on week two because their husband [8] failed to acknowledge their anniversary or [9] something. You know, that there is something [10] that's coming up that has caused them to feel hurt [11] or abandoned or rejected or they've had a horrible [12] time at work. There are also times when their [13] depression worsens and they don't become more [14] suicidal.

[15] Basically, if you really think about [16] it, the vast majority of patients who are suicidal, [17] and I mean seriously suicidal, you know, not just a [18] fleeting thought of suicide but a real persistent [19] desire to commit suicide, there's largely a few [20] reasons. One reason we call intolerable affect. [21] They're feeling so bad that death would be a [22] relief. Another major factor is that they're [23] feeling disconnected; that they are not in the [24] midst of a meaningful relationship with people;

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[1] that nobody cares, nobody loves them.

[2] And those are largely the two [3] psychological reasons lying behind the suicide. [4] And that usually in the course of evaluating a [5] patient who is suicidal you can identify either [6] what the underlying intolerable affect is or you [7] can ascertain that there is a lack of connection, a [8] lack of support and identify that. And that's part [9] of assessing and evaluating a suicidal patient.

[10] Q: I want to make sure I understand you, [11] Doctor. A patient's suicidality may increase due [12] to the fact that they have a loss of support from [13] family or friends or psychological stressors that [14] they are experiencing by way of major traumatic [15] events?

[16] A: I wasn't talking about stressors.

[17] MR. GREENWALD: Objection. That's [18] not what he said, Nina.

[19] A: What I'm talking about are, the two major [20] things are intolerable affect or isolation. And [21] the isolation isn't simply lack of support. It's [22] not that, "Oh, Sally hasn't called in two weeks." [23] It's more that they feel really cut off, isolated, [24] abandoned, they don't have anybody to turn to, and

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[1] so they're adrift, alone. And when evaluating [2] those people who are suicidal, I mean really [3] suicidal, not fleeting thoughts, you are finding [4] somebody who is facing intolerable affect, be that [5] humiliation, be that pain, be that panic attacks, [6] things that they just can't stand feeling and would [7] rather be dead than feel. Or their life feels [8] empty, meaningless, devoid of connection. And that [9] usually those core feelings and states underlie the [10] patient who is really suicidal.

[11] Q: Now, Doctor, you would agree with me that [12] the feeling of emptiness, loneliness, being cut [13] off, that is the patient's subjective reality of [14] those feelings. Correct?

[15] A: Yes.

[16] Q: It may be that they have a very [17] nurturing, loving family, a very caring set of [18] friends, but that their feelings of isolation, [19] alienation, distance, emptiness are their [20] experience, their personal experience of those [21] feelings?

[22] A: Yes.

[23] Q: So that those feelings may cause someone [24] to become increasingly suicidal?

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[1] MR. GREENWALD: Objection.

[2] A: Yes.

[3] Q: And that those feelings may be so [4] intolerable that they would rather be dead than [5] alive?

[6] MR. GREENWALD: Objection.

[7] A: Yes.

[8] Q: Okay, I understand you.

[9] Turning to page 917 of Exhibit 19, [10] the statement in the middle paragraph, you had [11] originally written "There is little thought, [12] however, that antidepressants might actually induce [13] serious nearly obsessive suicidal ideation in [14] depressed patients relatively free of these [15] thoughts prior to treatment." And Dr. Baldessarini [16] deleted "relatively free" and you accepted that [17] change. Correct? Your article says "These [18] patients were free of recent suicidal ideation." [19] Right?

[20] A: I didn't use that wording at all that was [21] in the draft. I mean, this was the opening [22] paragraph; it was not a discussion of the cases. [23] The opening paragraph was setting out propositions [24] about what antidepressants do or don't do. And

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[1] what I wound up saying was "However, standard [2] antidepressants are not known to induce severe and [3] persistent suicidal ideation in depressed patients [4] free of such thoughts before treatment." It is a [5] general statement about the state of knowledge.

[6] Q: Well, Doctor, is the phrase in your [7] published article, Exhibit 10, referring to [8] patients free of such thoughts before treatment [9] referring to your six patients that you report on [10] in the article?

[11] A: Free of recent serious suicidal ideation.

[12] Q: Turning to page 919 of Exhibit 19. [13] Dr. Baldessarini's handwritten note in the right- [14] hand margin. Can you read that? (Pause) Can you [15] read where it says "Hard to be sure this is" –

[16] A: Yeah. It's hard to read. "Hard to be [17] sure this something to fluoxetine. something with [18] limited past treatment history."

[19] Q: "Hard to be sure this is related to [20] fluoxetine"? Is that what it says. Doctor?

[21] A: I can't read all the words.

[22] Q: You have in your office, sir, the [23] original of this document with Dr. Baldessarini's [24] notes on it?

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[1] MR. GREENWALD: Doesn't even look [2] like a word. I don't know what it is. Almost [3] looks like a number.

[4] A: Let me look at the case for a second.

[5] Q: He is referring to what turns out to be [6] patient number 2 in your published article.

[7] A: Okay. (Pause) Yeah, it's hard to make [8] it out. What he's actually saying in the other [9] paragraph....

[10] Q: As I read that note it says "Hard to be [11] sure this related to fluoxetine, especially with [12] limited past treatment history." Did you consider [13] that note when you evaluated the comments on [14] patient number 2?

[15] MR. GREENWALD: Are you going to ask [16] him about this page?

[17] MS. GUSSACK: Yes.

[18] MR. GREENWALD: Can we get a copy of [19] this?

[20] MS. GUSSACK: Well, not now. I don't [21] have one. But I'll get one for you tonight.

[22] MR. GREENWALD: It's already almost [23] quarter after 5:00. He's been going since 5:30 [24] this morning and we were going to stop at 5:30

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[1] anyway. I thought. So maybe we could get done [2] soon. All right?

[3] A: I guess what I did, I put in some [4] additional information for case 2 that wasn't in [5] this write-up, so we indicated that he had managed [6] successfully with psychotherapy until two years ago [7] when his depression worsened after a divorce. So [8] we indicated a little bit more about his past [9] treatment history.

[10] Q: So you tried to find additional [11] information responsive to Dr. Baldessarini's [12] comment that this didn't look related to Prozac [13] because of the prior limited treatment history?

[14] A: Right.

[15] Q: Doctor, before I asked you that the [16] reason you dropped that patient from your case [17] report was because she was more complicated than [18] the others and you said no, that wasn't the case. [19] Didn't you testify that way sir, in Ransom on page [20] 72? Didn't you say that the patient you dropped [21] out of the case series was even more complicated [22] than the six that you reported on in the Ransom [23] transcript at page 72?

[24] A: Right.

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[1] Q: How was she more complicated? Because [2] she didn't fit the series as we discussed already?

[3] MR. GREENWALD: I'm going to object. [4] I think he's already answered that question.

[5] A: Let me check something. (Pause) She [6] wasn't more complicated clinically in the sense of [7] didn't have more problems, more diagnoses, more [8] neurological disturbances, more history of [9] medication. She was more complicated in the [10] Ritalin, methylphenidate response being a [11] significant confounding factor. Depending on how [12] you envision methylphenidate is going to interact [13] with fluoxetine, it could either be supportive or [14] it could be not supportive.

[15] Q: So she had an additional confounding [16] factor that made it hard for you to draw any causal [17] assessment between her exposure to fluoxetine and [18] her suicidal preoccupation?

[19] A: Yes.

[20] Q: On page 923 of Exhibit 19, Doctor, there [21] is some comment by Dr. Baldessarini in the margin. [22] What is that reference with an exclamation mark? [23] Can you read it?

[24] A: You mean the one with the question mark.

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[1] the double question mark?

[2] Q: No; at the bottom.

[3] MR. GREENWALD: In the circle? The [4] circle in the lower left-hand corner?

[5] THE WITNESS: Do you mean this over [6] here (indicating)?

[7] MR. GREENWALD: You mean that one [8] with the circle around it?

[9] THE WITNESS: Or do you mean this [10] (indicating)?

[11] (Pause)

[12] MS. GUSSACK: Let me see if I can [13] find a better copy for you.

[14] MR. GREENWALD: Which marking were [15] you referring to?

[16] MS. GUSSACK: The one down here, at [17] the bottom.

[18] MR. GREENWALD: The one with the [19] circle around it and the "wow" comment after it.

BY MS. GUSSACK:

[21] Q: While we're looking for a better [22] copy, Doctor, let me ask you to refer to page 72 of your [23] testimony in the Ransom criminal matter. (Pause)

[24] MR. GREENWALD: Do you have page 73?

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[1] Can I see it?

[2] A: I think there's a mistake in this.

[3] Q: Having reviewed it, Doctor, in your [4] testimony in the criminal matter in the Ransom case [5] you were asked about the alternative explanations [6] you considered with respect to the patients you [7] reported on in your 1990 article. Correct?

[8] A: Yes.

[9] Q: And you testified there that obviously [10] one of the things you considered was that this was [11] simply a coincidence. Right?

[12] A: Yes.

[13] Q: That this was simply an event you saw as [14] temporally associated, that the suicidal [15] preoccupation simply was temporally related in time [16] with the exposure to fluoxetine. Right?

[17] A: Yes.

[18] Q: And that it may have had nothing to do [19] with the administration of fluoxetine. Correct?

[20] MR. GREENWALD: Objection to the form [21] of the question. Anything's possible.

[22] A: Yes, that was a hypothesis.

[23] Q: That was a hypothesis?

[24] A: Correct.

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[1] Q: And your case report considers the [2] possibility that Prozac caused suicidal [3] preoccupation as a hypothesis. Correct?

[4] A: Yes.

[5] Q: In fact, you thought it was a surprising [6] possibility. Correct?

[7] A: That's some of the words that we used, [8] yes.

[9] Q: And you have said that possibility is [10] something between greater than zero percent but [11] less than 50 percent. Right?

[12] MR. GREENWALD: Objection.

[13] A: I may have said that at some point. I'm [14] not sure of the firm statistical

definition of [15] possibility.

[16] Q: You have testified that you were raising [17] the possibility that the administration of [18] fluoxetine caused suicidal preoccupation in these [19] six patients. Correct?

[20] A: Right.

[21] Q: And you have testified, sir, haven't you, [22] that that possibility to you meant something [23] greater than zero percent and less than 50 percent. [24] Correct?

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[1] A: Do you have that someplace?

[2] Q: Did you say that, sir?

[3] A: I don't recall.

[4] Q: You don't recall?

[5] A: I mean, it's somewheres between zero and [6] a hundred. I'm not sure I put it down to fifty.

[7] Q: Do you recall saying it was less than [8] 50 percent?

[9] A: No.

[10] MR. GREENWALD: Objection. He just [11] says he doesn't recall.

[12] BY MS. GUSSACK:

[13] Q: And, Doctor, did you –

[14] MR. GREENWALD: Hold on. Can I just [15] make my objection? He says he doesn't recall. If [16] you have something you want to show him where he [17] says it, to refresh his recollection, show it to [18] him. But if he doesn't remember, he doesn't [19] remember.

[20] BY MS. GUSSACK:

[21] Q: You testified, didn't you, Doctor, that [22] these six patients do not evidence concrete [23] definitive evidence of a causal association? [24] Correct?

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[1] A: Yes.

[2] Q: One of the other hypotheses that you have [3] had to entertain is that there were other events in [4] these six patients' lives that contributed to their [5] increased suicidality. Correct?

[6] A: Yes.

[7] Q: Meaning stressors in their lives?

[8] A: Right. Which we talked about, yes.

[9] Q: And also the possibility that they were [10] having a drug interaction with other medications [11] they were taking?

[12] A: Yes.

[13] Q: Four out of six of those patients were [14] taking other psychoactive medications while they [15] were taking fluoxetine. Correct?

[16] A: Yes.

[17] Q: And there is the possibility of a drug [18] interaction?

[19] A: Yes.

[20] Q: And in fact you have testified, haven't [21] you, that you find that there is greater [22] disinhibition and greater impulsivity in patients [23] taking Valium. Right?

[24] A: Compared to?

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[1] Q: Patients who haven't taken Valium.

[2] Right?

[3] A: Okay.

[4] Q: And that you have seen what you believe [5] to be the Prozac-related effect in patients who [6] take Valium and Prozac. Right?

[7] A: Prozac-related effect in patients who [8] take Valium?

[9] MR. GREENWALD: Objection.

[10] A: Could you rephrase that?

[11] Q: Haven't you testified that the suicidal [12] preoccupation that you have seen you find to be [13] more evident in patients who have taken Valium and [14] Prozac?

[15] A: I don't have a specific recollection of [16] stating that. I think that I have stated that [17] there have been discussions of suicidality and [18] impulsivity emerging in patients taking [19] benzodiazepines, whether it's Valium or Xanax or [20] Halcion, and that it has also been associated in [21] Prozac, and that the combination may be pretty [22] likely or relatively speaking to be at increased [23] risk. But I'm not sure that I specifically said [24] that I see this more in patients who are on that.

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[1] Q: On what?

[2] A: On the combination. I don't see that [3] many patients on the combination.

[4] Q: I see. But three out of six of your [5] patients were in fact on a combination of Valium, [6] Xanax or Halcion and Prozac. Correct?

[7] A: But not specifically Valium and Prozac, [8] which is what you asked.

[9] Q: But now I've changed the question to [10] include Valium, Xanax or Halcion as you said?

[11] A: Yes.

[12] Q: You also have entertained the hypothesis [13] that there is a sensitizing effect between drugs [14] that these patients previously took prior to the [15] administration of Prozac and the administration of [16] Prozac. Right?

[17] A: That's correct.

[18] Q: And you did not reject any of these [19] hypotheses as possible explanations for what you [20] were observing in these patients. Right?

[21] A: No, I did not.

[22] MR. GREENWALD: Objection.

[23] BY MS. GUSSACK:

[24] Q: Doctor, how many of these six patients

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[1] that you reported on had dissociative symptoms [2] before beginning fluoxetine?

[3] A: Dissociative symptoms?

[4] Q: Yes.

[5] A: Cases 3, 4, 5 and 6, those four as far as [6] I can tell from looking at this right now.

[7] MS. GUSSACK: It's almost 5:30. Why [8] don't we take a couple of minutes and discuss [9] scheduling.

[10] MR. GREENWALD: Okay.

[11] (Discussion off the record.)

[12] MS. GUSSACK: To clarify the record, [13] let's mark finally as Exhibit 20, which we can do [14] in a moment, Dr. Teicher's folder that contains his [15] correspondence to and from counsel in this matter. [16] Contained within that file were a series of –

[17] MR. GREENWALD: This is going to be [18] No. 20?

[19] MS. GUSSACK: 20, yes.

[20] MR. GREENWALD: We'll call that [21] correspondence file.

[22] What I have removed from that file is [23] a letter to Mr. Pavsner dated June 20, 1996; a [24] draft pleading; a letter to Mr. Pavsner dated

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[1] August 12, 1996; a fax to Dr. Teicher dated August [2] 14, 1996; and a letter with an attachment from me [3] to Dr. Teicher dated August 20, 1996. So that [4] there are five items that I have removed. And [5] I will call Steve this evening and discuss this [6] issue with him.

[7] MS. GUSSACK: Let me clarify for the [8] record that Dr. Teicher has testified that he [9] prepared a letter from which an affidavit was drawn [10] by your office in response to the motion to compel. [11] He has submitted a bill requesting reimbursement [12] for time spent incurred in responding to the [13] subpoena. And he has been questioned about time [14] incurred in responding to the motion to compel, all [15] of which I believe are implicated by the documents [16] that you are withholding, so I would suggest to you [17] that they are all subject to production.

[18] MR. GREENWALD: It may be that [19] tomorrow there won't be an issue but I would like [20] to clarify it. Okay? So for the time being I am [21] going to take these documents with me so I can [22] discuss them with Mr. Pavsner this evening, and [23] I will return with them

tomorrow.

[24] MS. GUSSACK: Off the record.

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[1] (Discussion off the record.)

[2] MR. GREENWALD: There is one other [3] thing he had in his file that he brought with him. [4] There is a letter here which has nothing to do with [5] this case from an attorney seeking information from [6] 1991 –

[7] MS. GUSSACK: Seeking information [8] about what?

[9] MR. GREENWALD: It has nothing to do [10] with this case.

[11] MS. GUSSACK: Seeking information [12] about Prozac?

[13] MR. GREENWALD: Actually, I don't –

[14] THE WITNESS: He just wanted a copy [15] of the study, that's all. That's all he wanted.

[16] MR. GREENWALD: Is that all he [17] wanted? It's up to you. I don't care.

[18] THE WITNESS: He wanted a copy of the [19] study gratis.

[20] MR. GREENWALD: It is a letter from a [21] lawyer asking for a copy of the study relating to a [22] custody case. There's an envelope that has nothing [23] in it. I have no idea what that means. And there [24] is a fax transmission from Dr. Teicher to Georgia

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[1] Sargent of Trial Magazine which appears to be under [2] date of 1991, which apparently – I'm guessing – [3] is something that they'd asked him to review that [4] they were going to put in the magazine. Is that [5] what that is?

[6] THE WITNESS: Yes.

[7] MS. GUSSACK: With regard to Prozac?

[8] MR. GREENWALD: Yes. I don't [9] understand this. The magazine is dated – Oh, [10] this is something they already published. This is [11] dated August 1990.

[12] THE WITNESS: I think that they may [13] have shown me an example. I'm not sure.

[14] MR. GREENWALD: I don't know.

[15] MS. GUSSACK: Why don't we have it [16] copied.

[17] MR. GREENWALD: Okay. Do you have [18] any problem with that?

[19] THE WITNESS: (Witness shrugged.)

[20] MR. GREENWALD: Okay, that's it as [21] far as I know. You have all those boxes over there [22] and I haven't looked through them. It just appears [23] to be a lot of books and stuff.

[24] MS. GUSSACK: And the materials you

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[1] took with you to review during lunch that [2] Dr. Teicher had produced are where?

[3] MR. GREENWALD: That's what we just [4] talked about. Because I think you may have left [5] the room. I gave your assistant all of that stuff [6] before we left.

[7] MS. GUSSACK: Thank you.

[8] MR. GREENWALD: The only thing I took [9] with me was the correspondence file to discuss [10] these other issues with him. So as far as I know [11] and of course I didn't pack these boxes but I did [12] carry one of them up here, but you have [13] everything. And that's all I have for now.

[14] (Deposition recessed at 5:40 p.m. to [15] Wednesday, October 30, 1996, at 9:00 a.m.)

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DEPONENT'S ERRATA SHEET & SIGNATURE

The original of the Errata Sheet has been delivered to Andrew E. Greenwald, Esq. When the Errata Sheet has been completed by the deponent and signed, a copy thereof should be delivered to each party of record and the original thereof delivered to Nina M. Gussack, Esq., to whom the original deposition transcript was delivered.

INSTRUCTIONS TO DEPONENT

After reading this volume of your deposition, indicate any corrections or changes to your testimony and the reasons therefor on the Errata Sheet supplied to you, and sign it. DO NOT make marks or notations on the transcript volume itself.

PLEASE REPLACE THIS PAGE OF THE TRANSCRIPT WITH THE COMPLETED AND SIGNED ERRATA SHEET WHEN YOU RECEIVE IT.

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Commonwealth of Massachusetts)
County of Suffolk)

COURT REPORTER'S CERTIFICATE

I, J. Edward Varallo, RPR/RMR (Registered Professional Reporter, Registered Merit Reporter) and Notary Public in the Commonwealth of Massachusetts, hereby certify that there came before me on October 29, 1996, at the time and place specified above, Martin H. Teicher, M.D., Ph.D., the deponent herein, who was duly sworn by me to testify to the truth and nothing but the truth, and thereafter examined under oath by counsel.

I certify that the questions asked of the deponent and the answers given were taken down by me stenographically and thereafter transcribed by me using computerized translation software and printed out (laser printer) in typewritten transcript format; and that the foregoing is a true and accurate transcript of the questions asked of the deponent and the answers given.

I certify further that I am neither attorney, counsel, or relative of any party litigant, nor otherwise interested in the event of this suit.

J. Edward Varallo, RPR/RMR
MY COMMISSION EXPIRES
JANUARY 11, 2002

DATED: _____

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
JOAN LUCILLE ROSENBLOOM GREER,)
Personal Representative of the)
Estate of Michael Rosenbloom,)
Plaintiff) Civil Action
v.) No. 91-1790 JGP
ELI LILLY AND COMPANY,)
Defendant)
Deposition of Martin H. Teicher, M.D., Ph.D.
Wednesday, October 30, 1996
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PROCEEDINGS

9:40 a.m. MARTIN H. TEICHER, M.D., PH.D., having been previously sworn on oath, was examined and testified further as follows:

EXAMINATION, resumed BY MS. GUSSACK:

Q: Doctor, you understand that you are still under oath from yesterday?

A: Yes.

Q: If I might, I need to do a little bit of housekeeping with you about some things we discussed yesterday just to make sure we're clear about some things. In Exhibit Teicher 12 you indicated that there were some documents pertaining to a statistical analysis that you performed on BGA data. Can you show me which pages those are?

A: This. And this is also relevant. Can I just see that a moment? (Pause)

Q: Doctor, does your comment that you have some papers there referring to an update mean that you performed a statistical analysis on some separate information?

A: Yes. There was the fluoxetine safety

update of 6/20/86 that was a separate document. The basis for that were these sheets which I think Lilly had labeled Safety Update.

Q: And what do you have in front of you there?

A: And these go with that. These are the analyses I have done on that data.

Q: Doctor, just so that the record is clear, I am going to just mark 12-G, 12-H and 12-I, three pages of documents that you have handed me from Teicher 12 which, as I understand it, refer to your analysis of data submitted to BGA for approval of fluoxetine. Is that correct, sir?

A: Yes.

Q: 12-G would be a chart that you prepared?

A: Yes.

Q: 12-H is data that you prepared?

A: It is a statistical analysis of the data.

Q: And the same is true of 12-I?

A: Yes.

MR. GREENWALD: Do you want to staple those together?

MS. GUSSACK: I am going to put them back in Exhibit 12.

BY MS. GUSSACK:

Q: And for convenience of reference, I am going to mark 12-J, the document you have identified as your chart analysis of fluoxetine safety update June 20, '86. Correct?

A: Yes.

Q: And 12-K is your statistical analysis of that data?

A: Yes.

Q: And 12-L and 12-M are documents you believe are from Lilly with regard to the safety update?

A: Yes.

Q: Now, Doctor, if I hand you your folder that has all the red paper clips on it which you gave us yesterday, can you tell me which pages you were referring to when you performed your analysis of the BGA data?

A: Yes.

Q: And would you mind giving me the PZ number that you will see stamped on the bottom of each of those pages.

A: It's PZ2811692.

Q: Any other page, sir?

A: That's the relevant page.

Q: You have red paper clips on a lot of these documents. What do those red paper clips signify?

A: Those were things that I found interesting when I read them and thought that there may be questions that came up today that I might want to be able to find these for.

MR. GREENWALD: Let me just ask you a question, Nina. That folder is not an exhibit to the deposition.

MS. GUSSACK: Not yet.

MR. GREENWALD: Are you going to make it an exhibit?

MS. GUSSACK: I may. I'm not sure.

MR. GREENWALD: Well, if you don't then obviously he will take it back with him. But if you do, we are going to probably need to go through and just put on the record which pages have paper clips on them.

MS. GUSSACK: If I make it an exhibit I will try to copy it in a way that the paper clip would be evident.

MR. GREENWALD: Or we could just read

off the page numbers. Then you would have them in case in transport the paper clips come off or something like that.

BY MS. GUSSACK:

Q: Doctor, yesterday we referred to Teicher 19, Dr. Baldessarini's comments on your draft manuscript which you submitted to the American Journal of Psychiatry. Do you recall?

A: Yes.

Q: And you have been kind enough to furnish us today with a more legible copy that we are going to substitute for Exhibit 19 for ease of reference. Now, sir, can I show you, please – I may have to look over your shoulder – the second page of Teicher Exhibit 19, which is the cover page that you have in front of you, and can you read me now the handwritten comments that appear at the very top of that page?

MR. GREENWALD: Where is the copy that you took out? Do you have that someplace?

(Document handed by Ms. Gussack to Mr. Greenwald.)

A: It says "chilling," exclamation and three underscores, and then it says "shorten,"

underlined, and "try to soften anti-fluoxetine posture and go for it," parenthesis, "AJP," exclamation, close parenthesis.

Q: Doctor, did you speak with Dr. Baldessarini about the comments that you just read after he made those comments?

A: I discussed the manuscript at vari-

ous[8] stages with Dr. Baldessarini but I didn't [9] specifically discuss those comments.

[10] Q: Did you know what he meant by your [11] anti-fluoxetine posture in this manuscript?

[12] A: I believe I did, yes.

[13] Q: Pardon me?

[14] A: I believe I did.

[15] Q: And what did you understand him to mean?

[16] A: I think he meant, you know, present the [17] data: soften it in terms of specificity to [18] fluoxetine.

[19] Q: And why, sir, do you think he thought [20] that was a good idea?

[21] A: Dr. Baldessarini is very conservative and [22] this is the kind of caution that he would bring to [23] any academic discussion.

[24] Q: Did you in fact try to soften your

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[1] anti-fluoxetine posture?

[2] A: I believe I did.

[3] Q: By doing what?

[4] A: I think I was more cautious in the final [5] draft.

[6] Q: And what did you change that is evidence [7] of your greater caution?

[8] A: I think that there's a lot of caveats and [9] cautions throughout the manuscript in terms of how [10] much we understand, how much we know, and more the [11] attitude that we're raising this as a possibility [12] than saying this is a conclusion.

[13] Q: So, sir, you would want clinicians and [14] the scientific community reading your article to [15] have taken away from reading your series of case [16] reports that in fact they were simply hypotheses. [17] Correct?

[18] A: Right.

[19] Q: You published it, as I understand, to [20] provoke discussion, research?

[21] A: Yes.

[22] Q: Analysis?

[23] A: Thought, yes.

[24] Q: And in fact it did that, didn't it?

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[1] A: Yes.

[2] Q: And in fact one might say it even created [3] a firestorm of attention, wouldn't you say?

[4] MR. GREENWALD: Objection.

[5] A: It generated a lot of attention, yes.

[6] Q: Now, would you say that your colleagues [7] at McLean, for instance, were skeptical of your [8] case reports?

[9] MR. GREENWALD: Objection. Are [10] you talking about all his colleagues or who he talked [11] to?

[12] Q: Colleagues that you presented your slides [13] to at McLean.

[14] A: No.

[15] Q: No? They embraced your observations?

[16] MR. GREENWALD: Objection.

[17] A: I think the –

[18] MR. GREENWALD: Wait a minute. You [19] have to wait until she finishes the question and [20] give me a chance.

[21] I am going to object to the [22] terminology of the question.

[23] BY MS. GUSSACK:

[24] Q: Doctor, can you answer the question?

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[1] A: I think there was a heterogeneity of [2] opinion. There were some colleagues who said yes, [3] I've seen cases. There were other colleagues who [4] said, well, you know, this is probably akathisia. [5] There are other colleagues who said, no, fluoxetine [6] is perfectly safe, I've never seen anything like [7] that.

[8] So there was a heterogeneity of [9] opinion. I would not say that I got from my [10] colleagues at McLean much in the way of criticism [11] at all from them.

[12] Q: Did you get criticism from others, [13] Doctor?

[14] A: There was, again, a lot of heterogeneity [15] of opinion. I have many colleagues who called to [16] describe cases and to say that they had seen the [17] same thing. I had other colleagues who said, what [18] are you talking about? I've never seen a case.

[19] It wound up very much from my [20] impressions of people who spoke to me face to face [21] about it or spoke to me on the telephone that [22] either they had seen similar cases and thought that [23] it had great validity or they had not seen similar [24] cases and they were critical of it. So it tended

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[1] to slice one way based on what their experience [2] was.

[3] Q: When you presented your observations at [4] the meeting of the American College of [5] Neuropsychopharmacologists were you greeted with [6] some skepticism?

[7] A: Oh, yes.

[8] MR. GREENWALD: Objection.

[9] BY MS. GUSSACK:

[10] Q: A great deal of skepticism. Right?

[11] A: There was a substantial degree of [12] skepticism, yes.

[13] MR. GREENWALD: We're still talking [14] about the 1990 paper, right?

[15] MS. GUSSACK: Yes. Thank you. [16] Attorney Greenwald.

[17] BY MS. GUSSACK:

[18] Q: Dr. Teicher, the cases that your [19] colleagues mentioned to you they had seen did not [20] prompt you to write another article reporting on [21] other cases in a series other than the patient that [22] you describe in your '93 article. Is that right?

[23] A: Right.

[24] Q: Do you believe you have seen this

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[1] phenomenon of obsessive suicidal preoccupation [2] after use of fluoxetine in other patients you have [3] personally treated other than the seven patients [4] we've defined now?

[5] A: The seventh patient who was sent to me [6] was somebody who had developed it before, so it [7] wasn't –

[8] Q: So it wasn't your personal patient?

[9] A: She became my personal patient but she [10] had developed the reaction before she started to [11] see me. And –

[12] Q: Let me just clarify that. In 1993 when [13] you report on that patient in your drug safety [14] article, you are reporting the observations of [15] another practitioner, not your own?

[16] A: It was the patient reporting the data to [17] me, but fluoxetine was not prescribed by me; it was [18] prescribed by another practitioner.

[19] Q: And she was not under your care –

[20] A: At the time.

[21] Q: – when she exhibited those symptoms that [22] you associate with fluoxetine?

[23] A: Correct.

[24] Q: Doctor, for the convenience of the court

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[1] reporter and the record, you have to tell me I'm [2] correct at the end of my questions. Hopefully. [3] Thank you.

[4] MR. GREENWALD: But, Doctor, if she [5] is not correct at the end of her question you don't [6] need to tell her that.

[7] BY MS. GUSSACK:

[8] Q: So other than the six patients that you [9] personally were responsible for that you've [10] described – I'm sorry. That needs to be [11] clarified. Other than the four patients that you [12] were personally responsible for in the 1990 [13] article –

[14] A: Plus the fifth one that was not reported.

[15] Q: Plus the fifth one that was not reported, [16] have you seen this phenomenon that you have [17] described in

any other patients for whom you are [18] personally responsible?

[19] A: The answer to that is I'm not sure. And [20] there was one other case in which I raised the [21] possibility, but I was not convinced one way or the [22] other. Other than that, the answer is no.

[23] Q: Now, when you raised the possibility in [24] your 1990 article, Doctor, and you published it in

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[1] the hope that further research would occur, you [2] would agree, wouldn't you, that the further [3] research would not be additional reports of [4] individual cases that would confirm or deny the [5] observations?

[6] A: No. That would be the first stage. The [7] first stage of confirmation would be for [8] elicitation independently of other cases, hopefully [9] simpler cases.

[10] Q: And after that first stage what do you [11] hope for for scientific verification of your [12] observations?

[13] A: That there would be data from [14] surveillance studies, that there would be data from [15] rechallenge studies, and it would have been nice if [16] there was some data from controlled studies.

[17] Q: Sir, have you initiated any prospective [18] controlled study to test the hypothesis that you [19] raised in your 1990 article?

[20] A: I've tried but I wasn't able to get one [21] funded.

[22] Q: You've tried, sir?

[23] A: Yes.

[24] Q: What did you do to try?

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[1] A: I have submitted applications for funding [2] and haven't received funding to do it.

[3] Q: Who did you submit applications to?

[4] A: NARSAD, the American Suicide Foundation, [5] and through Shervert Frasier to Lilly.

[6] Q: Who is Shervert Frasier?

[7] A: He was the psychiatrist and chief of [8] McLean Hospital.

[9] Q: And, sir, have you produced any of those [10] applications in response to the subpoena that was [11] served upon you?

[12] A: I think it may be in this stack.

[13] Q: Would you mind showing me where they are?

[14] A: (Pause) I don't seem to have the NARSAD [15] application here. But here are two.

[16] Q: Doctor, I take it by the fact that none [17] of these documents bears the MHT stamp that was [18] used in response to the subpoena, that these are [19] not documents that you have previously provided to [20] us in response to the subpoena. Is that correct?

[21] A: I guess not.

[22] MR. GREENWALD: I'm not sure that you [23] asked for those. I don't remember. Did you?

[24] MS. GUSSACK: I'm pretty sure we

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[1] did.

[2] BY MS. GUSSACK:

[3] Q: Now, Doctor, none of the places to which [4] you made a proposal gave you funding. Is that [5] right?

[6] A: Correct.

[7] Q: Do you know why?

[8] A: Let's see. In the case of the American [9] Suicide Foundation, Carol Glod was the first author [10] and I was going to be the mentor. It was a junior [11] award. And they were originally going to award it [12] and then they called and said, well, this is a [13] junior award and though Carol is junior you're too [14] senior, you're too much a professional researcher [15] and it's not appropriate for the category. So they [16] didn't fund it.

[17] Q: Is that contained in a document anywhere, [18] sir?

[19] A: No. It was a phone conversation.

[20] Q: With whom?

[21] A: Dr. Gil Noam.

[22] Q: What about the other applications?

[23] A: NARSAD doesn't provide any feedback. [24] They either say that we've chosen you or not chosen

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[1] you. And Dr. Frasier made a personal visit to [2] Lilly and it seemed like nothing came out of it.

[3] Q: When did Dr. Frasier make his personal [4] visit to Lilly?

[5] A: I wouldn't recall the exact date. [6] I would imagine it was in '91 or '92.

[7] Q: Do you have any record of that, sir?

[8] A: No.

[9] Q: What did Dr. Frasier tell you occurred [10] when he visited Lilly?

[11] A: He said he had an interesting [12] conversation with them and that they were going to [13] think about it, but nothing ever came of it.

[14] Q: This was in 1991 or '92?

[15] A: Yes.

[16] Q: This was at a time when you had already [17] enlisted with Mr. Greenwald to be an expert witness [18] against Lilly in litigation. Correct?

[19] MR. GREENWALD: Objection.

[20] A: I don't know if it was before or after.

[21] Q: Let's see. By April 1991 you had issued [22] a report in this case. Correct?

[23] A: Right. So it could have been before, it [24] could have been after.

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[1] Q: But '91 or '92?

[2] A: Right. Is there a date on it?

[3] Q: Not that I see, sir.

[4] Doctor, can you identify for the [5] record what NARSAD is?

[6] A: It's the National Alliance for Research [7] in Schizophrenia and Affective Disorder.

[8] Q: So other than these proposals that you've [9] just identified, have you ever undertaken yourself [10] a prospective controlled study to test the [11] hypotheses that you raised in your 1990 article?

[12] A: No, I have not.

[13] Q: Did you ever draft a protocol as part of [14] your proposals to any of the entities that you have [15] previously identified?

[16] A: There was probably a brief discussion of [17] one in the NARSAD application. There is discussion [18] of protocols in these. But a formal, detailed [19] protocol was not written.

[20] Q: Doctor, have any of the cases that have [21] been reported to you by your colleagues in the [22] aftermath of your publication of Exhibit 10 been of [23] a type that you felt warranted publication?

[24] A: There have been a number of published

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[1] case reports.

[2] Q: Yes, I am aware of that, sir, but I asked [3] you about the reports that were provided to you by [4] your colleagues which you referred to in the [5] aftermath of your publication of Teicher 10.

[6] A: That would be my colleagues' decision.

[7] Q: So you were not motivated to report on [8] any of those cases that were provided to you?

[9] MR. GREENWALD: Objection.

[10] BY MS. GUSSACK:

[11] Q: Were you, sir?

[12] MR. GREENWALD: There's a [13] definitional problem with "motivated." I object to [14] the question.

[15] BY MS. GUSSACK:

[16] Q: Doctor, do you understand?

[17] A: Yes. I think there were a number of [18] cases reported to me that were very interesting and [19] they would have been worthy of a case report [20] presentation because they brought up in-

teresting[21] events, but they were my colleagues' cases and it [22] was their decision as clinicians or scientists [23] whether they wanted to proceed to write them up as [24] case reports.

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[1] Q: Did you initiate any discussion with any [2] of your colleagues about collaborating on a joint [3] publication of case reports that had been reported [4] to you by your colleagues?

[5] A: No. It was my decision not to present [6] additional case report material.

[7] Q: And why was that?

[8] A: The case reports had generated a lot of [9] attention and I figured that – I felt the next [10] step was to provide information other than case [11] reports, so that's why I wrote the 1993 drug safety [12] paper.

[13] Q: Doctor, in your 1993 drug safety paper [14] you offer possible ideas of the mechanisms by which [15] the observations reported in your 1990 article [16] could be explained. Correct?

[17] A: It goes beyond that. That's part of it, [18] to offer explanations, not just in reference to the [19] 1990 paper but to reference the whole body of [20] literature about drugs and suicide and to provide a [21] sort of composite enlarged theoretical framework [22] for how drugs can induce or exacerbate suicidal [23] behavior, and then to review the available data at [24] the time about antidepressant medications and

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[1] suicide.

[2] Q: There is no original research of yours [3] reported on in the 1993 article, is there, sir?

[4] A: Oh, sure there is.

[5] Q: What is that?

[6] A: The original research is in the form of [7] analysis of a great body of material. There's not [8] a controlled study reported on but there's a [9] tremendous amount of research.

[10] Q: Well, let me clarify that. I understand [11] you reviewed a great deal of literature to report [12] on in that article. Correct?

[13] A: And analyzed them in different ways and [14] put together new hypotheses and did that based on [15] what would be considered reanalysis of published [16] reports. But that's research.

[17] Q: Reanalysis of published reports is the [18] research that is contained in the '93 article?

[19] A: Yes.

[20] Q: Reanalysis of published reports in ways [21] that are inconsistent with the protocols that [22] existed prior to the studies. Correct?

[23] A: Inconsistent with the protocols? What do [24] you mean?

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[1] Q: Let's take Fava and Rosenbaum which you [2] mentioned yesterday. You reanalyzed that data in a [3] manner which was inconsistent with how [4] Dr. Rosenbaum and Dr. Fava identified their [5] procedures for evaluating those patients. Correct?

[6] A: No, no, no, not at all. It is not [7] inconsistent with their protocol. It is not [8] inconsistent with their means of evaluating their [9] patients. It was a different analysis of their [10] data. Had nothing to do with their protocol. Has [11] nothing to do with their means of analyzing their [12] patients. It was a different technique or way of [13] analyzing the published data.

[14] Q: Didn't they identify, sir, in advance of [15] their study the ways in which they were going to [16] analyze their data?

[17] A: When you have a body of data, there are [18] ways in which you can select to analyze that body [19] of data. Also –

[20] Q: They selected a certain way. Correct?

[21] A: Yes.

[22] MR. GREENWALD: Objection. How about [23] if we let the doctor finish his answer.

[24] BY MS. GUSSACK:

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[1] Q: Please finish your answer.

[2] A: They analyzed their data in one way. [3] There are alternative ways of analyzing the data [4] which may be better; and in this case I believe [5] that there are ways of analyzing the data that were [6] better, that were more scientifically appropriate, [7] that were more statistically sound, and that's what [8] I presented.

[9] Q: Did the authors of that study agree with [10] your approach, Doctor?

[11] A: I have spoken with Dr. Rosenbaum about [12] the issue but we never discussed whether he did or [13] didn't agree with the statistical analysis.

[14] Q: You are familiar with his letter to the [15] editor in the aftermath of Dr. Brewerton's [16] reanalysis of his study, aren't you, sir?

[17] A: I've read it. Haven't read it in a [18] number of years but, yes, I did read it.

[19] Q: And he disagrees with the reanalysis that [20] you report on in your '93 article. Right?

[21] A: I do not recall from his letter that he [22] disagreed with the reanalysis. He went on to [23] indicate that there was a patient whom they [24] included in one group which was after the fact, but

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[1] I do not recall that he disagreed with the [2] analysis. (Pause) Did you want to show that to [3] me?

[4] Q: Yes. I will come back to Dr. Rosenbaum [5] and Dr. Fava in a moment.

[6] MR. GREENWALD: Of course, if we have [7] it here, then you can ask the doctor to look at it [8] if you'd like and he can comment on it. He said he [9] hadn't read it in a long time. If you want to do [10] that, you're certainly welcome to do it.

[11] MS. GUSSACK: Thank you.

[12] BY MS. GUSSACK:

[13] Q: Turning your attention to Teicher 19, [14] I believe it is, Doctor, would you turn to page 7, [15] please. Page 7 is MHT000923 of Exhibit 19. It [16] says "Ms. F became hypomanic on daily doses of [17] haloperidol 4 milligrams." Do you see where I'm [18] reading in the bottom paragraph?

[19] A: Yes.

[20] Q: And other medications are listed there?

[21] A: Yes.

[22] Q: Now, Doctor, it is true, isn't it, that [23] your patient numbers didn't track the ultimate [24] patients reported on in your 1990 article?

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[1] A: Correct. There was one deletion, so the [2] number –

[3] Q: So do you know which patient you're [4] referring to here?

[5] A: In the 1990 article?

[6] Q: Yes.

[7] A: I think actually case 6 is case 6. Do [8] you have the article?

[9] Q: It's right here. So the reference in the [10] draft Teicher 19 to Ms. F is a reference to patient [11] number 6 in the 1990 article?

[12] A: Yes.

[13] Q: Now, in the draft you are reporting that [14] patient number 6 became hypomanic on medications [15] other than fluoxetine. Is that correct, sir?

[16] A: Mm-hmm.

[17] Q: Does that appear anywhere in the final [18] draft of your article published –

[19] A: No.

[20] Q: – with respect to patient number 6?

[21] A: No.

[22] Q: While you have the article in front of [23] you, and I apologize if I asked you this yesterday, [24] Doctor, on page 207 you say that these patients

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[1] were free of severe persistent suicidal ideation [2] before treatment. Do you see what I'm referring [3] to?

[4] A: Free of recent serious suicidal ideation. [5] Is that where you're referring?

[6] Q: The statement is "However, standard [7] antidepressants are not known to induce severe and [8] persistent suicidal ideation in depressed patients [9] free of such thoughts before treatment."

[10] A: That has nothing to do with the patients [11] in the series. That is a statement in general [12] about the state of knowledge of psychiatry.

[13] Q: Okay. I believe you told me yesterday [14] that the patients reported on in this article were [15] free of severe suicidal ideation at the time of [16] treatment. Is that right?

[17] A: As I put it right in the abstract, free [18] of recent serious suicidal ideations.

[19] Q: Thank you, sir. That's what I was [20] looking for. In the abstract the phrase is "Six [21] depressed patients free of recent serious suicidal [22] ideation developed intense violent suicidal [23] preoccupation after two to seven weeks of [24] fluoxetine treatment." And my question is: How

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[1] long had they been free of recent serious suicidal [2] ideation?

[3] A: That varied from patient to patient.

[4] Q: Do you know how long?

[5] A: I would have to go and look at each case [6] and tell you or see if there's a general statement [7] in the article.

[8] Q: (Pause) Doctor, are you looking at the [9] patient descriptions of each individual to come up [10] with the answer?

[11] A: Yes.

[12] Q: Then let me stop you now, because I'm [13] going to ask you to look at each patient a little [14] bit later and I'll come back to that question.

[15] Can you tell me, sir, whether any of [16] the patients in your 1990 article experienced [17] preoccupation with suicidal thoughts after five or [18] six days on medication at 20 milligrams?

[19] A: In this article, the patients that we [20] described, the onset of the intense suicidal [21] thoughts emerged between twelve and fifty days [22] after starting. So no one emerged within five in [23] this article.

[24] Q: And in that article those symptoms abated

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[1] in a range between three days to –

[2] A: Three to forty-nine they abated.

[3] Q: Three to forty-nine. Although, for [4] instance, the patient you report on in your '93 [5] article, their symptoms didn't fully abate for six [6] months, you said. Right?

[7] A: What I said in here was they faded in [8] intensity an average of 27 days, a range of three [9] to 49, but they did not fully abate in most [10] patients until a mean of 87 days, a range 60 to 106 [11] after cessation.

[12] Q: And then, of course, the patient you [13] report on in the 1993 article is even farther out [14] than that?

[15] A: Yes, that's right.

[16] Q: But, sir, you would agree that a patient [17] who, for instance, is taking Prozac for a week [18] would have traces of the drug in them for at least [19] five weeks. Isn't that right?

[20] MR. GREENWALD: Objection.

[21] Q: Considering the half-life of the drug.

[22] A: On average. You would expect to have [23] traces not of the fluoxetine but of the [24] norfluoxetine metabolite.

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[1] Q: And that is an active metabolite?

[2] A: Right. It may be four to five weeks but [3] somewheres in that range and it could be six weeks.

[4] Q: So that, for instance, the patient whose [5] symptoms abated within three days still had [6] fluoxetine and norfluoxetine in their system at the [7] time?

[8] A: Yes.

[9] Q: And the patient whose symptoms abated [10] after six months didn't have fluoxetine left in [11] their system?

[12] A: Well, don't know. See, when we talk [13] about the half-life of fluoxetine we're talking [14] about the half-life of fluoxetine in the blood. [15] The half-life of fluoxetine in the blood may not be [16] the same as the half-life of fluoxetine in the [17] brain. That hasn't been quantified.

[18] Q: You are not aware of any data with [19] respect to that issue?

[20] A: Not in humans.

[21] Q: Doctor, are you aware of any data in [22] humans by which the mechanism is explained that [23] fluoxetine causes akathisia?

[24] A: We proposed a mechanism in our paper on

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[1] an animal model of fluoxetine, and the mechanism [2] that we proposed was a mechanism for humans.

[3] Q: But, sir, that article referred to rat [4] studies, didn't it?

[5] A: Sure. But that doesn't mean that you [6] can't from a rat study propose a human mechanism. [7] The data on how fluoxetine is supposed to work for [8] depression is based on animal studies that have [9] shown that fluoxetine binds to serotonin [10] transporters, or the serotonin uptake pumps. So [11] they have taken the animal data, the basic [12] neuropharmacology in animals, and used that to [13] hypothesize in man.

[14] Q: Would you say that the effectiveness of [15] Prozac is at a hypothetical stage, sir, or has it [16] been demonstrated in millions of patients?

[17] MR. GREENWALD: Objection.

[18] A: Oh, you're not talking about [19] effectiveness, you're talking about mechanism. The [20] mechanism for Prozac is based on a lot of the basic [21] research done by Dr. Fuller in animals. And that's [22] true for all antidepressant drugs.

[23] Q: Sir, the article that you are referring [24] to is called an animal model, isn't it?

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[1] A: Right, right.

[2] Q: Okay. Have you in humans, sir, tested [3] whether the hypothesis that you have generated from [4] your animal model of fluoxetine and akathisia is in [5] fact valid?

[6] A: I don't understand the question.

[7] Q: Have you applied in humans the [8] hypothetical theories that you derived in your rat [9] research?

[10] MR. GREENWALD: Objection. Do you [11] understand the question?

[12] A: It's not a very scientifically meaningful [13] question.

[14] Q: I apologize, sir. I think that's why I'm [15] a lawyer.

[16] MR. GREENWALD: But it's a good [17] lawyer's question. But you need to understand it [18] in order to answer it, Doctor.

[19] A: In psychiatry there are many theories [20] about how drugs work, how side effects emerge. The [21] theories are a combination of human and animal, so [22] that we basically know how the drug works in the [23] brain because we've looked in the brain of [24] mammals. We haven't looked in the brain of humans

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[1] in the same kind of way. We can't. You can't cut [2] up human brains and measure what the drug is doing [3] in those parts of the brain.

[4] So a lot of our knowledge, our [5] beliefs, our theories about how fluoxetine in man [6] works is based on experience in humans with the [7] drug and studies in animals in which you can get [8] more detailed neuro-

pharmacological data than you [9] can get from humans. And basically these theories [10] as a whole have not been substantiated in humans in [11] any ways near the way that they've been [12] substantiated – It is an extrapolation from the [13] animal data to the human data to apply to the human [14] condition, and that's what we were doing in that [15] case. We're extrapolating from animals to the [16] human condition.

[17] And there is data that largely [18] validates that humans are experiencing the same [19] thing as the animals do neuropharmacologically, but [20] the level of proof is nowheres near as clear in [21] humans as it is in animals. But we have also done [22] motor activity studies in humans as well as motor [23] activity studies in animals.

[24] Q: Doctor, I appreciate your comments, but

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[1] you haven't answered my question. Have you [2] performed in humans any studies that confirm the [3] theoretical work that you have done in rats with [4] respect to fluoxetine and akathisia?

[5] MR. GREENWALD: Objection. The [6] doctor just explained how that process works.

[7] MS. GUSSACK: I understand what the [8] doctor explained. It's a yes or no question.

[9] MR. GREENWALD: And Lilly hasn't done [10] it either.

[11] MS. GUSSACK: That's not what the [12] doctor said. Andy, if you want to make speeches, [13] do it when I'm finished with Dr. Teicher, but [14] otherwise keep your statements to objections.

[15] BY MS. GUSSACK:

[16] Q: Doctor, have you performed such studies [17] in humans?

[18] MR. GREENWALD: Objection to the [19] question. I think the doctor answered it and he [20] explained his answer.

[21] BY MS. GUSSACK:

[22] Q: Sir?

[23] A: No.

[24] Q: If I could ask you to turn to page

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[1] MHT000930 of Exhibit 19 before you, Doctor, can you [2] read there Dr. Baldessarini's handwritten notes at [3] the lower right-hand corner? Page 14 of the [4] handwritten numbers.

[5] A: The handwritten notes at the bottom of [6] the page you're interested in?

[7] Q: Yes, sir.

[8] A: "Would also emphasize long t half [9] especially with norfluoxetine" and then there's a [10] word I can't read, followed by data "as additional [11] risk on and off treatment," parenthesis, "slow [12] onset, slow recovery, risky," close parenthesis.

[13] Q: Sir, what did you understand from [14] Dr. Baldessarini's comment?

[15] A: What he is saying is that he would also [16] emphasize that Prozac has a long half-life duration [17] of action and that this was an additional risk on [18] and off treatment; that you would expect a slow [19] onset, so you can get fooled, or accumulate over [20] time, so that you can get fooled, and that you [21] would expect slow recovery, which makes the drug [22] risky.

[23] Q: What does t one-half mean to you?

[24] A: It's the half-life of the drug.

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[1] Q: Can you turn to page 000926, handwritten [2] page number 10.

[3] A: Page 10? This one doesn't have those [4] numbers.

[5] Q: I'm sorry.

[6] A: I have it.

[7] Q: Can you read the handwritten comment in [8] the left-hand margin?

[9] A: "Too strong, need to rule out [10] interaction."

[11] Q: And, sir, what did you understand [12] Dr. Baldessarini to be referring to there?

[13] A: In there I used the word, it's highly [14] crossed out but it looks like the word "unrelated," [15] so that I said "The remainder were given other [16] medicines unrelated to the fluoxetine trial." And [17] he suggested that it be changed to "The remainder [18] were given other medicines which had been present [19] before the fluoxetine trial." He felt that the [20] word "unrelated" was too strong.

[21] Q: Doctor, did you as I requested last night [22] review your draft to tell me where the word [23] "akathisia" appears?

[24] A: Yes, I did, and I did not find it in any

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[1] of the descriptions.

[2] Q: However, in your final article, the [3] published article, sir, you would agree that on [4] page 210 you state that "Four patients complained [5] of a disturbing sense of inner restlessness and [6] they may have had a form of akathisia, parens, [7] cases 1 to 3 and 6, which could be a contributing [8] factor." Correct, sir?

[9] A: Yes.

[10] Q: What was the reason that you inserted [11] that sentence in your published article?

[12] A: I don't have a detailed and specific [13] memory as to what the exact sequence of events was. [14] I know the question of akathisia was important. [15] I mean, Dr. Baldessarini pointed out a couple of [16] times that we should consider akathisia, rule it [17] out, and I know that I had a couple of [18] conversations with Dr. Cole specifically on [19] akathisia particularly because case 1 we're [20] indicating that the patient felt like jumping out [21] of her skin, which is usually a telltale sign of [22] akathisia.

[23] So I discussed this a number of times [24] with Dr. Cole to say could this possibly have been

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[1] akathisia. Also, I think at around this time [2] Dr. Lapinsky's paper on fluoxetine and akathisia [3] had appeared. Dr. Lapinsky had told me about his [4] observations of akathisia long before the paper was [5] published, so we were sensitized to that as a [6] possibility, so we wanted to consider this as one [7] of the hypotheses. And I believe for completeness [8] and accuracy this was added.

[9] Q: So, sir, it is accurate to say, isn't it, [10] that in the draft that you gave to Dr. Baldessarini [11] there is no mention of akathisia and in the [12] published article akathisia is identified as a [13] possible contributing factor to the observations [14] you reported on in your patients. Correct?

[15] A: Yes.

[16] Q: And previously in the draft you had [17] suggested that the heavily sedated hypersomniac [18] patient was at risk for suicidal preoccupation. [19] Correct? And we discussed that yesterday. Right?

[20] A: Right. And that is in the final version [21] too.

[22] Q: But now restlessness in your final [23] published report is a more key element, isn't it?

[24] A: No. The statement at the end is

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[1] "Patients who had previously been treated with [2] other antidepressants or who developed intense [3] fatigue, hypersomnia or restlessness while taking [4] fluoxetine may be at risk." So hypersomnia and [5] restlessness and fatigue are both right in the same [6] sentence.

[7] Q: Would you turn to page 15 of Teicher 19, [8] the Baldessarini draft, and in that last concluding [9] sentence that you have in your draft there does the [10] word "restlessness" appear anywhere?

[11] A: No.

[12] Q: Now, Doctor, you described yesterday and [13] I guess again today that these were possibilities [14] that you were reporting on. Yesterday I asked you [15] didn't you recall that you had said that [16] possibilities mean something less than 50 percent. [17] Do you recall

that?

MR. GREENWALD: Objection. That's not what the testimony was.

MS. GUSSACK: Let me ask the question in a more current version.

MR. GREENWALD: If you state it as a fact you need to state it accurately.

BY MS. GUSSACK:

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Q: Let me ask you to refer to your testimony in the Ransom case. First let me ask you, sir, the Ransom case was a murder case. Is that right?

A: Yes.

Q: And you were testifying on behalf of the defendant accused of murder?

A: Yes.

Q: Could you turn to page 86 of the transcript. In Ransom you testified under oath. Correct?

A: Yes.

MR. GREENWALD: Let me just state for the record that that was October 1991.

MS. GUSSACK: Thank you.

BY MS. GUSSACK:

Q: And in October of 1991 you were asked by counsel in the case whether you had definitive evidence of the observations you report on in 1990. Correct?

A: Yes.

Q: And in fact you had written the letter to the editor in the American Journal of Psychiatry in December 1990 saying that you lacked definitive evidence. Correct, sir?

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A: Yes.

Q: Now, you will see on page 86, lines 23 and 24, you were asked "What does 'possibly' mean to you?" And you answered, quote, "'Possibly' means there's some chance greater than zero." Correct, sir?

A: Yes. But it doesn't say less than 50 percent. Does it?

Q: Doctor, refer then, if you would, to lines starting at 11, your answer to the question about do you have definitive evidence and isn't it really a possibility, and starting on line 12 you say "I mean 'probably' is more likely than not. That's far from definitive." Then you say "That in science, when we say that something is definitive we indicate generally that we have greater than 95 percent confidence in this phenomenon, that we have less than a 5 percent probability that this could occur by chance, and that's what we mean scientifically by definitive. When we say something is probably true, we're talking about more than 50 percent, so that they're not the same thing. And what's 'possibly'? 'Possibly' means there's some chance greater than zero."

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A: And that's exactly how I meant it: greater than zero. So it's somewheres between zero and a hundred, not zero and fifty.

Q: Yes, sir.

On page 87 of the transcript, sir, as of October 1991 in response to the question that your report suggests the possibility that fluoxetine may induce suicidal ideation, you are still at the position of possible. Do you see where that line appears?

MR. GREENWALD: Can you give us a line number?

Q: Your answer on the top of page 87.

A: "Still at the position of possible," yes.

Q: Now, Doctor, are you aware of any blind rechallenges done to test your observations reported in your 1990 article?

A: No, I am not.

Q: Would you agree with me, sir, that one of the risks of an anecdotal report is that there is the possibility of reporter bias?

A: Yes.

Q: And if you have a series of reports from

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the same reporter, there is a concern about reporter bias. Correct?

A: Theoretically.

Q: There's always that possibility, that there is reporter bias when you are dealing with an anecdotal report?

MR. GREENWALD: Objection to the form of the question.

A: It's not the main thing I worry about but, yes, that –

Q: It is certainly a factor to consider. Correct?

A: Yes.

Q: And you would agree, sir, wouldn't you, that one of the reasons randomized controlled trials are the gold standard for looking at questions of cause and effect are because they try to eliminate such bias. Correct?

MR. GREENWALD: Objection.

A: Yes.

Q: The investigator is blinded. Correct?

A: Yes.

Q: The patient in a double blind controlled trial is blinded?

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A: Yes.

Q: And you really can eliminate the issues of that kind of reporter bias?

A: Theoretically. It turns out that in reality it's very hard because many patients know if they've received treatment or not and sometimes the treaters know that the drug has side effects. So it's an attempt at doing that, far from perfect.

Q: It is the best way we know how at doing that, isn't it, sir?

MR. GREENWALD: Objection.

A: The randomized controlled double blind prospective trial stands high in the hierarchy.

Q: If you would turn to page 77 of the Ransom transcript that is before you, sir, referring to starting at line 18, you see where the question starts to refer to the double blind controlled study?

A: Mm-hmm.

Q: And you have explained that the double blind study has the addition of the experimenter being blind?

A: Yes.

Q: And you're asked what is the purpose of

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that, sir?

A: Yes.

Q: Can you read what your answer was in the Ransom trial?

A: Yes. "To keep the experimenter honest in the study. We tend to see what we believe. We sometimes tend to see what we want to believe. In a study in which the experimenter knows whether a patient is on the drug or on a placebo, they may say they really want to see a drug effect, they may consciously or unconsciously, you know, bias their ratings a bit to make the drugs look better. The double blind condition, nobody knows so it keeps you completely honest."

Q: Would you read the next question, sir, at line 3 on page 78?

A: "Question: And that's about as careful a study as you can do in this type of situation. Is that correct?"

Q: And your answer, sir, was?

A: "Yes."

Q: Dr. Teicher, I want to put before you what I have had marked as Exhibit 21, which is a letter that Attorney Greenwald provided to me on

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October 25 listing information which has been sent to you. And if I direct

your attention to the [3] pages 2 through 5 of Exhibit 21, the question [4] I have for you, sir, upon your review of this [5] exhibit is to determine whether you recall [6] receiving these materials from Attorney Greenwald.

[7] MR. GREENWALD: What's the date of my [8] letter?

[9] THE WITNESS: October 25. Just a few [10] days ago.

[11] BY MS. GUSSACK:

[12] Q: Sir?

[13] A: It looks like a good list of materials [14] that I received. I did not go through to check and [15] see if each thing that is listed I received.

[16] Q: When did you receive these materials [17] identified on Exhibit 21? Can you tell me when you [18] received these materials?

[19] A: Well, the letter was dated October 25.

[20] MR. GREENWALD: That is a letter to [21] counsel. She wants to know when you received it.

[22] BY MS. GUSSACK:

[23] Q: When did you receive the materials that [24] are identified in Exhibit 21?

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[1] MR. GREENWALD: I am going to object, [2] not really to his answering, but some of the things [3] that were sent apparently had already been sent. [4] So in answer to the question, it's a difficult [5] answer because we realized also after we sent it [6] out that we had sent some of these things a long [7] time ago. So "received" is difficult.

[8] A: The documents he sent on the 25th [9] I believe he sent Federal Express and I received [10] them the next day.

[11] Q: On October 26?

[12] MR. GREENWALD: Why don't we look in [13] the correspondence file? There may be a letter to [14] him.

[15] A: Do you have a calendar?

[16] Q: Well, sir, yesterday we described the [17] fact that in some of the materials you've brought [18] with you to the deposition you have speed messages [19] from Joseph Greenwald & Laake enclosing copies of [20] depositions and other documents and those are [21] dated, for instance, October 15 and October 17, but [22] my question is based on what is contained in the [23] list identified in Exhibit 21: Do you know whether [24] you received those materials at or around the time

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[1] we discussed yesterday or even more recently than [2] that?

[3] MR. GREENWALD: Hold on. Can I just [4] clarify one thing with you? Because this list also [5] lists depositions. Some of these depositions it [6] turns out we sent him duplicates of. So when you [7] say received, are you talking about this package or [8] are you talking about any time that he got any of [9] these things?

[10] MS. GUSSACK: The package of [11] materials identified in Exhibit 21.

[12] MR. GREENWALD: Recognizing that some [13] of the things were duplicates?

[14] MS. GUSSACK: Yes, sir.

[15] A: And when you're pointing to these speed [16] letters on these documents, the documents that had [17] the speed letters on them that have other dates, [18] I basically received those at other dates.

[19] Q: I understand that.

[20] A: I received these documents I believe the [21] day after he mailed this.

[22] Q: In a Federal Express package dated [23] October 25?

[24] MR. GREENWALD: Objection. He didn't

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[1] say that. Why don't we look in the correspondence [2] file that you have for my letter?

[3] MS. GUSSACK: Excuse me, Andy. The [4] doctor can tell me if I've misunderstood him.

[5] BY MS. GUSSACK:

[6] Q: Dr. Teicher, did you just tell me that [7] you believe you received Federal Express these [8] documents identified in Exhibit 21 on –

[9] A: Oh, excuse me, excuse me, I'm sorry. [10] This is a list of documents that he had sent to me [11] and that I received, this letter by fax on the [12] 25th. He did send me by Federal Express some [13] documents that I believe I received the next day. [14] But he did not send me this entire list of [15] documents. This was to bring me up to date on what [16] it was that he had sent me I believe in toto.

[17] MR. GREENWALD: Nina, let me clarify [18] something. That list was prepared for you.

[19] MS. GUSSACK: I understand that.

[20] MR. GREENWALD: Not for Dr. Teicher. [21] So that we wanted you to know what additional [22] materials if any he had seen, so we asked that that [23] list be compiled in our office and sent to you so [24] that you would have a list of what other materials

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[1] he had seen to supplement the list that he had [2] before. So then you would have the total picture [3] as best we could reconstruct it of what materials [4] Dr. Teicher had been sent.

[5] BY MS. GUSSACK:

[6] Q: Doctor, you understand that your [7] deposition was originally noticed for last week on [8] Monday and Tuesday. Correct?

[9] A: Yes.

[10] Q: I understand you were at a conference in [11] the latter part of last week?

[12] A: Yes.

[13] Q: Where was that conference?

[14] A: Philadelphia.

[15] Q: Now, sir, you have handwritten notes in [16] Exhibit 12 that you have brought with you and these [17] notes are recorded on stationery from the Latham [18] Hotel which we all know and love at 17th and Walnut [19] in Philadelphia. Correct?

[20] A: Uh-huh.

[21] MR. GREENWALD: Correct that we all [22] love the Latham?

[23] MS. GUSSACK: Well, those of us who [24] have been there.

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[1] BY MS. GUSSACK:

[2] Q: And, Doctor, would you confirm for me, [3] were these notes made of materials that you [4] reviewed last week while you were staying at the [5] Latham?

[6] A: Can I see them?

[7] Q: Sure.

[8] A: Interesting. It's very funny. I didn't [9] stay at the Latham Hotel. And this material is not [10] from the Latham Hotel. It's like I'm getting very, [11] very confused. I stayed at the Marriott [12] (indicating).

[13] Q: Can I have your notes back? When did you [14] make the notes that are identified on the Latham [15] notepad?

[16] A: They were made at a friend's house and [17] I was looking for paper at the friend's house and [18] they had a pad of paper from the Latham Hotel and [19] I used it and it was done shortly before the [20] previous deposition was scheduled.

[21] Q: Shortly before?

[22] A: Yes.

[23] Q: So was your friend in Philadelphia?

[24] A: She had been there on a trip.

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[1] Q: I see. Can't get anything by us. We'll [2] track you down.

[3] MR. GREENWALD: This is one hell of a [4] revelation. I'm going to claim surprise!

[5] THE WITNESS: I've never been there, [6] I can tell you.

[7] (Discussion off the record.)

[8] BY MS. GUSSACK:

[9] Q: Doctor, do these notes that you

made, [10] what did you say, the weekend before your [11] deposition?

[12] MR. GREENWALD: Objection. He [13] said –

[14] A: I am not certain but I believe so.

[15] Q: Okay. – reflect materials you had [16] received from counsel shortly before you made those [17] notes?

[18] A: I couldn't say. I have had boxes and [19] stacks of paper from counsel sitting around for a [20] long time and a lot of it was a re-review.

[21] Q: When was the last time that you received [22] materials from Mr. Greenwald's office?

[23] A: Well, I guess this letter was dated the [24] 25th.

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[1] MR. GREENWALD: No, that's a letter [2] to Nina Gussack, Doctor. That's where the [3] confusion is.

[4] THE WITNESS: Oh, I thought you sent [5] this to me?

[6] MR. GREENWALD: No. That's what [7] I tried to clarify. That is a letter that counsel [8] said was sent to her wherein we sent her a list of [9] additional materials that we sent you so that she [10] would have a complete list of everything that you [11] were sent. That's why I kept saying when you were [12] looking at the letter, it's addressed to counsel.

[13] THE WITNESS: It would help to look [14] in the correspondence file because you usually put [15] a cover letter with everything you sent.

[16] MR. GREENWALD: No, that's her [17] letter. We sent that to her. There's no question [18] pending to you, Doctor.

[19] BY MS. GUSSACK:

[20] Q: The question that was pending was, [21] Doctor, when was the last time that you received [22] materials from Attorney Greenwald's office?

[23] MR. GREENWALD: You're right.

[24] A: Could I look in the correspondence file?

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[1] Q: You sure can. That would be different [2] than the billing file, right?

[3] (Discussion off the record.)

[4] BY MS. GUSSACK:

[5] Q: Doctor, would you please refer to your [6] correspondence file and tell me if you can identify [7] when was the last time you received materials from [8] Mr. Greenwald's office?

[9] A: I see the last date on here was October [10] 3. Let me see if on any of these things there's [11] something later.

[12] Q: On what things? Sir, we have already [13] clarified for the record that you have received [14] some materials as late as October 15th and 16th and [15] 17th.

[16] A: Yeah. And I don't see anything later [17] than that.

[18] MR. GREENWALD: What are we going to [19] do about the correspondence file? Has that been [20] marked or not?

[21] MS. GUSSACK: We are going to [22] identify it as Exhibit 20.

[23] BY MS. GUSSACK:

[24] Q: Let me put before you what I have had

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[1] marked as Teicher 22, Doctor, and ask you to [2] identify that for me.

[3] A: This is a letter that I wrote dated April [4] 26, 1991, to Attorney Greenwald regarding Michael [5] Rosenbloom in which I state that I've reviewed [6] material regarding the death by suicide of Michael [7] Rosenbloom on June 27, 1990. It is my opinion with [8] reasonable medical certainty that the drug [9] fluoxetine, Prozac, caused Michael Rosenbloom to [10] commit suicide on that date. So it's a letter of [11] opinion.

[12] Q: And that letter of opinion, Teicher 22, [13] coupled with Teicher Exhibit 2, sir, the expert [14] report you have submitted in this case, constitute [15] the expert opinions that you have submitted in this [16] matter. Correct?

[17] A: Yes.

[18] Q: There are no other expert opinions that [19] you have drafted that we have not received?

[20] A: Correct.

[21] Q: Is it fair to assume then, sir, that [22] Teicher 22 and Teicher 2 are an adequate [23] description of the opinions that you intend to [24] offer in this case at the time of trial?

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[1] A: Opinions on what?

[2] Q: The expert opinions you intend to offer [3] on the subject matters identified in those expert [4] reports.

[5] A: Well, those were expert reports. The [6] letter and to a large extent the documents talk [7] about the case and they provide the information [8] that I will be discussing about the case. As far [9] as my entire set of opinions regarding the matter [10] of Prozac and suicide, you know, that continues to [11] change with time, and some of the documents that [12] were sent may have some bearing on that that were [13] after those letters.

[14] Q: Sir, does Exhibit 2 represent the [15] opinions that you are going to offer against Lilly [16] at the time of trial in this matter with respect to [17] whatever issues you believe Lilly was negligent on [18] regarding Prozac?

[19] A: By and large, yes.

[20] Q: By and large, yes?

[21] A: Yes.

[22] Q: And Exhibit 2 is a description of the [23] opinions you intend to offer at the time of trial [24] in this matter as to the causal relationship

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[1] between Mr. Rosenbloom's use of Prozac and his [2] suicide?

[3] A: Yes. But let's say that before trial [4] something entirely new and important emerges in the [5] scientific literature. I wouldn't exclude that. [6] It doesn't mean that this is set in concrete.

[7] Q: Doctor, from your review of the materials [8] that have been provided to you by Attorney [9] Greenwald, are there any opinions you intend to [10] offer in this case at the time of trial that are [11] not identified in Teicher 2 or Teicher 22?

[12] MR. GREENWALD: And that he testified [13] to yesterday and today, you mean?

[14] MS. GUSSACK: Other than those.

[15] MR. GREENWALD: The reports and what [16] you have been asking him over these two days?

[17] MS. GUSSACK: Yes.

[18] MR. GREENWALD: You can review that, [19] if you want to, Doctor, to see if there's anything [20] you might want to take a look at.

[21] BY MS. GUSSACK:

[22] Q: Doctor, you understand what I'm asking is [23] that these reports are intended to put Lilly on [24] fair and adequate notice of the opinions you intend

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[1] to offer at the time of trial in this matter, and [2] I want to know whether there are any opinions you [3] intend to offer on any subject matter with regard [4] to Mr. Rosenbloom and Prozac that are not contained [5] in Exhibits 2, 22, or identified by your testimony [6] yesterday or today.

[7] A: I understand your point. And I want –

[8] MR. GREENWALD: Why don't you take a [9] minute to look that over.

[10] THE WITNESS: Okay.

[11] MR. GREENWALD: Why don't we take a [12] break while he's doing that. It's time for a [13] stretch.

[14] (In recess 10:50 a.m. to 11:00 a.m.)

[15] MS. GUSSACK: Let's put on the record [16] that with respect to the documents that plaintiff's [17] counsel withheld from Dr. Teicher's correspondence [18] file, Exhibit No. 20, counsel have reached the [19] agreement that

those documents will be produced [20] subject to my agreement that I will not argue work [21] product has been waived by production of those [22] documents. Is that a fair statement?

[23] MR. GREENWALD: Yes. That by giving [24] you those documents, we have not waived work

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[1] product, we have not waived any client confidence [2] issue that was raised yesterday, nor have we waived [3] anything else; and that you will not use this [4] as an [4] argument for anything that you may subsequently [5] seek saying that we have waived our right to argue [6] whatever we argue based on showing you those [7] documents. Okay?

[8] MS. GUSSACK: And I have agreed to [9] that on the understanding that if I have an [10] independent reason to argue waiver of work product [11] I may do so, but I am not doing so based on the [12] production of these documents. Are we clear?

[13] MR. GREENWALD: I understand what [14] you're saying.

[15] (Teicher Deposition Exhibit 20 marked [16] for identification.)

[17] MS. GUSSACK: Do you want to place [18] those documents in Exhibit 20?

[19] MR. GREENWALD: Yes. I am not going [20] to put the draft from my associate, if that's [21] okay. It is just an opposition. I mean, I'll show [22] it to you but I don't want it as part of the [23] record.

[24] MS. GUSSACK: Why don't you show it

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[1] to me?

[2] MR. GREENWALD: So is that okay?

[3] MS. GUSSACK: Well, let me see it and [4] then I can tell you if it's okay.

[5] MR. GREENWALD: No, I want to know if [6] it's okay before I show it to you. That's the way [7] we do things.

[8] BY MS. GUSSACK:

[9] Q: While counsel is pulling out that [10] document, Doctor, can you answer the pending [11] question?

[12] A: Yes.

[13] Q: What is your answer?

[14] A: The answer is that these documents [15] provide a complete blueprint of what I would be [16] testifying to. They don't cover all the details. [17] The details are in what you have in front of you. [18] There's nothing that you don't have available. But [19] like the statistical analyses, they're not [20] discussed in this document. It's indicated that we [21] may talk about the Lilly trial data but it doesn't [22] give the specific facts. So there's no surprises, [23] but this is a relatively short document compared to [24] the volume on the table in front of you.

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[1] Q: Sir, have you performed any other [2] analyses of the documents that are sitting in front [3] of me that you have not told me about?

[4] A: Well, you have, for instance, the slides [5] and on the slides or in the '93 drug safety paper [6] there is a reanalysis of the Fava and Rosenbaum [7] data, so there is that reanalysis.

[8] Q: Sir, I ask you to pause a moment. Look [9] at your report, Exhibit 2, and look at the [10] documents that you identify as relying upon. Okay? [11] And with that addition, does it help you to tell me [12] whether there are opinions or data you intend to [13] rely upon, opinions you intend to offer or data you [14] intend to rely upon that you have not identified [15] there?

[16] MR. GREENWALD: Wait a second now. [17] I thought the question was are there any analyses [18] that you have done that are not here, meaning all [19] the numerous documents and things that are on the [20] table. Obviously you know the doctor received [21] materials and depositions were taken and things [22] have happened since the deadline date that the [23] court set for the 26(a) status.

[24] MS. GUSSACK: Is that a question?

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[1] MR. GREENWALD: I'm making a [2] statement. Therefore, there may be things that he [3] has learned from depositions that have been taken [4] that weren't in existence at the time, and [5] I understand the purpose of your question is to [6] find out those things. The doctor has also [7] received additional materials that are not Exhibit [8] B to the report, I believe it is.

[9] MS. GUSSACK: Teicher 2.

[10] MR. GREENWALD: No, but the report [11] and the documents relied on, that's separate. And [12] there have been other materials sent to him since, [13] so they may or may not be part of what his opinions [14] are.

[15] BY MS. GUSSACK:

[16] Q: Let's try again, Doctor, now I [17] you [17] have had a chance to look at the attachment to [18] Teicher 2, which is an identification of materials [19] that you relied upon in offering the opinion dated [20] January 5, '96.

[21] A: Could I see the Exhibit 12, I guess it [22] is? I would like to look at my statistical [23] analyses to make sure that the sources for those [24] are enumerated in here.

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[1] MR. GREENWALD: Why don't you do that [2] for a minute and I'll talk to Ms. Gussack about [3] these papers.

[4] BY MS. GUSSACK:

[5] Q: Let me clarify something for a moment. [6] Doctor. You have already identified for me the [7] data that you reviewed in order to make your [8] statistical analysis, so that I am on notice about [9] those documents and I'm not concerned that they [10] don't appear in that list.

[11] A: Okay.

[12] Q: But what I am interested in and I am [13] concerned about is, are there other analyses that [14] you have performed of any data that you have not [15] either identified in that list or provided to us [16] and identified to us yesterday or today?

[17] (Pause)

[18] MS. CRAWFORD: Do you need the other [19] blue book?

[20] THE WITNESS: Yes.

[21] (Document handed by Ms. Crawford to [22] Dr. Teicher.)

[23] (Pause)

[24] BY MS. GUSSACK:

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[1] Q: Do you have my question in mind, Doctor?

[2] A: Yes, I do, and we're working on it.

[3] MR. GREENWALD: What do you need? [4] I'll see if I can help you find it.

[5] A: Well, let me try to answer the question. [6] This is pretty complete. There are two things that [7] may not be in here and one of these is a reanalysis [8] of data published by Inman. I also have a graph of [9] that and I can't find the graph. I thought it [10] would be in 12 or 15 but it's not. I don't know [11] where it is. I had printed it out and to the best [12] of my knowledge put it with this. Doesn't seem to [13] be there. It may be buried in one of these [14] things. So that that's one.

[15] I also have here an extraction of [16] information from Lilly's drug experience reports [17] that I would also wish to discuss as part of my [18] answer.

[19] MR. GREENWALD: Can I just clarify [20] something here? Does that file just contain Lilly [21] drug experience –

[22] THE WITNESS: Plus my notes.

[23] MR. GREENWALD: I just want to know [24] how to describe it. Are you going to make that an

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[1] exhibit?

[2] MS. GUSSACK: In a minute.

[3] BY MS. GUSSACK:

[4] Q: If the Inman data and your analysis of it [5] are not in your Exhibit 12 where

you thought it [6] would be, what is your best guess as to where it [7] would be?

[8] A: In one of these piles.

[9] Q: When did you prepare the data analysis of [10] Inman?

[11] A: A day or two before the deposition.

[12] Q: Do you have a copy in your computer?

[13] A: Yes.

[14] Q: So you could generate another copy?

[15] A: I could regenerate that.

[16] Q: So let's decide at the end of the [17] deposition if we haven't found it by then you will [18] generate it again and produce it because that would [19] be part of the opinion you are providing here.

[20] A: Yes, I will.

[21] MR. GREENWALD: Just send me a copy [22] of it and I will forward it to counsel.

[23] BY MS. GUSSACK:

[24] Q: With those qualifications, sir, are we

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[1] now agreed that Teicher 2 and 22 provide the [2] overview of the opinions you are prepared to offer [3] in this case?

[4] A: Yes.

[5] MR. GREENWALD: In addition to all [6] the materials that we have identified in the [7] testimony so far today.

[8] A: I think the word "overview" is good.

[9] Q: Doctor, I am going to ask you to take a [10] look at Teicher 23 which I have had marked.

[11] MR. GREENWALD: Currents from [12] September of 1990?

[13] MS. GUSSACK: Yes, sir.

[14] BY MS. GUSSACK:

[15] Q: You are familiar with Currents, sir, [16] aren't you?

[17] A: Yes, I am.

[18] Q: This particular Currents issue of [19] September 1990 reports on an interview of you by [20] the authors of the publication. Is that right?

[21] A: Yes.

[22] Q: You were interviewed by the authors of [23] Currents with respect to your case reports?

[24] A: Yes, Jack Rosenblatt.

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[1] Q: And if you would turn to page 3 of [2] Exhibit 23 and go to the second column at the [3] bottom where it says "Teicher," well, I'm sorry, [4] the question is above it, where it says "Currents: [5] Do you think fluoxetine-induced restlessness or [6] akathisia may have contributed to your patients' [7] suicidal preoccupations?" Do you see where I'm [8] reading, sir?

[9] A: Yes.

[10] Q: Now, is it accurate, sir, that you said [11] one patient had a driven inner restlessness but she [12] didn't have any motor restlessness?

[13] A: Yes.

[14] Q: You are referring there to patient number [15] 1 in your case series?

[16] A: Yes.

[17] Q: Then you go on to say that Dr. Cole, who [18] is an authority on movement disorders, said that [19] she didn't have akathisia?

[20] A: Right.

[21] Q: And that if it were akathisia, in your [22] opinion it was certainly an atypical akathisia?

[23] A: Right.

[24] Q: Now, sir, let me direct you just a little

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[1] bit further down, you see where it says by the [2] Currents interviewer Dr. Rosenblatt, and the other [3] case where akathisia may have contributed was the [4] question, and you refer to the adolescent. You are [5] referring to case number 3, sir?

[6] A: I believe it is case 3. Can I just [7] check, the 19-year-old? Yes.

[8] Q: In your answer to that question about [9] whether patient number 3 had akathisia you say it [10] seemed more like agitation than akathisia. [11] Correct?

[12] A: Mm-hmm, yes.

[13] Q: Sir, your article, Teicher 10, which is [14] before you, reflects that you received funds from [15] NIMH that supported your work in that article. [16] Correct?

[17] A: I think it says in part, supported in [18] part, mm-hmm.

[19] Q: And it refers to NIMH grant number?

[20] A: 43743.

[21] Q: And we asked in the subpoena that was [22] directed to you that you produce for us the grant [23] or application or any documents relating to the [24] grant that supported in part the work done in

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[1] Teicher 10.

[2] A: Yes.

[3] Q: And I have had marked as Teicher 24, sir, [4] what you produced as responsive to that request in [5] the subpoena.

[6] A: Yes.

[7] Q: Now, can you tell me, first of all, is [8] that grant abstract that you have produced anywhere [9] identified as 43743?

[10] A: No, it is not, and I would like to [11] actually check to make sure that this is it.

[12] Q: Whether this is what you produced?

[13] A: Yes.

[14] Q: Look at the bottom where it says MHT, the [15] numbers.

[16] A: 000933.

[17] Q: Right. Those are numbers that were put [18] on by counsel after you produced the document to [19] them.

[20] A: Right. I remember as we were sending it [21] off that there was confusion as to which grant was [22] MH-43743 and I want to make sure that you got the [23] right form. It doesn't matter. Neither of them [24] are terribly relevant to this piece of work. What

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[1] the grant provided was some equipment including the [2] computer, the word-processing software and printer [3] that we used in preparing the report, which is why [4] we acknowledged it. It didn't provide funding for [5] the work, but it did provide equipment that we used [6] in preparing the reports.

[7] Q: May I have Exhibit 10, please.

[8] When you identify a grant in whole or [9] in part, sir, aren't you telling the scientific [10] community that you have in fact applied and [11] received funds from the organization that are [12] supporting the research that is reported on in the [13] article?

[14] A: Oh, not at all. It is an acknowledgment.

[15] Q: It is an acknowledgment of what?

[16] A: I'm acknowledging the grant agency and [17] the grant, because it provided in this case [18] equipment that we used to generate the report, and [19] that it also paid for part of my salary. So that [20] some time that I spent working on this was covered [21] by that grant. It does not specifically mean that [22] this grant was written for that purpose. I did [23] submit to the grant agency this as one of the [24] publications that I worked on during the period of

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[1] support, but I did not imply or indicate and [2] acknowledgments never indicate and never are taken [3] to indicate that this was specifically funded by [4] the grant agency.

[5] Q: So is it your position, sir, that you can [6] apply to the federal government for funds, describe [7] a study that you intend to perform, receive funds [8] from

the federal government with regard to the [9] study that you have described, and then use those [10] funds for a different purpose?

[11] A: No. I used the funds for that purpose. [12] but that doesn't mean that I could not also do some [13] things in addition to what I was funded to do. You [14] know –

[15] Q: Sir, did NIMH grant MH-43743 have [16] anything to do with the study of humans treated [17] with fluoxetine and the effects of intense suicidal [18] preoccupation in those patients?

[19] A: No.

[20] Q: Did you certify in your grant application [21] 43743 that you were going to be doing research in [22] this general area?

[23] A: I don't think you understand.

[24] Q: You know what? Let's try it this way.

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[1] Let me have marked as Exhibit 27 –

[2] MR. GREENWALD: 25.

[3] MS. GUSSACK: No, Exhibit 27. We've [4] already marked 25 and 26.

[5] MR. GREENWALD: You have? What are [6] they?

[7] MS. GUSSACK: Off the record.

[8] (Discussion off the record.)

[9] BY MS. GUSSACK:

[10] Q: Before I turn to the abstract, Exhibit 26 [11] is a document you produced in response to the [12] subpoena with the numbers MHT000160. Do you [13] recognize MHT000160 now marked as Exhibit 26?

[14] A: Yes.

[15] Q: What is it, sir?

[16] A: A correspondence or something that was [17] given to me or sent to me.

[18] Q: By whom?

[19] A: An individual I don't know.

[20] Q: Whose handwriting is this? Do you know?

[21] A: No. I would venture to say –

[22] MR. GREENWALD: Well, if you don't [23] know, you can't testify.

[24] BY MS. GUSSACK:

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[1] Q: Is it McGreenery's?

[2] A: No.

[3] Q: Is it Nurse Glod's?

[4] A: No.

[5] Q: Whose handwriting do you believe it is?

[6] MR. GREENWALD: Objection.

[7] A: This document describes a 27-year-[8]ld man [8] in the –

[9] Q: Yes, sir, I understand.

[10] A: Give me one second. Okay? – in the [11] south of France who took Prozac and killed himself, [12] and my guess is this was prepared by the patient's [13] mother.

[14] Q: And can you read what it says at the top [15] of Exhibit 26, sir?

[16] A: "Want to give you a weapon for your fight [17] with Lilly."

[18] Q: Now, sir, did you convey to the author of [19] this document that you were engaged in a fight with [20] Lilly?

[21] A: No.

[22] Q: Did you describe to anyone that you [23] needed weapons for a fight with Lilly?

[24] A: No.

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[1] Q: Did you perceive that the publication of [2] your article and the focus of attention on the [3] conclusions of your 1990 article generated some [4] kind of fight with Lilly?

[5] A: No. This woman who gave this document [6] I believe also spoke at the hearing, the FDA [7] hearing, and read her statement about her son, and [8] I don't know if after that she mailed it to me or [9] if she handed it to me at that time. So that may [10] have been her perception. It wasn't mine.

[11] MS. GUSSACK: I am going to have [12] marked as Exhibit 27 a grant application.

[13] (Teicher Deposition Exhibit 27 marked [14] for identification.)

[15] BY MS. GUSSACK:

[16] Q: Doctor, would you take a look at what [17] I have marked as Exhibit 27?

[18] MR. GREENWALD: Does it have a date?

[19] MS. GUSSACK: It is a grant [20] application that bears a date at the bottom in [21] typed version January 28, 1987.

[22] BY MS. GUSSACK:

[23] Q: That contains your signature at the [24] bottom, does it not, sir?

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[1] A: Yes, it does.

[2] Q: And this is identified –

[3] A: This is the current abstract, yes.

[4] Q: I'm sorry, sir, I didn't hear you.

[5] A: This is the MH-43743.

[6] Q: This is the grant that is in fact [7] acknowledged in Teicher 10, your 1990 article. [8] Correct?

[9] A: Yes.

[10] Q: I will be the first to say that I'm not [11] proficient at reading grant applications in your [12] area, sir, but I am guided by what appears on page [13] 2 where you say that this first award is aimed at [14] advancing our understanding of the responses of the [15] developing mammalian brain to selective regional [16] damage of dopamine systems. Right?

[17] A: Yes.

[18] Q: And that would be an overview of what [19] follows in this grant application?

[20] A: Right.

[21] Q: And, sir, you go on to say, I think, that [22] the significance of the work that you would like to [23] do if your grant application is conferred is to [24] test the hypothesis that chronic psychotic disorder

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[1] may arise from early neurobiological defects or [2] perinatal trauma?

[3] A: Yes.

[4] Q: And, sir, you certified in this grant [5] application on page 62, didn't you, that this would [6] not be research done in human subjects. Correct?

[7] A: Right.

[8] Q: Nonetheless, sir, this is the grant that [9] was conferred by NIMH and which you acknowledge in [10] part in your article Teicher 10?

[11] A: Correct.

[12] Q: So you received funds from the federal [13] government as a result of this grant application [14] and you used those funds in part to support the [15] work that you did in your 1990 article?

[16] A: If I could explain?

[17] Q: Could you just answer me yes or no, sir, [18] first and then I would be glad to hear your [19] explanation.

[20] MR. GREENWALD: He has the right to [21] explain his answer.

[22] MS. GUSSACK: I would like to hear a [23] yes or no answer first.

[24] A: The answer is yes. Okay? The

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[1] explanation is this is an R-29 award, which is a [2] first award, which is a career development award. [3] It is a career award, basically. And it is also an [4] independent research grant. This award paid 50 [5] percent of my salary, and that was the time that [6] I spent doing academic work. It also provided a [7] word processor and printer. And what [8] I acknowledged in acknowledging its contribution to [9] the published article was that it provided the [10] funding for my time that I spent writing this and [11] that it also paid for the word-processing equipment [12] that I used to produce it. [13] It was then communicated to the [14] agency that this was one of the things that I did [15] during that period of time as an example of [16] scholarly activities,

and there is no preclusion or [17] limitation on additional scholarly activities that [18] one pursues outside of the scope of the grant.

[19] Q: Dr. Teicher, can you tell me anywhere on [20] Teicher 10 that it says you're acknowledging the [21] grant to acknowledge the funds used for word-[22] processing equipment or the like?

[23] A: It doesn't say anything specific. It [24] just says supported in part. Doesn't say how it

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[1] supported.

[2] Q: I see. In the grant application that you [3] have before you, sir, don't you itemize for NIMH [4] that you need a certain amount of money to purchase [5] rat litters?

[6] A: Sure.

[7] Q: And a certain amount of money for [8] administrative assistants to run the study?

[9] A: Sure.

[10] Q: Does it say anywhere in here, sir, that [11] you wanted funds for word-processing equipment to [12] support this study –

[13] A: Yes, Macintosh –

[14] Q: Let me finish my question.

[15] MR. GREENWALD: Let her finish first.

[16] BY MS. GUSSACK:

[17] Q: I think I was trying to say: Does it say [18] anywhere in Exhibit 27 that you were seeking funds [19] for word-processing equipment to support a series [20] of case reports you were publishing in 1990 on the [21] treatment of depressed patients with fluoxetine?

[22] A: Of course not.

[23] MR. GREENWALD: Objection.

[24] A: The grant was submitted in January of

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[1] 1987 and that was before I had even heard of Prozac [2] probably. It paid for the word-processing [3] equipment which I used.

[4] Q: Let me turn your attention back to [5] Exhibit 8, if I may, Doctor, and ask you to [6] identify for me on that exhibit something that you [7] have typed here, "Affidavit, respondent Shirley S. [8] Pointer v. Andrew L. Pointer." Do you see where [9] I'm referring?

[10] A: That is a document that was sent to me by [11] Attorney Pavsner or Attorney Greenwald.

[12] Q: What does it refer to, sir? What's it [13] about?

[14] A: This has to do with the settlement, [15] secret settlement by Lilly of the Fentress case, [16] and that I guess Andrew Pointer was one of the [17] plaintiffs in that case and received an undisclosed [18] secret settlement; and I think this was his wife or [19] his soon-to-be-ex-wife who was trying to get access [20] to that settlement or something like that.

[21] MR. GREENWALD: I didn't send it to [22] you. I don't even know what it is.

[23] THE WITNESS: It's in one of the [24] folders.

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[1] MS. GUSSACK: May I have that back, [2] sir? In fact, I want to keep all the exhibits over [3] here so you don't get them confused.

[4] BY MS. GUSSACK:

[5] Q: I want to turn your attention back to [6] Teicher Exhibit 16. Would you turn, please, to the [7] entry that we referred to yesterday regarding [8] Mr. Wesbecker. Now, sir, you testified yesterday [9] that you were consulted by plaintiff's counsel in [10] Wesbecker?

[11] A: Yes.

[12] Q: And you reviewed medical records in that [13] case?

[14] A: Yes.

[15] Q: My question, sir, is what was your [16] opinion after your review of those records about [17] what role if any Prozac played in Mr. Wesbecker's [18] suicide or his violent acts directed to others?

[19] MR. GREENWALD: Objection.

[20] A: My opinion was that I could not with a [21] reasonable degree of medical certainty indicate [22] that fluoxetine was responsible for his terrible [23] acts; and that while I thought that fluoxetine did [24] not help the patient and may have made him worse

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[1] and may have in part hastened the event, there [2] seemed to be reasons to believe that this may have [3] occurred anyway even if it were not for fluoxetine.

[4] Q: And what were those reasons, sir?

[5] MR. GREENWALD: Same objection.

[6] A: Long after I made this slide it became [7] available to me that there was a greater history of [8] previous violent thoughts and plans that predated [9] the fluoxetine. I also thought that there were [10] very significant potential psychosocial factors in [11] his work environment that may have contributed [12] largely to the act.

[13] Q: Prior to obtaining that knowledge you had [14] used Mr. Wesbecker's case as part of a slide [15] presentation to colleagues at McLean in support of [16] your observations about Prozac and violent [17] behavior?

[18] A: I wouldn't necessarily say that I used [19] this to say this is strong support. We don't have [20] here a typed addendum of what I said. I presented [21] this as one of the cases that has been discussed [22] and has generated a lot of media attention.

[23] Q: Did you at the time that you presented [24] that slide, sir, say that you didn't believe there

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[1] was any causal link, between Mr. Wesbecker's use of [2] Prozac and his violent behavior?

[3] MR. GREENWALD: I am going to object [4] because that's not what he just testified to.

[5] MS. GUSSACK: I didn't say he did.

[6] BY MS. GUSSACK:

[7] Q: I didn't say "you just testified," sir. [8] I asked a freestanding question. Do you have the [9] question in mind, sir?

[10] MR. GREENWALD: Objection.

[11] A: To the best of my recollection, and this [12] goes back now I would guess five years, I made the [13] slide and I presented the slide once. Although [14] I gave the talk more than once, I did not use every [15] slide with every presentation. And the best that [16] I can recollect, I only presented this slide once. [17] And the one time that I presented the slide was to [18] the talk that I gave to the manic-depressive and [19] depressive association, and I do believe at that [20] time I actually indicated that this was a very [21] problematic case and one that had gotten a lot of [22] media attention and one that is not a clear case at [23] all.

[24] Q: Sir, did you ever obtain any information

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[1] about Rhonda Hala, one of the slides in the exhibit [2] before you, that caused you to cast doubt on the [3] conclusions reflected there?

[4] A: (Pause) Can I see the '93 drug safety [5] paper?

[6] MR. GREENWALD: Exhibit 25.

[7] (Document handed to Dr. Teicher by [8] Ms. Gussack.)

[9] A: (Pause) I did not receive information [10] I'm aware of that has made me change my opinion on [11] that.

[12] Q: All right.

[13] Just for ease of reference, Doctor, [14] I have had marked as 20-A through 20-Y the [15] materials Attorney Greenwald removed from Exhibit [16] 20 last night because of some need to review them [17] before he produced them, and he has now produced [18] those documents with the exception of a draft which [19] counsel have agreed need not be produced. I want [20] to just direct your

attention to 20-A through [21] 20-I for a moment, if I could. Could you just tell [22] me whether those are your handwritten comments on a [23] draft affidavit that was provided to you by [24] plaintiff's counsel?

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[1] A: Yes. Yes.

[2] Q: Doctor, when was the last time that you [3] treated any of the patients reported on in Exhibit [4] 10?

[5] A: When was the last time I treated any of [6] them?

[7] Q: Yes. Let me ask it a different way. Do [8] you have –

[9] A: October 28.

[10] Q: Let me ask it better then. Today is the [11] 30th. You have ongoing medical responsibility for [12] some of the patients reported on?

[13] A: Yes.

[14] Q: Can you tell me which of the patients, [15] sir? By number.

[16] A: Can I see the case report series? 2, 4 [17] and 5.

[18] Q: 2, 4 and 5 continue to be your patients?

[19] A: Yes.

[20] Q: And you continue to see them on a regular [21] basis?

[22] A: Yes.

[23] Q: You mentioned yesterday that certain of [24] your patients had had MRIs or CAT scans.

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[1] A: Yes.

[2] Q: Can you tell me whether those procedures [3] had been performed prior to the time that you [4] published your 1990 article?

[5] A: There is a letter to the editor, a [6] response to a letter to the editor that discussed [7] the neurological status, I think, of the patients [8] which I think might have a date in there. So [9] I would like to check that if I could?

[10] Q: Sure. I'm glad to have you check that, [11] but I think my question is really much narrower, [12] which is: Are you aware whether prior to the time [13] you published your case reports you had in hand CAT [14] scans or MRIs on any of the patients you reported [15] on?

[16] A: It would help if I could see that and [17] actually look at the cases too. Because what I can [18] tell you is that on most of the cases we had CT or [19] MRI data. What is going to be very hard to tell [20] you is how much that was before or after the case [21] report.

[22] Q: What would you need to look at to tell me [23] that?

[24] A: Well, I might be able to tell a bit

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[1] better from the letter to the editor.

[2] Q: That would be in your August '91 letter [3] to the editor?

[4] A: Yes.

[5] (Document handed by Ms. Gussack to [6] Dr. Teicher.)

[7] MS. GUSSACK: While you are perusing [8] that, Doctor, let me just clarify for the record [9] that the documents I earlier said I had identified [10] as 20-A through Y extend in fact past Z to 20-AA. [11] I just want the record to be clear.

[12] MR. GREENWALD: Well, that certainly [13] clears that up.

[14] BY MS. GUSSACK:

[15] Q: Are we clear that that is the right [16] letter to the editor you want to be looking at?

[17] A: Yes, it is, yes.

[18] Q: All right.

[19] (Pause)

[20] MS. GUSSACK: While the doctor is [21] looking at that, would you mark this as the next [22] exhibit.

[23] (Teicher Deposition Exhibit 28 marked [24] for identification.)

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[1] BY MS. GUSSACK:

[2] Q: Can you answer the question that is [3] pending, sir?

[4] A: Yes. In this series of cases there were [5] two subjects who had had MRI studies and three [6] subjects who had had CT scans. I can tell you that [7] the three CT scans occurred before the case reports [8] were published. With case 1 –

[9] Q: Say that again.

[10] A: Three cases, cases 4, 5 and 6, had had [11] their CT scans done prior to the publication of the [12] case reports. Case 1, which is Dr. Cole's patient [13] who had an MRI study, I'm not sure if that occurred [14] before or after the study. And case 3 had an MRI [15] study, and I'm not sure if that occurred prior to [16] the episode or actually took place during the [17] hospitalization for that episode, I think. So that [18] it may have occurred at or around the same time and [19] the data would then have been available before the [20] case was written.

[21] Q: Doctor, I have had marked as Exhibit 28 [22] Dr. Fava and Rosenbaum's reply to Dr. Brewerton's [23] reanalysis of their initial data. You are familiar [24] with that. Right?

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[1] A: Again, I haven't read it in years.

[2] Q: But it has been marked as Exhibit 28 and [3] it is before you. First, sir, let me ask you, the [4] reanalysis of Dr. Fava and Rosenbaum's data that [5] you performed is very similar to Dr. Brewerton's. [6] Correct?

[7] A: Yes.

[8] Q: And you earlier told me that [9] Dr. Rosenbaum and Dr. Fava didn't disagree with [10] this reanalysis of their data, and I'm asking you [11] based on the Exhibit 28 and your review of that [12] whether you can see points of distinction that [13] Drs. Fava and Rosenbaum have drawn as to why [14] Dr. Brewerton's reanalysis was improper?

[15] A: What they're saying is, they say that we [16] believe the approach recommended by Dr. Brewerton [17] to be inappropriate and that this post hoc change [18] in our a priori distinction between the groups [19] would not be consistent with the neutrality of the [20] methodological approach we used to examine the [21] relationship between suicidality and individual [22] classes of antidepressants.

[23] Q: Doctor, would you agree that the [24] combination of Prozac with a tricyclic

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[1] antidepressant creates a pharmacologically unique [2] compound that is distinct from each of the [3] individual components?

[4] A: That it creates a compound? I don't [5] think it creates a compound.

[6] Q: It creates an effect. Are we agreed that [7] it would create an effect that is distinct from the [8] individual compounds?

[9] A: I am not aware of any data to support [10] that. It may. I'm not aware of any data that [11] shows one way or the other. Sometimes it [12] potentiates these other actions but that does not [13] mean it is not an amplification of what you are [14] going to see with one alone.

[15] Q: Paragraph 3 of the reply, Exhibit 28, in [16] which the authors say the combination of fluoxetine [17] with a TCA is a pharmacologically unique treatment.

[18] A: That generates a very rapid [19] downregulation of beta adrenoreceptors. So what [20] happens is that the beta adrenoreceptors [21] downregulate anyway; they occur more rapidly in [22] combination. But that doesn't make it – I would [23] argue with the word "unique." I would remark that [24] it amplifies and hastens the action, but it is not

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[1] unique.

[2] Q: The action that the combination produces [3] is different than the individual components taken [4] alone?

[5] A: No, no, it's the same action; it just [6]

occurs sooner.

Q: If we include whether it happens sooner as a difference in effect, the difference in effect of the two compounds combined is different than the individual compounds taken alone?

A: I would not use that wording. If X causes Y and Z causes Y, they both have the same effect even if X causes Y to occur sooner than Z so that they have a difference in time course. They don't have a difference in effect.

Q: Drs. Fava and Rosenbaum reported, didn't they, sir, that they did not see any intense obsessive preoccupation with suicidality as you had described in your 1990 article. Correct?

A: They indicated in their publication that they did not. Dr. Rosenbaum has subsequently discussed cases with me.

Q: Has he, sir?

A: Yes.

Q: Which cases has he discussed?

A: He discussed a very dramatic case of emergence of intense suicidality preoccupation, not on fluoxetine, on the drug Xanax. So he has since seen what he would call this kind of phenomenon.

Q: I see. But that is not my question, sir, and I really would like you to focus on my question because I'm concerned that you are going to be answering things that are not responsive to me and then we are going to have confusion. My question is: Didn't Drs. Fava and Rosenbaum report in their article that they had not observed in their study the intense obsessive suicidality preoccupation that you had observed with fluoxetine in your 1990 article?

A: Yes. But that wasn't the question that you had asked.

Q: I believe it was, sir. But if not, I stand corrected and –

A: You hadn't used the word fluoxetine, which was part of the problem.

Q: And I apologize because that certainly was my intent. And the answer to that, sir, would be?

A: Yes, that is correct, they did not. They said they had not observed it.

Q: Okay.

May I direct your attention to Exhibit 2, your expert report, and turning to page 2, paragraph 3, Doctor, you make the statement that Prozac in a small but identified group of patients can cause obsessive preoccupation with violent death. Correct?

A: Yes.

Q: Now, sir, can you tell me as best you are able how you would identify that small group of patients, small but identified group of patients? I would like as best you can the criteria that you use to identify that group of patients that are at risk.

A: They are identified by their reactions. I didn't say predictable; I said identifiable. They are identified by their reaction.

Q: And yesterday, sir, you told me that not all depressed patients who are preoccupied with suicide and who take Prozac are induced to be preoccupied because of Prozac. Right?

MR. GREENWALD: Objection. Do you

follow that?

BY MS. GUSSACK:

Q: Do you remember we discussed that yesterday?

A: I think it would help to have that specific question and answer back because I'm not sure that was the exact wording.

Q: Well, let me ask you now, sir, is it your position that all depressed patients who have suicidal ideation and who are also taking Prozac are induced to have that suicidal ideation by Prozac?

A: That is a change from what you just asked in terms of ideation versus preoccupation. There are patients who had suicidal ideation before they start on Prozac and their suicidal ideation remains the same on Prozac. Prozac did nothing to cause or worsen or change their suicidal ideation.

Q: And is it your view that all patients who become preoccupied with suicidal ideation and who are taking Prozac are induced to become preoccupied with suicidal ideation by Prozac?

A: No.

Q: How do you distinguish between who is and

who isn't?

A: That would depend on a number of factors. First, if there were very clear other precipitants for the suicidal preoccupation and we could identify with good certainty that this is a very clear reason why the patient was feeling suicidal and if something happened to change the situation and their suicidal preoccupation remitted and they continued to be on fluoxetine, I would not conclude that fluoxetine was the factor.

Q: Okay. That's one way you would say it wasn't Prozac-induced?

A: Right. So the first thing is to look for alternative explanations. If one could find and establish a credible alternative explanation, I would go with the alternative explanation.

The second is how the patient does when you discontinue the medication. If the condition does not change, if the condition worsens, deteriorates, it would be much harder to make the association that it was fluoxetine.

I would strengthen the association if the patient had known side effects that were also attributable to fluoxetine, say, akathisia,

hypersomnia, fatigue. That would also strengthen the association that this fits profiles that we have seen in other patients.

If the patient had in general evidence that they were responding atypically and nonbeneficially to the drug, that would strengthen the association.

If there was much in the way of what we consider secondary gain from the association, that would cast doubt on it.

Q: What does that mean?

A: In psychiatry we talk about factitious disorders, malingering. There are some people who will fake symptoms, will fake mental problems, sometimes for attention, sometimes in order to get out of work on a disability, get insurance money, the whole gamut of things. If somebody was claiming to have a side effect with the idea of using that to get financial remuneration, that would in my mind cast doubt on the validity of it.

Q: So someone whom you know to be prone to make up symptoms would cut against causing you to assume there is any linkage between their drug exposure and their side effects?

A: Right.

Q: Any other way that you distinguish between what's Prozac-induced suicidal preoccupation and what's not?

A: It would also depend a great deal on their history.

Q: In what way?

A: If the patient has been in treatment for a long time, if a great deal is known about the nature and course of their condition, and if this is a very distinct and clear change from their previous

state and it really represents a [13] qualitative change and then after the trial they go [14] back to assuming their previous course, that would [15] also be stronger evidence that the drug was causing [16] it.

[17] Q: Doctor, do all of those explanations also [18] hold true for how you distinguish between whether [19] someone who commits suicide while taking Prozac is [20] related to the drug or is not? Do you understand [21] my question?

[22] A: Yes.

[23] Q: Okay. In distinguishing between patients [24] who commit suicide while taking the drug, I'm

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[1] asking how do you determine which are caused or [2] induced suicides by the drug, and my question [3] really is: Does your former answer apply to this [4] question as well?

[5] A: Yes, it does.

[6] Q: Is there anything additional you would [7] add?

[8] A: I think that covers the territory. You [9] know, you have to change them a little bit. If [10] somebody does commit suicide you don't get any [11] additional data as to how they do after they stop [12] the drug.

[13] Q: When in your opinion, sir, did Michael [14] Rosenbloom become obsessively preoccupied with [15] suicide?

[16] A: Can I check something in here for a [17] moment?

[18] Q: Sure. And let me also ask you at the [19] same time while you're looking at that to make sure [20] you have Teicher 22 in front of you as well.

[21] MR. GREENWALD: When are we going to [22] break for lunch?

[23] (Discussion off the record.)

[24] BY MS. GUSSACK:

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[1] Q: Doctor, you have my question in mind?

[2] A: Yes. I'm trying to see if in here I ever [3] state that Rosenbloom developed obsessive [4] preoccupation with suicide. I can't see any part [5] in here where I say that he developed an obsessive [6] preoccupation with suicide.

[7] Q: Well, sir, is it your opinion that he [8] did?

[9] A: I don't know if he did.

[10] Q: Turning to Teicher 22, sir, your April [11] '91 opinion, you say that Prozac could produce [12] marked worsening of depression or induce or amplify [13] suicidal thoughts. So my question to you, sir, is [14] what evidence if any do you have that [15] Mr. Rosenbloom after [16] taking Prozac had suicidal [16] thoughts induced or amplified?

[17] A: Oh, I believe his thoughts were [18] amplified; that he had what Dr. Sandler described [19] as inconsequential suicidal thoughts before taking [20] fluoxetine and after taking fluoxetine his suicidal [21] thoughts were so consequential that he killed [22] himself.

[23] Q: And what is the evidence, sir, that you [24] have of that?

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[1] A: That he killed himself. I have Sandler's [2] evidence that shortly before the thoughts were [3] inconsequential; then I have the fact that they [4] became so severe that he killed himself.

[5] Q: And you are also aware that within the [6] last week of his life there were precipitating [7] events that I think you described as psychosocial [8] stressors, sir?

[9] A: Yes.

[10] Q: You are aware of that, sir?

[11] A: Yes.

[12] Q: But referring to the same paragraph of [13] your Teicher 2, Doctor, you say that this obsessive [14] preoccupation with violent death can lead to [15] suicide attempts or fatalities in those who would [16] not otherwise be likely to kill or attempt to kill [17] themselves.

[18] A: Excuse me. Where are you?

[19] Q: Teicher 2, your expert report, page 2, [20] paragraph 3.

[21] A: Okay, yes, I see that.

[22] Q: Sir, how do you know who is likely to [23] kill or attempt to kill themselves?

[24] A: We can assess relative risk.

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[1] Q: Based on what?

[2] A: Based on clinical knowledge, based on [3] statistical inference.

[4] Q: Who of the depressed population is not at [5] risk for suicide attempts?

[6] A: The vast majority are not at risk for [7] suicide.

[8] Q: Suicide attempts I said.

[9] MR. GREENWALD: Wait a second now. [10] Have you finished your answer, Doctor?

[11] BY MS. GUSSACK:

[12] Q: Did you understand my question?

[13] A: Yes, and I was answering it in terms of [14] suicides.

[15] Q: But could I ask you to do that when I ask [16] you that question. My question was, who of the [17] depressed population is not at risk for suicide [18] attempts?

[19] MR. GREENWALD: And he said the great [20] majority of them. That was his answer.

[21] A: No, I said of suicide.

[22] Q: Right. So could we just focus on suicide [23] attempts first?

[24] A: Yes.

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[1] Q: Okay.

[2] A: There are depressed patients who have no [3] history of impulsive behavior and who have no [4] history of suicidal ideation and who are [5] absolutely, totally dead against suicide for any [6] reason, often because of strong religious beliefs, [7] and those are ones who are not likely to attempt [8] suicide.

[9] Q: Dr. Teicher, are you aware of any [10] evidence that Michael Rosenbloom was obsessively [11] ruminating about suicide from the time that he was [12] prescribed Prozac until the time of his death?

[13] A: No.

[14] Q: Did he speak to anyone as far as you know [15] about obsessive preoccupation with suicide?

[16] A: No, he did not.

[17] Q: Doctor, you presented your observations [18] based on your 1990 article at the [19] Psychopharmacologic Drug Advisory Committee to the [20] FDA. Correct?

[21] A: That's right.

[22] Q: And that was in September 1991?

[23] A: I believe so.

[24] Q: You were invited there by the committee

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[1] as a consultant to express the views that had [2] triggered a lot of this debate within the [3] scientific community?

[4] A: Yes, by the FDA. I'm not sure it was by [5] the committee.

[6] Q: By the FDA?

[7] A: Yes.

[8] Q: And you in fact attended?

[9] A: Yes.

[10] Q: And you spoke?

[11] A: Yes.

[12] Q: Sir, is it fair to say that the committee [13] by their unanimous vote rejected your position that [14] there was a risk of suicidal preoccupation or [15] emergence of suicidal ideation with fluoxetine?

[16] MR. GREENWALD: Objection.

[17] A: It was my impression that by their vote [18] they indicated that the data was not yet in.

[19] Q: Well, sir, can you show me any document [20] that you can refer to where they say that?

[21] A: Yes. It's in – Do you have the [22]

conclusions? And I remember their discussion that [23] they had and basically they indicated that they [24] would need to keep an eye on it. They certainly

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[1] were not saying "Gee, your idea is wrong, it has no [2] substance, go away." They were –

[3] Q: Well, is that how scientists talk to one [4] another?

[5] A: If they feel that way they do. They were [6] more saying that the available data is not – [7] There isn't available data yet to support the [8] hypothesis; that more data is needed, and that at [9] this time we can't conclude that this is a valid [10] association. And that is much more the way that [11] scientists talk.

[12] Q: Scientists and physicians look to data to [13] support or refute conclusions. Correct?

[14] A: Yes.

[15] MS. GUSSACK: Mark this, please.

[16] (Teicher Deposition Exhibit 29 marked [17] for identification.)

[18] BY MS. GUSSACK:

[19] Q: Doctor, have you ever seen before the [20] Talk Paper issued by the Food and Drug [21] Administration on October 18, 1991?

[22] A: Yes. I believe I have.

[23] Q: So you are familiar with the fact that [24] after the Psychopharmacologic Drug Advisory

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[1] Committee, the FDA issued a position summarizing [2] the conclusions of the committee's findings. [3] Correct?

[4] A: Yes.

[5] Q: And, sir, it is true, isn't it, that the [6] committee unanimously agreed that there is no [7] credible evidence of a causal link between the use [8] of antidepressant drugs including Prozac and [9] suicidality or violent behavior. Correct?

[10] A: Yes.

[11] Q: You were there when they took that [12] unanimous vote. Right?

[13] A: Yes.

[14] Q: And, sir, despite the fact that you told [15] them at that advisory committee that you felt that [16] fluoxetine presented a greater risk than the other [17] SSRIs, the committee rejected that position, didn't [18] they?

[19] MR. GREENWALD: Objection.

[20] A: I don't see that they specifically [21] addressed that one way or the other. But what's [22] important here is they also voted six to three [23] against making a labeling change because they [24] considered increasing the warnings on fluoxetine.

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[1] and some of the committee members felt they should [2] and that there was a consensus that more research [3] is needed to further explore all the potential [4] implications of these reports, not only for Prozac [5] but for other antidepressants as well.

[6] So what I took back was a very clear [7] need for further research and they were not closing [8] the door; that at this point in time there wasn't [9] credible evidence but they felt that there was [10] clearly a further need for more research.

[11] Q: And the "at this time," sir, that there [12] was no credible evidence they're referring to is [13] October 1991?

[14] A: Yes.

[15] Q: If you look at page 3 of the exhibit that [16] is before you, you will see in the first full [17] paragraph that the committee was asked to consider [18] whether or not the evidence supported a conclusion [19] that antidepressant drugs generally and Prozac in [20] particular caused the emergence or intensification [21] of suicidality or other violent behaviors, and they [22] said there was no such evidence. Correct?

[23] A: Right.

[24] MR. GREENWALD: Is this a good time

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[1] now to take a lunch break? If you're at the close [2] of a topic, I'm just wondering if it's a good time.

[3] MS. GUSSACK: Sure, sure.

[4] MR. GREENWALD: Good.

[5] (Luncheon recess at 12:10 p.m.)

[6] AFTERNOON SESSION

[7] 1:10 p.m.

[8] BY MS. GUSSACK:

[9] Q: Doctor, we have had marked as Exhibit 30 [10] your handwritten notes that were contained in a [11] folder labeled Drug Experience Reports, and Exhibit [12] 30 appear to be those handwritten notes and at the [13] top it bears the comment "up to 8/13/86."

[14] A: Yes.

[15] Q: Are those your notes of your review of [16] drug experience reports that you were provided by [17] plaintiff's counsel?

[18] A: Yes.

[19] MS. GUSSACK: For the sake of the [20] record, then, why don't we make the drug experience [21] reports which you reviewed in order to make those [22] handwritten notes 30-A.

[23] (Teicher Deposition Exhibit 30-A [24] marked for identification.)

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[1] BY MS. GUSSACK:

[2] Q: Teicher Exhibit 30 is an attempt to do [3] what, sir?

[4] A: It was to –

[5] MR. GREENWALD: Objection to the word [6] "attempt."

[7] A: It was my extraction from the adverse [8] reports all of the patients who had engaged in [9] suicidal actions or had marked suicidal ideation [10] that were listed on the adverse reports up until [11] 8/31/86, I believe.

[12] Q: Doctor, do you know whether the documents [13] that you were making notes of which are labeled [14] drug experience reports through June 25, '89, are [15] in fact a document that came from Lilly?

[16] A: I believe it was their adverse drug [17] experience reports, yes.

[18] Q: Do you believe this document, page 1 [19] through, well, it looks to be a series of [20] documents. Let me refer to it this way. Are the [21] documents that are contained in Teicher 30-A as far [22] as you are concerned documents that existed at [23] Lilly?

[24] A: Yes.

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[1] Q: You are unaware, then, sir, as to whether [2] documents contained in 30-A represent data that has [3] been collected, organized or reorganized by [4] plaintiff's counsel in this case or any other case?

[5] A: Correct.

[6] Q: We have had marked as Teicher 31 what you [7] had previously identified to us as a proposal that [8] you made to test the hypotheses offered in your [9] 1990 article, and I'm showing you what you had [10] earlier indicated in a folder called Lilly [11] Aggression Proposal.

[12] A: This manila folder that is sitting inside [13] this green folder is not the manila folder that [14] goes in this green folder.

[15] Q: How about if we put the manila folder [16] labeled Lilly Aggression Proposal in the folder [17] labeled Lilly Aggression Proposal and see if that [18] works. (Pause)

[19] Is that the proposal that you earlier [20] discussed you had made through the director of [21] McLean to Lilly to test the hypotheses in your 1990 [22] article?

[23] A: There's a piece of paper in here that's [24] not relevant to this.

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[1] Q: Okay. Would you leave it in there, sir. [2] And that piece of paper is called what?

[3] A: Letters to the editor.

[4] Q: Okay. But for the integrity of the file, [5] let's leave it in the file as we found it.

[6] But the other papers in 31 refer to [7] the proposal that you were making to Lilly?

[8] A: Yes. And to clarify this most [9] accurately, I would say that this was a proposal to [10] explore the hypothesis that fluoxetine is [11] associated with aggression.

[12] Q: Not suicidal preoccupation?

[13] A: No.

[14] Q: So you did not make a proposal to Lilly [15] to test or – What was the phrase you used, sir?

[16] A: To explore the association between [17] fluoxetine and aggressive behavior. And that could [18] include self-destructive behavior. It doesn't [19] exclude suicide, but it could also include other [20] forms of aggressive behavior.

[21] Q: We have had marked as Teicher 32 –

[22] MR. GREENWALD: What's 31? What are [23] we calling that? What is it?

[24] MS. GUSSACK: The proposal.

[1] MR. GREENWALD: To Lilly?

[2] MS. GUSSACK: Yes.

[3] BY MS. GUSSACK:

[4] Q: Teicher 32 is a manila folder labeled [5] Suicide Grant, sir. Is that right?

[6] A: Right.

[7] Q: What does Exhibit 32 represent?

[8] A: It seems to me to be thoughts about [9] submitting a grant to the National Institute of [10] Mental Health, which we never did.

[11] Q: What was the thought that you were going [12] to be looking at if you submitted something to the [13] National Institute of Mental Health?

[14] A: What I was beginning to think about [15] was – (Pause) I can't honestly recall what the [16] hypothesis was that we were thinking about doing. [17] There's a lot of notes on here about different [18] things to look at, but the hypothesis isn't [19] articulated on this sheet of paper.

[20] Q: Did you ever submit anything to NIMH as a [21] proposal?

[22] A: No.

[23] MS. GUSSACK: I am going to have [24] marked as Exhibit 33 a folder labeled Suicide

[1] Foundation Grant.

[2] (Teicher Deposition Exhibit 33 marked [3] for identification.)

[4] BY MS. GUSSACK:

[5] Q: Doctor, is Exhibit 33 the other proposal [6] that you made seeking funding for a study to test [7] the hypotheses that you published in 1990?

[8] A: (Pause) Yes.

[9] Q: Was that intended to look at suicidal [10] preoccupation as a result of fluoxetine use?

[11] A: That is certainly part of it.

[12] Q: What is the other part of it?

[13] A: Well, part of it is to look for [14] associated risk factors and potential biological [15] markers.

[16] Q: Doctor, if Lilly wanted to do a study to [17] further explore the observations and hypotheses [18] that you generated in your 1990 article, could you [19] define the inclusion criteria for the patients that [20] would need to be enrolled in such a study?

[21] A: It depends on how they would want to do [22] the study. I mean, there are different acceptable [23] and valuable scientific methods of exploring the [24] question. One would be a randomized prospective

[1] controlled trial. Another would be essentially a [2] rechallenge study. Now, the criteria for entering [3] into those two studies would be different.

[4] Q: Let's take the first one first, the [5] randomized controlled trial.

[6] A: Randomized prospective controlled trial. [7] Then again the inclusion and exclusion criteria [8] would be based on what the hypothesis is that you [9] have and the question that you want to ask. So [10] there are two basic ways that one could design such [11] a study.

[12] The first hypothesis may be to ask [13] the question as to whether there is a risk of [14] patients treated with fluoxetine developing [15] obsessive suicidal preoccupation or engaging in [16] suicidal activities. And you may want that to be [17] general information for patients who are likely to [18] be treated with fluoxetine and so your sample would [19] specifically be those patients who are likely to [20] receive treatment with fluoxetine and in this case [21] for depression. And that would be the basis for [22] the sample.

[23] You may do a more firm test – [24] An alternative would be to do a more firm test of

[1] the case reports. And in that situation you may be [2] wanting to verify the outcome or verify the case [3] reports by saying, well, this phenomenon was [4] reported in complicated patients with preexisting [5] conditions, often a history of medication [6] refractoriness, previous exposure to MAOIs, so you [7] would want to design a controlled trial that would [8] duplicate those kind of criteria and look into that [9] because you might consider that to be the high-risk [10] subgroup in a sense.

[11] So you could either do it two ways. [12] You could get information about the general patient [13] population, which would be very useful information [14] from the standpoint of the clinician. Or you can [15] try to look at the specific subgroup, which would [16] be scientifically interesting in terms of testing [17] the hypothesis in the most clearly at-risk group.

[18] Q: Are you familiar with prospective [19] controlled trials that have been done to look at [20] depressed patient populations and determine if they [21] have an increase in suicidal thinking or acts?

[22] A: No, I am not.

[23] Q: You are not aware of any that have been [24] done?

[1] A: I am not aware of any that were done that [2] were specifically intended for that purpose with [3] adequate experimental design to test the [4] hypothesis.

[5] Q: Which trials are you aware of that have [6] inadequate design?

[7] A: The trials that were analyzed by Beasley, [8] the trials that were analyzed by Tollefson. Those [9] were not prospective trials; those were [10] retrospective analyses of previously conducted [11] trials. A very different situation.

[12] Q: Are you familiar with Dr. Tollefson's [13] agitation baseline study?

[14] A: Yes.

[15] Q: Is that a prospective trial study?

[16] A: No, it is not. That was a retrospective [17] reanalysis.

[18] Q: Are you familiar with the Warshaw-Keller [19] article?

[20] A: That was a naturalistic study. That was [21] not a randomized controlled trial.

[22] Q: And as far as you know, other than the [23] Lilly trials that you believe are retrospective as [24] to this issue, you are not aware of any

[1] prospectively designed controlled trials looking at [2] the issue of the use of fluoxetine and the [3] incidence of suicidal ideation or acts?

[4] A: No, I am not.

[5] Q: Sir, are the proposals that you have [6] identified as Exhibits 31, 32 and 33 – I withdraw [7] that. Let me ask you a

different way.

[8] The proposal that you made to Lilly, [9] Exhibit 31, I take it represented your best [10] thinking at the time about how to further explore [11] the issues of violence –

[12] A: Aggression, which could include suicide.

[13] Q: Aggression including suicide at the time [14] you prepared this exhibit, Exhibit 31?

[15] A: Yes.

[16] Q: And would that be true, sir, also as well [17] of Exhibit 32, that at the time you prepared this, [18] this was your best thinking and most careful [19] attempt to identify how you would go about further [20] evaluating the issues regarding suicide, suicidal [21] behavior in conjunction with fluoxetine?

[22] A: That is the one that just has the one [23] sheet of paper?

[24] Q: No, sir.

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[1] A: One sheet of my handwritten paper.

[2] Q: Yes. And three other documents in here.

[3] A: Can I please see that?

[4] No, this does not represent any type [5] of grant proposal or application at all. This was [6] just preliminary thoughts on the possibility of [7] submitting an application, which was never [8] submitted.

[9] Q: So 32 was never submitted; 31 you believe [10] was submitted?

[11] A: Yes.

[12] Q: And Exhibit 33, a proposal to the suicide [13] foundation, you believe was submitted?

[14] A: Yes.

[15] Q: Was that your effort to accurately and [16] clearly define what your goals were in evaluating [17] risk factors and biological markers in patients [18] with fluoxetine-induced suicidal ideation?

[19] A: Yes.

[20] Q: Doctor, have you undertaken any effort to [21] conduct a study, a prospective controlled study to [22] test any of the mechanisms identified in your 1993 [23] drug safety article?

[24] A: Have I undertaken or proposed to

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[1] undertake?

[2] Q: Have you undertaken?

[3] A: No.

[4] Q: And I'll bite. Have you proposed to [5] undertake?

[6] A: We don't have here the application to [7] NARSAD and I would have to look at that one.

[8] Q: Do you believe you have that application [9] in your office, sir?

[10] A: It should be there, yes.

[11] Q: Let me ask that you identify it and [12] produce it.

[13] MS. GUSSACK: And I take it, [14] Mr. Greenwald, that you would want the doctor to [15] produce the document responsive to his answer here.

[16] MR. GREENWALD: The doctor will send [17] me a copy. I will take a look at it and forward it [18] on.

[19] Make a note, Doctor, to look for [20] that.

[21] BY MS. GUSSACK:

[22] Q: Doctor, would you agree with me that your [23] case reports are not scientific evidence of a cause [24] and effect relationship between the use of Prozac

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[1] and the emergence of suicidal ideation or [2] preoccupation?

[3] MR. GREENWALD: Objection.

[4] A: I would agree they are not conclusive [5] scientific evidence.

[6] Q: And you would agree with me, sir, [7] wouldn't you, that you need to perform additional [8] tests or studies to obtain information that would [9] be conclusive?

[10] MR. GREENWALD: Objection.

[11] A: Yes.

[12] Q: Are you aware, sir, of any tests or [13] studies that have been done which you find to be [14] conclusive on this subject?

[15] A: I am aware of several studies that [16] provide important additional information that makes [17] the conclusion significantly more conclusive.

[18] Q: Do any of them alone, sir, provide you [19] with conclusive information, scientifically [20] conclusive information about a causal link between [21] the use of Prozac and the emergence of obsessive [22] suicidal ideation?

[23] MR. GREENWALD: Objection to the form [24] of the question. I don't know what you mean by

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[1] "conclusive."

[2] BY MS. GUSSACK:

[3] Q: Doctor, can you answer, please?

[4] MR. GREENWALD: And also that is not [5] the standard for the conclusion. But he can [6] answer.

[7] A: The answer to that very specific question [8] is, I am not aware of any one study that provides [9] conclusive evidence for the emergence of suicidal [10] preoccupation. I am, however, aware of single [11] studies that provide what I would believe is [12] virtually conclusive scientific evidence that there [13] is increased risk of suicide on Prozac.

[14] Q: Would you identify those studies, sir?

[15] A: Yes. It is the BGA analysis that [16] I conducted on data that was submitted to the BGA.

[17] Q: You mean the BGA statistical analysis [18] that has been identified as an exhibit in this [19] deposition?

[20] A: Yes.

[21] Q: Anything else, sir?

[22] A: It also applies to their response to the [23] BGA, which is additional data. So analysis of [24] their own clinical trial data.

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[1] Q: Your reanalysis of Lilly's clinical trial [2] data is the data that you believe provides [3] virtually conclusive evidence of –

[4] A: Increased risk of suicide attempts.

[5] Q: Increased suicide attempts?

[6] A: Or suicidal actions on fluoxetine.

[7] Q: Is there anything else, sir?

[8] A: No.

[9] Q: Your 1993 article, sir, which has been [10] marked as Exhibit 25, presents again hypotheses of [11] mechanisms. Is that correct, sir?

[12] A: Yes.

[13] Q: And in Exhibit 25, I think it's at page [14] 187, you identify possible mechanisms that are [15] being offered in this article. Correct?

[16] A: Well, yes, that's true. I'm not sure [17] where on 187 it is.

[18] Q: You're not sure what? Pardon me.

[19] A: I'm not sure where on page 187 it says [20] that, but that's true.

[21] Q: And at the conclusion of your 1993 [22] article, Dr. Teicher, you say that sophisticated [23] studies would be necessary – page 207, "Very [24] sophisticated studies will need to be conducted to

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[1] ascertain whether" Do you see where I'm [2] reading?

[3] A: Can you help me find it?

[4] Q: First column at the bottom, page 207. [5] Can you read that sentence?

[6] A: "Very sophisticated studies will need to [7] be conducted to ascertain whether this is true if [8] on balance the antidepressant produces an overall [9] incident rate similar to placebo."

[10] Q: Are you aware, sir, of any such [11] sophisticated studies that have been conducted?

[12] A: No. But this indicates – If I could [13] explain for a second? What I indicate

here is that [14] if the incident rate is virtually the same on drug [15] as on placebo, you would need to conduct very [16] sophisticated studies; and that what I was led to [17] believe as of 1993 – Actually, when did I submit [18] the paper? Around 1993. I can't tell you exactly [19] when I submitted it. At around that time I was led [20] to believe by the Beasley reanalysis that the [21] incident rates were largely the same for fluoxetine [22] and Prozac. Excuse me. For Prozac and placebo.

[23] What I have observed in the BGA data [24] and in their first reapplication to the BGA, that

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[1] the incident rates were not the same. The incident [2] rates were significantly different. That changes [3] the whole situation.

[4] MS. GUSSACK: Let's mark this as [5] Exhibit 34.

[6] MR. GREENWALD: Are we going to call [7] that the red-paper-clipped file?

[8] MS. GUSSACK: Sure.

[9] MR. GREENWALD: What exactly can we [10] call that that would be a little more [11] sophisticated? Doctor, what name can we give that [12] file with the red paper clips? Is that the BGA [13] material?

[14] THE WITNESS: In part it is BGA [15] material; in part it is Lilly memoranda and [16] e-mails.

[17] MS. GUSSACK: Well, why don't we mark [18] it first.

[19] MR. GREENWALD: But how are we going [20] to describe it?

[21] MS. GUSSACK: I'll describe it once [22] we mark it. How's that?

[23] (Teicher Deposition Exhibit 34 marked [24] for identification.)

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[1] BY MS. GUSSACK:

[2] Q: I have had marked as Teicher 34, Doctor, [3] your folder that contains documents obtained from [4] counsel as well as deposition transcripts, and you [5] have labeled on the side of the folder "BGA data." [6] Correct?

[7] A: Mm-hmm.

[8] Q: You have placed a series of paper clips [9] on these pages and I believe you told us earlier, [10] to identify things that were of significance to [11] you?

[12] A: Yes.

[13] Q: You have previously identified the page [14] that you believe you used to generate your [15] statistical analysis. Correct?

[16] A: Yes.

[17] Q: Would you tell me, sir, where you believe [18] in Exhibit 34 are the documents that support your [19] view that the risk is not the same as between [20] placebo and fluoxetine for suicide attempts?

[21] A: Okay. It says here, the first three [22] paragraphs –

[23] Q: Sir, can you read the PZ number?

[24] A: It's PZ2811692. The first three

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[1] paragraphs discuss patients who had made suicide [2] attempts and which they wanted to exclude from [3] counting in the final analysis.

[4] MR. GREENWALD: "They" being? I'm [5] sorry. Just for clarification.

[6] A: This whole document –

[7] MR. GREENWALD: Wait one second. [8] Could I just ask the doctor not to [9] use pronouns so just so we'll be clear who we're [10] talking about, he, they, you. We need to know who [11] you're talking about. If the "they" is Lilly, if [12] the "they" is somebody else, Rosenbaum or whoever, [13] it's just a little difficult to follow since we [14] don't have the exhibit.

[15] THE WITNESS: I'm sorry.

[16] MR. GREENWALD: Go ahead.

[17] A: This represents data from Lilly. It was [18] a correspondence from Dr. Johanna Schenk and it is [19] involving their endeavor to receive marketing [20] approval for fluoxetine in Germany, and this [21] provides a breakdown of attempted or successful [22] suicides of inpatients who are receiving the [23] various forms of treatments used in the controlled [24] therapeutic trial, which included fluoxetine,

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[1] placebo, and comparative drugs. And in this they [2] indicate the number of attempted or successful [3] suicides that were observed in the trials that they [4] presented initially to the BGA. And they indicated [5] here that there was one out of 71 patients on [6] amitriptyline, twelve out of 1,352 patients on [7] fluoxetine, zero out of 134 doxepin patients, zero [8] out of 394 persons on imipramine, and zero out of [9] 378 patients on placebo postrandomization.

[10] Then they eliminated from that one [11] patient on fluoxetine who ingested twice her [12] prescribed dose of fluoxetine plus half a bottle of [13] rum. They concluded that that was not an attempted [14] or a successful suicide, so they dropped that. [15] Otherwise there would have been thirteen out of [16] 1,352 patients on fluoxetine.

[17] And that is the data to which I am [18] referring.

[19] Q: Doctor, have you analyzed the data that [20] was submitted to BGA using patient-years of [21] exposure?

[22] A: No.

[23] Q: Would that be of significance to you in [24] your analysis?

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[1] A: It wasn't provided in that document.

[2] Q: Would that information be of use to you [3] in making an analysis of the BGA data?

[4] A: No.

[5] Q: Why is that, sir?

[6] A: It wouldn't be useful because most of the [7] effects emerged early and that was a problem in the [8] experimental design, that is, that they didn't [9] allow for equal time on drug. They had procedures [10] within their experimental design which they could [11] cross patients over.

[12] Q: In how many studies, sir, was that a [13] design problem?

[14] A: I don't know the exact number of studies [15] in which that was a design problem.

[16] Q: More than one?

[17] A: Yes.

[18] Q: More than five?

[19] A: I have no idea.

[20] Q: How many studies were considered in your [21] statistical analysis?

[22] A: I don't know the number of studies.

[23] Q: Do you know what the treatment-years of [24] exposure were across treatment groups? Patient-

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[1] years of exposure over treatment groups.

[2] A: No.

[3] Q: Sir, did you apply a two-tailed Fischer [4] test to your analysis to either of these?

[5] A: Both two-tailed and one-tailed.

[6] Q: Excuse me?

[7] A: I applied both two-tailed and one-tailed.

[8] Q: And with a two-tailed Fischer test did [9] you find statistical significance?

[10] A: Strong trends.

[11] Q: Did you find statistical significance?

[12] A: That's an arbitrary question. Yes, [13] that's significant.

[14] Q: Is it statistically significant using a [15] two-failed Fischer test?

[16] A: In that sample, yes.

[17] Q: And are you referring both to the [18] analysis performed for 12-G and 12-J?

[19] A: If I could see them, I believe they

are [20] both P equals .08. (Pause) Yes, P equals .08.

[21] Q: Actually, Doctor, before I remove this [22] from you, can you tell me what number did you use [23] as a denominator for your analysis?

[24] A: There were several numbers used as

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[1] denominators.

[2] Q: For your chart on 12-G what number of [3] patients were you comparing?

[4] A: It was the number that was for each [5] group. There's a denominator for each group, so [6] there's more than one denominator.

[7] Q: And that would be drawn from PZ2811692?

[8] A: Yes.

[9] Q: Doctor, I am showing you the Hamilton [10] psychiatric rating scale for depression and I ask [11] you to turn your attention to item 3 of that, if [12] you would. Just by way of comparison, sir, I am [13] putting before you Teicher 16, your slide [14] presentations on your 1990 patients, and on page [15] MHT643 you have a summary of the Hamilton [16] depression rating scale. Right? Item 3, Doctor.

[17] A: Yes.

[18] Q: Do you see, sir, that your description [19] for the rating number 4 on item 3 differs from the [20] Hamilton depression rating scale, item 3, category [21] number 4?

[22] A: Yes, but I don't know what this is.

[23] Q: You don't recognize that, sir?

[24] A: Well, this is a version of the Hamilton

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[1] depression scale, but this is not Hamilton's 1962 [2] article. Do you have his article?

[3] Q: You believe there is a difference in how [4] category number 4 is defined?

[5] A: In this one it says attempts at suicide, [6] 4, parenthesis, "Any serious attempt rates 4," [7] close parenthesis. On my scale it is attempts [8] at suicide, parenthesis, "Only serious attempt [9] rates 4."

[10] Q: Do you believe your slide presentation [11] of item 3 of the Ham D is the accurate version of [12] item 3?

[13] A: I would have to check the original paper.

[14] Q: For purposes of my questions I think we [15] can use either one, whichever one you're [16] comfortable with.

[17] A: I think they're virtually the same. [18] There is more ambiguity in this one, but they are [19] probably the same.

[20] Q: When you say "this one" you're referring [21] to the Hamilton depression scale I put before you, [22] the complete scale?

[23] A: Yes.

[24] Q: So for our purposes now we are going to

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[1] use Teicher 16, and I also think you might want to [2] have before you your 1990 article.

[3] MR. GREENWALD: Wait a second. This [4] is a loose paper. Can I just ask, does it come [5] from this folder?

[6] MS. GUSSACK: It comes from the [7] folder you have. It just came from there, yes.

[8] MR. GREENWALD: It did? Okay.

[9] (Discussion off the record.)

[10] BY MS. GUSSACK:

[11] Q: Before we leave Teicher 12-G, your [12] statistical analysis for the data submitted to BGA, [13] can you tell me – and just for clarification I'll [14] mark it 12-H now – what the reference on your [15] statistical analysis that you earlier described, [16] what the reference to "Significance tests are [17] suspect" means?

[18] A: Yes. This is a printout from a computer [19] program called SYSTAT and they're providing data on [20] in this case a three-group comparison, that is, [21] fluoxetine, placebo, and tricyclic. And what it [22] showed was that the significant difference between [23] the three groups couldn't have occurred by chance, [24] P less than .01 according to the Pearson chi-square

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[1] and P equals .012 for the likelihood of ratio of [2] chi-square. There is, however, a problem with the [3] chi-square test when you have sparse frequency in [4] one of the cells, so that if the probability of an [5] event occurring in a cell is very low, it renders [6] the chi-square test not highly accurate.

[7] It is a good approximation, but you [8] have to know that. And that's why when I put the [9] data on for the other ones I used the Fischer Exact [10] test, which is not affected in the same way. And [11] there's often a correction that you can apply to [12] the chi-square, which is the Yates correction, [13] which makes it more accurate.

[14] Q: So there are some questions about the [15] validity of that conclusion?

[16] A: No.

[17] Q: Well, Doctor, if you have some concerns [18] about –

[19] A: No, I presented the Fischer data. The [20] Fischer data is not subject to that conclusion. [21] The chi-square data is subject to that conclusion.

[22] Q: Okay, I understand.

[23] Can you tell me where you have [24] offered the scientific opinion that Prozac causes

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[1] people, depressed patients, to become obsessively [2] preoccupied with suicidal ideation or to commit [3] suicide other than in the expert reports you've [4] offered in this case?

[5] A: I haven't.

[6] Q: So the only place that you have offered [7] that as a scientific conclusion is in the context [8] of this litigation?

[9] A: Correct.

[10] Q: Let me turn to patient number 1 in [11] Teicher 10, your 1990 article. Sir, do you recall [12] that when you were present at the [13] Psychopharmacologic Drug Advisory Committee you [14] testified about patient number 1 that she basically [15] thought for about three seconds that she wanted to [16] take all her pills, said it was foolish and went no [17] further?

[18] A: That was prior to fluoxetine.

[19] Q: Yes, sir.

[20] A: Yes. I would like to see where I said it [21] but I have some recollection of it.

[22] Q: I apologize for my highlighting. But on [23] page 256 at the bottom I believe there is a [24] reference to the patient. Correct?

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[1] MR. GREENWALD: I'm sorry. Where [2] does that come from?

[3] MS. GUSSACK: In the [4] Psychopharmacologic Drug Advisory Committee [5] meeting.

[6] A: That's what I said. I believe it's a [7] reasonably accurate quote.

[8] Q: So at the time that patient number 1 felt [9] this way prior to her taking fluoxetine, how would [10] you have rated her on item 3 of the Ham D?

[11] A: She would have gotten a 3.

[12] Q: And why is that, sir?

[13] A: It says suicide ideas.

[14] Q: Is that how you would have rated Michael [15] Rosenbloom the day that he was prescribed Prozac [16] before he took it?

[17] A: Yes, I believe so.

[18] Q: Now, did you prior to publishing the case [19] report have any occasion to look at Dr. Cole's case [20] report forms that he completed on patient number 1?

[21] A: No, I did not.

[22] (Teicher Deposition Exhibit 35 marked [23] for identification.)

[24] Q: I am putting before you what's

been

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[1] marked Teicher 35, Doctor, a letter from Dr. Cole [2] to Dr. Houston at Lilly dated February 26, 1986. [3] And you will see, sir, that the patient's name has [4] been redacted. Correct? Do you see that, sir?

[5] A: Yes.

[6] Q: Do you recognize that the information [7] contained in this letter refers to patient number 1 [8] in your case series?

[9] A: I don't know. It says here that she's a [10] 58-year-old single secretary and this is dated 1986 [11] and it says in case 1 that she's a 62-year-old [12] woman, so there's a four-year age difference, so [13] I'm not sure if they're the same patient. Now, [14] there may have been a lag between when he wrote [15] this letter and when she was started on fluoxetine [16] and when the case – But this would have been the [17] age that she was at the time she went on [18] fluoxetine, so it would be hard for me to [19] indicate. I can't say with certainty that this is [20] the same case.

[21] MS. GUSSACK: Off the record.

[22] (Discussion off the record.)

[23] A: Also they said in here she's also a [24] secretary and if I recall correctly, this was a

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[1] Ph.D.

[2] MS. GUSSACK: This will be the next [3] exhibit.

[4] (Teicher Deposition Exhibit 36 marked [5] for identification.)

[6] BY MS. GUSSACK:

[7] Q: Doctor, I place before you Teicher [8] Exhibit 36, which I am going to identify for you as [9] the case report form that was submitted by Dr. Cole [10] on patient number 1, and ask if you would review [11] it, please.

[12] A: (Pause) Yes, I see this in front of me.

[13] Q: And do you recognize that that refers to [14] patient number 1 in your article?

[15] A: If Dr. Cole said it did, it does. Is [16] that the case, that Dr. Cole provided this for you [17] as case 1?

[18] Q: You see Dr. Cole's signature on this [19] document?

[20] A: I know this is one of Dr. Cole's. I am [21] fully aware that this seems to be one of Dr. Cole's [22] patients. Did Dr. Cole verify that this is [23] case 1?

[24] Q: Dr. Teicher, I am going to ask you

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[1] assume for the purposes of my questions now that [2] this case report form refers to patient number 1. [3] Okay?

[4] A: Okay.

[5] Q: And I want to direct your attention, sir, [6] if I can, to page PZ590701. Do you have that page?

[7] A: Yes.

[8] Q: Do you recognize what that appears to be, [9] sir?

[10] A: This is what they call the SCL 58. It is [11] a self-rating symptom scale and it is generally [12] items, well, it is items extracted from I believe [13] the Hopkins checklist 90. So it is a subset of the [14] SCL 90.

[15] Q: And this is a scale that is used by the [16] patient as a self-evaluative measurement?

[17] A: Yes.

[18] Q: And in fact the instructions at the top [19] of PZ590701 on this self-rating scale ask the [20] patient to circle the number that best describes [21] how much that problem has bothered or distressed [22] you during the past week. Correct?

[23] A: Yes.

[24] Q: Let me direct your attention first, sir.

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[1] to item number 15, thoughts of ending your life. [2] Do you see that?

[3] A: Yes.

[4] Q: You see the patient has identified 4 [5] under the category of extremely?

[6] A: Yes.

[7] Q: That means that the patient felt that she [8] was extremely bothered by thoughts of ending her [9] life during the past week?

[10] A: Yes.

[11] Q: And you will note, sir, at the top of [12] that page that this is visit one. Correct?

[13] A: Yes.

[14] Q: This would be before the patient has been [15] started on medication in the standard procedures [16] for clinical trials. Correct?

[17] A: I wouldn't – I don't know how this [18] works.

[19] Q: You don't know how a case report form [20] works?

[21] MR. GREENWALD: Objection. That's [22] not what he said.

[23] A: I don't know how the compassionate use [24] protocol works.

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[1] Q: Well, Doctor, direct your attention

then [2] and take a moment to look at the document starting [3] on PZ590693, and starting on PZ590694 you will see [4] where it says "visit one." Correct?

[5] A: Okay, it says visit one, yes.

[6] Q: And a history is being taken of the [7] patient, excluding the present illness?

[8] A: Yes.

[9] Q: And information is completed about the [10] patient's physical examination?

[11] A: Yes.

[12] Q: Dr. Cole has signed on PZ590695?

[13] A: Yes.

[14] Q: And you see on PZ590698 in fact there is [15] the Hamilton psychiatric rating scale for [16] depression?

[17] A: Yes.

[18] Q: And under item 3, sir, you see that [19] Dr. Cole has circled 3 on item 3?

[20] A: Correct.

[21] Q: Now, turning back to the self-rating [22] symptom scale on PZ590701, you see item number 3, [23] sir, which asks "How much were you bothered by [24] being unable to get rid of bad thoughts or ideas?"

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[1] And this patient on visit one has circled 4, [2] meaning extremely. Correct?

[3] A: Yes.

[4] Q: Turning to item number 22 you see where [5] the patient has said that they were bothered by a [6] feeling of being trapped or caught, with a 4 under [7] the category "extremely"?

[8] A: Yes, mm-hmm.

[9] Q: Similarly for item number 26, blaming [10] yourself for things, the patient has checked [11] "extremely," number 4?

[12] A: Yes.

[13] Q: And also for item number 29, feeling [14] lonely, item 30, feeling blue?

[15] A: Yes.

[16] Q: Item number 31, "How much were you [17] bothered by worrying or stewing about things?" And [18] the patient checked "extremely," number 4. [19] Correct?

[20] A: Yes.

[21] Q: And item number 54, feeling hopeless [22] about the future, this patient said they were [23] bothered in the past week extremely and rated it a [24] number 4. Correct?

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[1] A: Correct.

[2] Q: So if I understand you correctly, sir, [3] you did not review the case report form or any [4] evaluative standards

completed by patient number 1 [5] prior to publishing your case report. Is that [6] right?

[7] A: I did not review it, no. Do you have [8] additional case report forms on this patient?

[9] Q: May I have the exhibit, please. Exhibit [10] 36 is the case report form for visit one. Correct?

[11] A: The one I just saw two seconds ago?

[12] Q: That represents the case report form for [13] visit one. Correct?

[14] A: Yes.

[15] Q: Doctor, were any of these self-evaluative [16] comments made by the patient contained in your 1990 [17] article?

[18] A: Yes, to a certain extent. But I don't [19] know – I would like more clarification as to her [20] medication status at the time that this was done.

[21] Q: What do you mean by that, sir?

[22] A: Well, it says visit one, and I don't know [23] what her medication status was at visit one. For [24] all I know, and I have no way of knowing this, the

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[1] baseline might be visit zero. I don't know how [2] this thing is designed. Or it may be visit B for [3] baseline, I mean. I don't know if she was on [4] fluoxetine at this time or not on fluoxetine at [5] this time.

[6] Q: Patient number 1 was on medication how [7] long, according to your article, sir?

[8] A: It says that she received 20 milligrams [9] first week, 40 milligrams day eight to ten, 60 [10] thereafter. On day eleven she began to experience [11] forced obsessional suicidal thoughts. This led to [12] some anxiety, that she felt that death would be a [13] relief. And then it said fluoxetine was [14] discontinued. So I would assume that it was around [15] eleven days. It doesn't specifically say.

[16] Q: Let me show you what is identified as [17] PZ950720, sir, and you will see that it has a [18] reference to visit two and it says "drug stopped [19] March 18, 1986."

[20] A: It says drug stopped on 3/18.

[21] Q: 3/18/86. Correct?

[22] A: I would believe, yes.

[23] Q: So if we count back eleven days, sir, we [24] get to visit number one, March 7, 1986, PZ590693,

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[1] the document before you?

[2] A: Yes, that would be eleven days.

[3] Q: Okay. So can we assume that on visit one [4] medication had not yet been started when this [5] history was taken?

[6] A: Yes.

[7] Q: So we now have adequate clarification [8] that visit one occurred before medication –

[9] A: Yes.

[10] Q: – and this was information that this [11] patient presented and contributed about her own [12] condition prior to drug treatment –

[13] A: Yes.

[14] Q: – with fluoxetine?

[15] A: Yes.

[16] Q: Now, sir, referring again now to the [17] letter of Dr. Cole to Dr. Houston dated February [18] 26, 1986, you see the chronology in which Dr. Cole [19] is seeking permission for compassionate use for a [20] patient?

[21] A: Yes.

[22] Q: I am going to ask you to assume for [23] purposes of my question, sir, that this patient [24] described in the February 26, 1986 letter to

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[1] Dr. Houston is in fact referring to patient number [2] 1. And maybe we can by virtue of the questions in [3] fact confirm that to be the case.

[4] A: It seems like that's very likely.

[5] Q: It seems very likely that the patient [6] described in the letter dated February 26, 1986, is [7] in fact patient number 1?

[8] A: It would seem from that document 36 and [9] this PZ590720 it is clearly patient 1. The letter, [10] that's more probable.

[11] Q: More probable?

[12] A: I'm bothered by the age and occupational [13] difference.

[14] Q: Well, sir, it is true, isn't it, that [15] when you write case reports on patients you [16] sometimes change some facts about the patients like [17] age or occupation or family member relationship in [18] order to conceal their identity?

[19] A: I wouldn't change age on a case report. [20] I don't think that would be legitimate. I would [21] use a euphemism for occupation so that for somebody [22] who may be, say, a lawyer I might say a [23] professional.

[24] MR. GREENWALD: Thank you!

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[1] THE WITNESS: I'll give you guys the [2] benefit of the doubt.

[3] A: But, no, I wouldn't deliberately distort. [4] I would just make it more vague. And I would not [5] change age, I would not change gender, I would not [6] change race, nothing like that that may in some [7] ways be important in terms of understanding the [8] case.

[9] Q: But, sir, if I understood you yesterday, [10] you didn't prepare this summary with respect to [11] this particular patient that appears in your 1990 [12] report. Correct?

[13] A: No, I did not prepare that summary.

[14] Q: So it is possible that the person who did [15] prepare it may have changed age to conceal the [16] identity of the patient?

[17] MR. GREENWALD: Objection to the form [18] of the question. Anything's possible.

[19] A: Boy, I would hope – That's not – [20] I mean, yes, anything's possible. That is not [21] within the bounds of what I would consider [22] plausible. I mean, what I would be more likely to [23] believe is that Dr. Cole dictated this letter and [24] that he was not checking his records carefully and

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[1] that he approximated her age in this letter, and [2] that in this letter to get her into a compassionate [3] use trial it wasn't critical whether she was 58 or [4] 62.

[5] Q: In this letter Dr. Cole says that the [6] patient has failed at least six tricyclics and two [7] MAO inhibitors, Xanax, adinazolam, oxaprotiline, [8] lithium, Tegretol, Depakote, and ECT?

[9] A: Yes.

[10] Q: Now, sir, that is generally consistent [11] with the description of patient number 1 being [12] extremely treatment-refractory?

[13] A: Except that adinazolam and oxaprotiline [14] are not licensed. But it does say five [15] investigational compounds, so that's consistent. [16] And those are investigational drugs.

[17] Q: So it appears quite likely that this [18] letter is in fact referring to patient number 1?

[19] A: Can I take one second? For my own [20] clarification.

[21] Q: Sure.

[22] A: It does have the date of birth on here. [23] I would like to know how old she really was. She [24] was 61-1/2.

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[1] Q: So now you're more assured that it is –

[2] A: Well, again, that has to do with this, [3] but this fits with that, and that is further [4] confirmation.

[5] Q: That flurry of pronouns has confused me. [6] But can we agree that this letter appears to be a [7] description of patient number 1?

[8] A: Yes.

[9] Q: By Dr. Cole to Dr. Houston?

[10] A: Yes.

[11] Q: Okay.

[12] I refer you to the first paragraph of [13] the letter where Dr. Cole describes the patient. [14] quote, "She occasionally (about one day in 40) has [15] a good day or two but mainly she barely survives at [16] work and spends her free time in bed. depressed and [17] helpless"?

[18] A: Yes.

[19] Q: Were you familiar with that description [20] of this patient prior to her treatment with Prozac. [21] sir?

[22] A: I had not seen this letter.

[23] Q: Do you see, sir, in the sentence that [24] I earlier read to you where Dr. Cole says that this

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[1] patient has failed ECT?

[2] A: Yes. You mean the second part of it [3] where it says antidepressant history?

[4] Q: No, sir. In the first paragraph, "She [5] has failed on at least six tricyclics" and the end [6] of that sentence "and ECT."

[7] A: Yes, yes.

[8] Q: It is true, sir, isn't it, that your 1990 [9] article states that she had a moderate response to [10] ECT?

[11] A: Yes, it does.

[12] Q: We could have facilitated this for you a [13] little bit because I knew there was a code I was [14] looking for. You will see in the right-hand corner [15] of Teicher 35 there is a reference to 022 and 135 [16] and those match the code numbers for –

[17] A: I see the 022, yes.

[18] Q: And the 135 right under it? It matches [19] the patient number on the case report that you have [20] before you.

[21] A: Oh, this sheet has a 135. The other ones [22] don't have the 135, they have the 022. But, okay.

[23] Q: And in fact Dr. Cole's letter states that [24] she failed ECT?

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[1] A: Yes.

[2] Q: Does it anywhere in your summary of [3] patient number 1 appearing in your 1990 article [4] talk about how treatment-refractory this patient [5] was?

[6] A: I'm not sure.

[7] Q: You're not sure?

[8] A: It certainly does. It said "Previous [9] treatment trials have included most available [10] tricyclic antidepressants, phenelzine, [11] tranylcypromine, trazodone, alprazolam, [12] carbamazepine, lithium, methylphenidate, and five [13] investigational compounds." And then it says [14] "Ms. A had a moderate response to a course of ECT [15] and to a trial of moxapine but the benefits were [16] short-lived." So basically that indicates that she [17] had been on virtually every known treatment and [18] that you can infer from that she's treatment- [19] refractory.

[20] Q: Could you say from that that she's [21] extremely treatment-refractory?

[22] A: Yes.

[23] Q: And the list of medications attached to [24] Dr. Cole's alert of February 26, 1986, would be a

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[1] list of the antidepressants she has taken and [2] failed presumably in the course of treating her [3] depression?

[4] A: These would be certainly the [5] antidepressants that she was on during the course [6] of treatment.

[7] Q: Doctor, so that you can refer to pages in [8] Teicher 18, drafts of your case reports, if you [9] turn to page MHT687, you will see the entry about [10] five lines down where it says ETOH?

[11] A: Where?

[12] Q: About five lines down.

[13] A: Yes.

[14] Q: What does that stand for?

[15] A: Alcohol.

[16] Q: Drinks to escape?

[17] A: Yes.

[18] Q: And then it says "drinks for relief, [19] helps a bit with depression"?

[20] A: Yes.

[21] Q: Do you know, sir, whether this patient [22] was drinking during the time that she was taking [23] fluoxetine?

[24] A: It really doesn't say in the case

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[1] report. Does it?

[2] Q: No, sir, not that I know of.

[3] A: I didn't see it.

[4] Q: About eleven lines down you see there is [5] a reference hospital, h-o-s-p?

[6] A: Yeah, times 16 months.

[7] Q: Does that mean that this patient had been [8] hospitalized at a Yale facility for sixteen months?

[9] A: Probably.

[10] Q: Do you know when that hospitalization [11] occurred?

[12] A: It doesn't give a date.

[13] Q: Sir, after the word "Yale" above the line [14] it says "and here," meaning McLean?

[15] A: This thing above the X, I'm not sure what [16] that would say. What it looked like to me on first [17] glance was the word "when." So I think that the [18] person who wrote this, which was Carol Glod, wanted [19] to know when that hospitalization was.

[20] Q: And these are Carol Glod's notes on [21] patient number 1. Correct?

[22] A: Yes.

[23] Q: On page 687 at the bottom you see the [24] reference where it says "Somewhat jumpy on

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[1] Wellbutrin, agitated, but no forced suicidal"?

[2] A: Yes.

[3] Q: Do you know what that is a reference to, [4] sir?

[5] A: It seems to indicate what her response [6] was to the drug Wellbutrin.

[7] Q: Do you know when she had that response to [8] the drug Wellbutrin?

[9] A: No, I don't. It is not in the list of [10] antidepressant history that was provided before, so [11] my guess would be that it was after fluoxetine. [12] Wellbutrin was not available, it was approved about [13] the same time as fluoxetine, so it wouldn't have [14] been on the market yet.

[15] Q: This was a patient who was so discouraged [16] that she couldn't participate in another controlled [17] clinical trial and that's why Dr. Cole sought to [18] get her Prozac on a compassionate basis?

[19] MR. GREENWALD: Objection.

[20] A: It seems to be what Dr. Cole was implying [21] in his letter.

[22] Q: In a letter to the editor in the American [23] Journal of Psychiatry in September '91 the [24] possibility was raised, was it not, that the active

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[1] metabolites of amoxapine remained in her system [2] when she began her Prozac treatment and that the [3] akathisia described with respect to patient number [4] 1 may have resulted from that interaction. Do you [5] recall that?

[6] A: Vaguely, yes.

[7] Q: I believe I handed to you earlier your [8] August '91 letter to the editor in the American [9] Journal of Psychiatry in which you reported that [10] patient A had an abnormal waking EEG and MRI [11] findings that were, quote, compatible with areas [12] of glyosis most likely due to microvascular [13] disease?

[14] A: I remember reading that, yes. I remember [15] reading something like that, yes.

[16] Q: And that she showed, quote, mild diffuse [17] atrophic changes throughout the cerebrum?

[18] A: Yes.

[19] Q: Now, sir, did you consider what effect [20] this evidence of brain disease had on patient 1's [21] response to fluoxetine?

[22] A: What I had said before was I wasn't sure [23] whether those neurological assessments were done [24] before or after she received fluoxetine. I think

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[1] in the response to the letters to the editor we did [2] talk about the possibility that patients who have [3] CNS abnormalities or abnormalities in their limbic [4] system may be at increased risk.

[5] Q: At increased risk for?

[6] A: For having an adverse response to [7] fluoxetine. Can I see that just to get the – ?

[8] Q: The letter to the editor?

[9] A: Yes. Just to get the wording more [10] precise. (Pause) So basically I state here that [11] "While we agree that limbic system dysfunction may [12] be a significant risk factor," so

[13] Q: Were you finished?

[14] A: Yes.

[15] Q: Now, Doctor, turning to patient number 2 [16] in your case report, you identified this individual [17] as having a 21-year history of dysthymia and [18] episodic major depression without suicidal ideation [19] and managed by psychotherapy. Correct?

[20] A: Yes.

[21] Q: I believe you also referenced that after [22] six months on Marplan he had passive suicidal [23] thoughts?

[24] A: Right.

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[1] Q: How long did he have those suicidal [2] thoughts for?

[3] A: It doesn't say in the article.

[4] Q: Can you tell by looking at your notes or [5] detailed synopses, Exhibit 18?

[6] A: Let me look. (Pause) I indicated that [7] he had some suicidal thoughts on 6/2, on June 2nd, [8] and that they were not active. There were no [9] further comments about suicidal thinking until [10] 7/15, and I can't tell you from this whether they [11] had gone away or not. My guess is that they [12] probably were present to a small extent.

[13] Q: You believe that these suicidal thoughts [14] were present on June 2nd, did you say?

[15] A: On June 2 it says "some suicidal [16] thoughts." And that would be after the And [17] passive suicidal thoughts, yes.

[18] Q: And that is two weeks before he starts on [19] Prozac. Correct?

[20] A: Yes.

[21] Q: So although the article refers to him as [22] being without suicidal ideation, we know from [23] referring to MHT675, Exhibit 18, that –

[24] A: Wait a second, wait a second. Where does

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[1] the article say that he was without suicidal [2] ideation?

[3] Q: Refer to your summary of patient 2.

[4] A: It doesn't say that he was without. It [5] says "but no previous suicidal ideation" up in the [6] top, in the third line of the description. And [7] then he had no suicidal ideation until he developed [8] these passive suicidal thoughts.

[9] Q: Do you say that in the article, sir?

[10] A: Yes, yes.

[11] Q: Could you tell me where, sir?

[12] A: Sure. It starts out that he's a 39-year-[13] old man with a 21-year history of dysthymia and [14] episodic major depression but no previous suicidal [15] ideation. He had managed successfully with [16] psychotherapy until two years ago when his [17] depression worsened. It goes on to say that he got [18] a therapeutic trial of isocarboxazid and then he [19] developed tolerance to this, he became more [20] depressed, and he developed some passive suicidal [21] thoughts. So up until that time he had been [22] somebody without a history of suicidal thinking; [23] now this is the first time that we're aware of in [24] his clinical history that he had –

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[1] Q: Two weeks before he starts on Prozac?

[2] A: Yes.

[3] Q: Okay, I'm with you.

[4] However, I am a little confused by [5] the reference on page 209 of Exhibit 10 where you [6] say "One patient had no prior suicidal ideation [7] (case 2)." Do you see where I'm reading from, [8] under Discussion?

[9] A: Under Discussion? Where is that?

[10] Q: Under Discussion, in the first [11] paragraph.

[12] A: (Pause) I see that, yes.

[13] Q: And again on page 209, sir, in the second [14] column almost towards the bottom of the third [15] paragraph you refer to, quote, "Patient 2, who had [16] no prior suicidal thoughts." Do you see where I'm [17] referring?

[18] A: Yes.

[19] Q: So this summary does not say this patient [20] had no prior suicidal thoughts until two weeks [21] before he started Prozac. It says he had no prior [22] suicidal thoughts. Are we on the same wavelength [23] here?

[24] A: We're on the same wavelength.

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[1] Q: Okay. Now, sir, referring to page 681, [2] you indicate in your notes that prior to Prozac [3] administration to patient number 2, Stelazine was [4] added. Correct?

[5] A: 681?

[6] Q: Page 681. (Pause) 681 refers to – trifluoperazine.

[8] A: Yes.

[9] Q: That's Stelazine?

[10] A: Yes.

[11] Q: That was added prior to Prozac?

[12] A: Yes, that was added before the Prozac as [13] an attempt to potentiate the isocarboxazid.

[14] Q: Stelazine is a neuroleptic?

[15] A: Yes.

[16] Q: Now, you recall that in the subpoena we [17] served upon you, sir – (Pause)

[18] In the subpoena that we served on [19] you, Doctor, we requested you to produce all [20] documents that you had in your possession [21] reflecting comments made by your peers at Harvard. [22] Do you recall?

[23] MR. GREENWALD: Do you want to show [24] him that?

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[1] MS. GUSSACK: Category number 3.

[2] A: Yes, I see that.

[3] Q: And also, sir, in category number 36 we [4] asked for any records of notes, referral notes, [5] correspondence that you had related to patients A [6] through F?

[7] A: Right. I see that.

[8] Q: Which, for purposes of consistency today, [9] we're referring to patients 1 through 6. Correct?

[10] A: Yes.

[11] Q: And you did not produce any documents [12] responsive to that, did you, sir?

[13] A: Do we have the response letter here?

[14] MR. GREENWALD: We do.

[15] (Document handed to Dr. Teicher by [16] Mr. Greenwald.)

[17] A: So 36 was opposed and 23 was to my [18] knowledge, no internal peer review.

[19] Q: What number are we up to?

[20] MR. GREENWALD: Can we take a break? [21] I would like to take a bathroom break.

[22] MS. GUSSACK: Sure.

[23] MR. GREENWALD: Thank you.

[24] (In recess 2:45 p.m. to 2:55 p.m.)

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[1] BY MS. GUSSACK:

Q: Doctor, you produced documents in response to item 9 of the subpoena, which sought all correspondence sent to or received from psychiatrists, physicians, or mental health professionals including referral notes, consultation reports, notes and letters referring or relating to the article published in the American Journal of Psychiatry, patients A through F?

A: Number 9?

Q: Yes. You are familiar with that request?

A: I'm familiar with the request. I'm trying to see what our response was.

MR. GREENWALD: Where is the thing he was just looking at? (Pause) Okay, here it is. Item 9, isn't that the stuff that was redacted?

THE WITNESS: A lot of that, I guess I sent – I tried to respond to it, sent what we had.

BY MS. GUSSACK:

Q: Now, you've told me you know Dr. Rosenbaum at Harvard. Right, Doctor?

A: Yes.

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Q: He sent you a letter about patient number 2, didn't he?

A: Yes, he did.

Q: But you didn't produce that to us, did you, sir?

A: No. That would have been confidential.

Q: Well, Doctor, I have had marked as Teicher No. 37 and am putting before you a letter dated November 21, 1991, to you from Dr. Jerrold Rosenbaum. Does this letter –

MR. GREENWALD: Now, may I ask from where this letter comes?

MS. GUSSACK: Do you have some question about the authenticity?

MR. GREENWALD: I just want to know where it came from.

MS. GUSSACK: Well, I don't think that's a pertinent question right now.

MR. GREENWALD: I think it is extremely pertinent if it was confidential information. In fact, I can't think of a more pertinent question. If Dr. Rosenbaum provided that letter to you and breached a confidence, I think that is very significant.

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BY MS. GUSSACK:

Q: You will see that the letter dated November 21, 1991, has deleted any patient names or identifying factors. Correct, Doctor?

A: Yes.

Q: And this is a copy of a letter that you received at or around the time of November 21, 1991?

A: Yes.

Q: Now, sir, you see in the first paragraph that Dr. Rosenbaum was advising you that he saw patient number 2 in consultation on January 24, 1989. Correct?

A: Yes. I referred him to him for consultation.

Q: You referred patient number 2 to Dr. Rosenbaum for consultation?

A: Yes.

Q: Okay. And that visit, by the way, January 24, 1989, or that consult occurred prior to the publication of your 1990 article. Correct? Your article is dated February 1990, isn't it?

A: No, no, the article was received January 1989.

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Q: Excuse me?

A: The article was received in January 1989.

Q: Was the article published prior to February 1990?

A: Yes, but it was received, revised, accepted. So it sits in their press for a while, so that it was a done deal well before it came out.

Q: I think you misunderstand my question. Dr. Rosenbaum's consultation visit with patient number 2 occurred prior to the publication of your February 1990 article. Correct?

A: Well, let me try to get the question clear now. Could you please ask it again?

Q: Dr. Rosenbaum is stating in the first sentence of his letter that he saw in consultation patient number 2 on January 24, 1989, and that consult occurred prior to the publication date of your article in February 1990. Correct?

A: I did not refer him to Dr. Rosenbaum in 1989. I referred him to Dr. Rosenbaum in 1991. Okay? And this was –

Q: I appreciate that clarification, Doctor.

A: So I am not aware of – I do not believe I am aware of what Dr. Rosenbaum had seen in 1989.

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Q: The letter tells you what he goes on to see and we can talk about that in a minute.

A: But I did not receive this letter until November of '91, long after the article came out. Okay?

Q: Yes, sir. But all I am establishing is that the first visit that Dr. Rosenbaum reports seeing patient number 2, January 24, 1989, was a visit that occurred prior to the publication of your article?

A: Yes.

Q: And then he says he saw him again on October 30, 1991.

A: Yes.

Q: And we would agree that that visit occurred after the publication of your article?

A: Yes.

Q: Is it your testimony, sir, that you referred patient number 2 to Dr. Rosenbaum on only one occasion?

A: Yes.

Q: And that would be the October 30, 1991 consult?

A: Yes.

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Q: Now, sir, in the third paragraph of Exhibit 37 you will see that Dr. Rosenbaum refers to the fact that "First, on January 24, 1989, I wrote to you that Mr. B reported to me that he had experienced occasional suicidal thoughts as part of his usual pattern of depressive symptoms well before he undertook a trial of pharmacotherapy and my notes from 1989 indicate that periods of feeling suicidal were present since his wife left in 1981." Correct, sir? I read that accurately?

A: You read that accurately.

Q: Okay. Do you have a recollection, sir, that on or around January 24, 1989, Dr. Rosenbaum wrote you conveying the information I just read?

A: I do not have a recollection of it.

Q: Would you have any records of it?

A: If I had it, I would have a record of it.

Q: Do you know whether you do?

A: I don't know if I have it or not. It doesn't ring a bell at all.

Q: Dr. Rosenbaum tells you that the reason he's writing on November 21st of 1991 is that upon reviewing your summary of patient number 2 he was, quote, "startled by some of the discrepancies

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between my 1989 evaluation, my 1991 evaluation, and the case presentation in your 1990 report." Correct?

A: Yes.

Q: Now, Dr. Rosenbaum says on the next page, I believe, at the January 1989 evaluation that patient number 2 had not told Dr. Rosenbaum about the, quote, constant suicidal preoccupation and violent self-destructive fantasies

on Prozac. [10] Correct?

[11] A: Correct, yes.

[12] Q: And Dr. Rosenbaum goes on to write that, [13] quote, "Given the apparent dramatic nature of these [14] symptoms and the referral for consultation (in [15] which I went on to recommend new trials with [16] Prozac) I am surprised that neither he nor you had [17] thought to mention this adverse event." Correct?

[18] A: Yes, he writes that.

[19] Q: Do you recall, sir, that Dr. Rosenbaum in [20] fact recommended that the patient initiate [21] treatment with fluoxetine again in his consultation [22] and recommendation to you?

[23] A: I recall this note. I don't recall any [24] other note.

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[1] Q: Sir, do you have a file in your office [2] from which you could tell whether you had received [3] a note at or around the time of January 1989 from [4] Dr. Rosenbaum?

[5] A: Yes.

[6] Q: Dr. Rosenbaum says "Patient number 2 [7] mentioned then and now," then meaning 1989, and now [8] the October 30, 1991 consult, "that he experienced [9] distressing physical symptoms on starting Prozac [10] including headache and nausea although he had also [11] reacted very badly with increased agitation and [12] anxiety to several tricyclics including desipramine [13] and imipramine." Correct?

[14] A: Yes.

[15] Q: And is that accurate, sir, what [16] Dr. Rosenbaum just related? (Pause) Do you have [17] my question in mind?

[18] A: If you could restate your question?

[19] Q: Do you know whether Dr. Rosenbaum is [20] accurate when saying that the patient number 2 [21] experienced distressing physical symptoms on [22] starting Prozac including headache and nausea [23] although he had also reacted very badly with [24] increased agitation and anxiety to several

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[1] tricyclics including desipramine and imipramine?

[2] A: I recall that he wrote this.

[3] Q: Do your notes with respect to patient [4] number 2, Mr. B, provide you any basis on which to [5] determine whether Dr. Rosenbaum was accurate in [6] stating that he had had increased agitation and [7] anxiety to several tricyclics?

[8] A: There's nothing in the case report that [9] would indicate it because his exposure to other [10] antidepressants was after this, not before this.

[11] Q: And what are you referring to as the [12] basis for the statement that he took these [13] tricyclics after the fluoxetine treatment?

[14] A: That isocarboxazid was his first [15] antidepressant trial, which then led to his [16] fluoxetine trial. So I believe it was subsequent. [17] And then it says "During the next three months [18] trials of imipramine, doxepin and methylphenidate [19] provided little relief," so the imipramine was [20] after.

[21] Q: Dr. Rosenbaum states at the bottom of the [22] first page of his November 21, 1991 letter that [23] when he asked patient number 2, Mr. B, to describe [24] his suicidal experience on Prozac he stated, quote,

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[1] "I never thought that I was any more suicidal on [2] Prozac than I was before or after, but I suppose [3] Dr. Teicher is more sensitive to this issue," end [4] quote. Did I state that accurately, sir?

[5] A: Yes.

[6] MR. GREENWALD: You mean is that what [7] it says on the paper?

[8] MS. GUSSACK: Yes.

[9] BY MS. GUSSACK:

[10] Q: And my question to you, sir, is did Mr. B [11] ever tell you that he didn't feel any more suicidal [12] on Prozac before or after?

[13] A: I was very concerned when I received this [14] letter and I sat down with the patient and we went [15] over it and asked him about that. And he indicated [16] to me that he did not have very good recollection, [17] so I pulled out my notes and I went over my notes. [18] And my notes are, as I've said, generally near- [19] verbatim notes from what he said. And as he went [20] over the notes he said "Oh, yeah, yeah, I remember, [21] I remember" and he said, you know, "That's what [22] I experienced."

[23] It is a very strange and perplexing [24] problem that this patient did not have good recall

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[1] for what happened. And, in fact, I guess a lot of [2] the information he provided Dr. Rosenbaum was very [3] inaccurate based on the notes that I took at the [4] time. It's very surprising. And he was able to [5] verify when he saw them and when there were other [6] external validators like his mother calling and [7] things like that that were all objective facts that [8] helped, you know, jog his memory. But he gave [9] Dr. Rosenbaum a very different slant on what [10] happened than what my documented notes showed.

[11] Q: And, sir, the notes reporting on patient [12] number 2's feelings at the time that he was on [13] fluoxetine have not been produced to us. Correct?

[14] A: Correct.

[15] Q: Did you make process notes, as you call [16] them, of your conversations with Mr. B, patient [17] number 2, when you were reviewing Dr. Rosenbaum's [18] letter with him?

[19] A: I would have a process note for that [20] session. But during the process of reviewing? [21] I wouldn't have made process notes of the process [22] of reviewing, because I'm reading him the notes and [23] I can't....

[24] Q: Would you have a note, sir, of where he

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[1] said "Oh, yes, oh, yes, I remember that"? Would [2] that be in your records?

[3] A: Probably, yes.

[4] Q: And those records have not been produced [5] here, sir?

[6] A: No.

[7] Q: Now, sir, on page 2 of Dr. Rosenbaum's [8] letter to you where he says "I recognize that a [9] patient is not always an accurate historian," do [10] you know where I'm referring?

[11] A: Yes.

[12] Q: And he goes on to say "For example, [13] Mr. B, patient number 2, informed me he was [14] restarted by you on Prozac about a year' later and [15] tolerated it well on that occasion but that it was [16] discontinued for lack of benefit. Your note, [17] however, indicates that he again became suicidal on [18] the drug."

[19] A: Yes.

[20] Q: Sir, do you recall that Mr. B, patient [21] number 2, was restarted on Prozac after his initial [22] treatment with it and tolerated it well?

[23] A: He did not tolerate it well and he did [24] become suicidal on it. That was part of his –

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[1] After the event the patient felt that he had [2] received some benefit from the Prozac. He was not [3] willing to attribute necessarily his marked [4] worsening of suicidal ideation to the Prozac and [5] wanted to try it again, and we did it. We did it [6] very cautiously, very slowly, and at the first [7] signs that the suicidal ideation was reemerging we [8] stopped it.

[9] Q: And that period of time was approximately [10] how long on this second administration of [11] fluoxetine?

[12] A: I would have to check that.

[13] Q: This is the same patient, sir, that you [14] said was challenged with clomipramine and became [15] suicidal?

A: No, no. I don't think so. Does it say that?

Q: No. You told me this morning or yesterday, I guess, when I asked you which patient was treated with clomipramine and became actively suicidal, you said it was patient number 2.

A: Did I say 2? Well, then it was. But we're talking a rechallenge now with fluoxetine.

Q: Yes, I understand. But I just wanted to

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clarify, this is in fact the same patient that you later treated with clomipramine and who later became suicidal on that drug?

A: Yes.

Q: Now, referring to page 2 of Dr. Rosenbaum's letter to you, in the third paragraph you see where he says, quote, "From my interview with Mr. B in 1989 and again in 1991 it is apparent that this is a chronically or at least recurrently suicidal man. The implication that his suicidality disappeared with the absence of Prozac is very misleading. Indeed, he reported to me most recently that he continues to suffer suicidal ideation but feels constrained from acting on it because of the impact it would have on his young son." Do you see where I was reading from?

A: No, I haven't found it. Sorry.

Q: Paragraph 3, page 2, in the middle of that paragraph.

A: (Pause) That's what he wrote, yes.

Q: Now, sir, did you believe that patient number 2, Mr. B, was chronically or at least recurrently a suicidal man?

A: No. What I indicated in the case report

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was accurate, and that his intense suicidal thoughts persisted for a substantial period of time, we're talking about months, after stopping the fluoxetine and then they remitted on the tranylcypromine; and I indicated that. And at that period of time he indicated, documented in my notes, that he was free of suicidal ideation, which is what I put in. I don't know, can't tell from this what medication he was on at the time that he saw Dr. Rosenbaum for consultation.

Certainly I never would have sent him to Dr. Rosenbaum for consultation if I didn't expect him to be very consistent with this. And I have continued to treat this individual and he has never made a suicide attempt and he is largely free of suicidal ideation, has some passing suicidal thoughts, but he is largely free of it. Nothing like what he experienced, what he reported to me during the times that he was on fluoxetine or in that case clomipramine.

MS. GUSSACK: May I have this marked as Exhibit 38, please.

(Teicher Deposition Exhibit 38 marked for identification.)

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BY MS. GUSSACK:

Q: Doctor, I have had marked as Exhibit 38 your December 4, 1991 letter to Dr. Rosenbaum which you have stated was your response to Dr. Rosenbaum's letter?

A: I believe so. Can I see it?

Q: I'm sorry. I thought it was in front of you. (Pause)

May I refer you to paragraph 2 of your letter dated December 4, 1991, Doctor. And again, sir, you will recognize that reference to patient number 2 or Mr. B, identifying references have been redacted. But do you recognize that this letter refers to patient number 2 of your 1990 case series?

A: Yes.

Q: Mr. B, same patient?

A: Yes.

Q: In paragraph 2 of your letter responding to Dr. Rosenbaum, sir, you state that you initially saw this patient on August 11, 1987. And just to put things in context, sir, your notes reflect that he was prescribed Prozac on June 16, 1988, almost a year later. Right?

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A: Excuse me? What was the question again?

Q: You see you say that you first saw Mr. B, patient number 2, on August 11, 1987, and referring to your earlier testimony he wasn't prescribed Prozac for the first time until June 16, 1988. Correct?

A: Yes.

Q: Okay. You say, sir, when you initially saw the patient on August 11, 1987, he denied any history of suicidal ideation. Quote, "I did not feel that he was suicidal or posed any degree of suicidal risk. He was, however, chronically depressed."

A: Yes.

Q: And you then go on to say, sir, that he experienced having a self-destructive fantasy in May 1988?

A: Yes.

Q: That would be, again, prior to his first use of Prozac?

A: Yes.

Q: Now, sir, I believe you describe in your letter to Dr. Rosenbaum that you began lithium potentiation of the Prozac?

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A: Yes.

Q: That was in July 1988?

A: Yes.

Q: On July 15, 1988, he developed constant, obsessive suicidal ideation with violent suicidal fantasies and you made changes in his lithium and fluoxetine regimen over the next ten days by telephone?

A: Yes.

Q: So he was not such a great suicidal risk that you felt you had to hospitalize him?

A: No, we did not hospitalize him.

Q: And you didn't have to bring him in to be seen, you could adjust his medications by phone?

A: I'm sure that I saw him but I was also changing the medication by phone.

Q: Do you have any records, any notes in front of you that would show that you saw him in these ten days after he became obsessively suicidal with violent suicidal fantasies?

A: I couldn't tell you – Wait a second. (Pause)

I would imagine, I can't tell you for certain, but he would probably have been seen on

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6/24, 7/15 and 7/26.

Q: And what are you referring to, sir, for that?

A: I am referring to the case notes and the dates in the case notes.

Q: Can you give me a page number?

A: MHT00661, 00662.

Q: Do you know whether those were phone calls or visits in person?

A: These were almost certainly – These were very likely to be visits, these dates.

Q: Do you know for sure?

A: I don't know for sure. I haven't checked.

Q: At the bottom of page 1 of your response to Dr. Rosenbaum, sir, you say that you discontinued the fluoxetine and then resumed it again and that you didn't feel it was necessary to detail this brief withholding of fluoxetine in your summary of patient number 2 published in your case

series.

[22] A: Right.

[23] Q: Why is that, sir?

[24] A: I only held the dose from 7/19 to 7/21

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[1] and then resumed it again on 7/22. That's a very [2] brief period of time. The fluoxetine would have [3] remained in his system.

[4] Q: What was the last phrase you said, sir?

[5] A: The fluoxetine would have remained in his [6] system.

[7] Q: This patient's mother as well as his [8] girlfriend, you say, called because they feared [9] this patient had become so suicidal and were [10] concerned about his safety. Correct?

[11] A: Yes.

[12] Q: So it was obvious to his elderly mother [13] and his girlfriend that this patient presented a [14] suicidal risk?

[15] A: Yes. They were concerned enough to call.

[16] Q: I believe, sir, and I ask you to confirm [17] this, that in your August '91 letter to the editor [18] of the American Journal of Psychiatry, which we [19] should have marked as the next exhibit, but before [20] we mark it, is this the letter in which you [21] describe the rechallenge of patient number 2?

[22] A: Yes.

[23] MS. GUSSACK: Can we have that marked [24] as Exhibit 39.

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[1] (Teicher Deposition Exhibit 39 marked [2] for identification.)

[3] BY MS. GUSSACK:

[4] Q: Sir, the Exhibit 39 letter to the editor [5] refers to the fact that at the patient's request he [6] was rechallenged with Prozac. Correct?

[7] A: Yes.

[8] Q: And that the rechallenge occurred over a [9] two-month period?

[10] A: Yes.

[11] Q: And that the patient gradually became [12] more depressed as the dose was increased?

[13] A: Yes.

[14] Q: And finally began to ruminate incessantly [15] about suicide. Correct?

[16] A: Yes.

[17] Q: The trial was stopped and the symptoms [18] abated within two weeks?

[19] A: Right.

[20] Q: Now, sir, can I turn your attention back [21] to Exhibit No. 38, your letter to Dr. Rosenbaum. [22] On page 2, paragraph number 3, would you review [23] there where you describe the rechallenge with [24] fluoxetine that you administered to patient

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[1] number 2?

[2] A: Okay. "As I noted in my brief note prior [3] to your last consultation, the patient was [4] rechallenged with fluoxetine" –

[5] Q: Sir, you can review it to yourself before [6] I ask you questions.

[7] A: Oh. I thought you wanted me to read it. [8] Yes, yes.

[9] Q: You are familiar with that?

[10] A: Yes.

[11] Q: Now, sir, at the time that you began to [12] administer fluoxetine to patient number 2 for the [13] second time he had mild passive thoughts, correct, [14] of suicide? Quote, "He had mild passive thoughts [15] that he could easily put out of his mind."

[16] A: That's there, yes.

[17] Q: And then you say "On August 27, 1990," [18] and I calculate for you, sir, as best I can, that's [19] fifteen months later, not two months later as you [20] describe in your August '91 letter to the editor in [21] the American Journal of Psychiatry, that patient [22] number 2 became very suicidal.

[23] MR. GREENWALD: What's the question?

[24] A: The 5/23/89 to 8/27/90 is fifteen months.

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[1] so my guess is that's 5/23/90, not 5/23/89.

[2] Q: So you believe you made an error in your [3] letter to Dr. Rosenbaum or do you believe there is [4] an error in your letter to the American Journal?

[5] A: No, no, I believe that this 5/23/89 [6] should be 5/23/90.

[7] Q: Well, you go on to say, sir, in the [8] letter to Dr. Rosenbaum that you told the patient [9] to stop taking fluoxetine. Correct?

[10] A: Yes.

[11] Q: Nonetheless, sir, he continued to take [12] the fluoxetine, didn't he?

[13] A: Yes, he did.

[14] Q: Unbeknownst to you, according to your [15] notes here.

[16] A: Yes.

[17] Q: Sir, how did he get three months' worth [18] of fluoxetine unbeknownst to you?

[19] MR. GREENWALD: Objection.

[20] A: I imagine that the prescription I wrote [21] had refills.

[22] Q: Three months' worth of refills?

[23] A: That is often the case. I usually write [24] for three months.

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[1] Q: For a patient who became intensely [2] suicidal on the drug?

[3] A: In my wildest idea I would not imagine a [4] patient would continue it if they were having a bad [5] response on it. And I don't know how much he had [6] saved up from his previous trial, so I don't know [7] where he got the medication to continue.

[8] Q: Was he seeing anyone else for psychiatric [9] care during the time that you were seeing him other [10] than people you referred him to?

[11] A: Not to my knowledge. But I don't know [12] that for a fact.

[13] Q: So during those three months that he was [14] still taking fluoxetine but kept it from you, sir, [15] you report to Dr. Rosenbaum he continued to remain [16] actively suicidal?

[17] A: Yes.

[18] Q: And, sir, did you have any concerns about [19] rechallenging this patient with fluoxetine as an [20] outpatient when he had become actively suicidal [21] during the first course of treatment with [22] fluoxetine?

[23] A: I certainly had concerns and we discussed [24] them. At one point I had discussed with him the

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[1] possibility of hospitalization. He was able to [2] provide assurances for his safety. And although he [3] suffered, he remained safe.

[4] Q: Sir, in the entire time that this patient [5] was actively suicidal as you describe him, did he [6] ever attempt suicide?

[7] A: I think he indicated at one point that he [8] believed he had come close to making an attempt but [9] he did not make an attempt.

[10] Q: In the final paragraph of page 2 of your [11] letter to Dr. Rosenbaum you say that the one thing [12] about patient number 2 that needs to be noted is, [13] quote, "that he often withholds information and he [14] is not entirely forthright." Correct?

[15] A: Yes.

[16] Q: And you found that to be true of patient [17] number 2 in providing information to you?

[18] A: Yes. Do you want me to check that May [19] '89 or '90 date?

[20] Q: Yes, sir. Do you have anything you could [21] refer to that's here with you today to check that [22] '89 date and see whether that is an error?

[23] A: I don't have anything here I could [24] check. I could check in my office.

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[1] Q: What would you be checking in your [2] office?

[3] A: My notes.

[4] Q: Those would be your process notes?

[5] A: Yes.

[6] Q: And those would be the notes that you [7] haven't produced in this litigation. Correct?

[8] A: Correct.

[9] Q: Turning to patient number 3 in your case [10] series, sir, and you have before you Exhibit [11] No. 18, your draft notes –

[12] A: Do you know what page number the whole [13] thing started with?

[14] Q: The exhibit?

[15] A: Yes.

[16] Q: Do you have Exhibit 18 in front of you?

[17] A: I'm trying to find the start of it so [18] I can put it back in order again.

[19] (Discussion off the record.)

[20] BY MS. GUSSACK:

[21] Q: Patient number 3 was the adolescent [22] inpatient. Correct?

[23] A: Yes.

[24] Q: And this was a patient who was not under

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[1] your personal care?

[2] A: Correct.

[3] Q: And whom you did not personally observe?

[4] A: Correct.

[5] Q: And Nurse Glod was the one who summarized [6] her case and went to the hospital records to [7] summarize it for purposes of the article. Is that [8] correct?

[9] A: Yes.

[10] Q: Referring to page MHT657 of Exhibit 18, [11] towards the bottom of the page before that final [12] paragraph there's reference to the "intermittent [13] past times of suicidal." Correct?

[14] A: Yes.

[15] Q: And, Doctor, just for context sake, can [16] you tell me when fluoxetine was started with [17] patient number 3? And I would refer you maybe just [18] to page 656 where you will see an entry sort of [19] halfway down that first paragraph, 4/28 on the [20] right-hand side. I'm sorry, wrong page. On 657, [21] the page that you were on, at the top it says [22] "fluoxetine started 5/2, 20 milligrams." At the [23] top there's an asterisk.

[24] A: Yes.

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[1] Q: Okay. Referring back to page 656 now of [2] Exhibit 18, there is an entry labeled "priv, [3] colon." Is that relating to privileges in the [4] hospital?

[5] A: Where? Oh, yes, yes.

[6] Q: And I see dates that refer to, for [7] instance, 1/4 four lines down? Dated 1/4?

[8] A: Yes.

[9] Q: "Four-points for assault"?

[10] A: Assault risk, yes.

[11] Q: For assault risk?

[12] A: Mm-hmm.

[13] Q: What does that mean, sir?

[14] A: That she was put in four-point restraints [15] because they perceived the risk that she might [16] assault herself or assault somebody else. It [17] doesn't say who.

[18] Q: It then says she was boarded for yelling. [19] What does that mean, sir?

[20] A: It means that she was moved to another [21] hall.

[22] Q: Why?

[23] A: I guess for yelling and being out of [24] control.

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[1] Q: Out of control is a quote from the [2] record, sir?

[3] A: Yes.

[4] Q: And she kicked the wall?

[5] A: I guess on 1/7. Or, it looks like it's [6] "kicked wall 1/7."

[7] Q: Then there is an entry, for instance, in [8] the next line, "1/22, sup sharps." What does that [9] mean, sir?

[10] A: Supervise sharps.

[11] Q: What does that mean?

[12] A: It means that if the patient wants to use [13] a sharp object like a knife, pair of scissors, that [14] a staff needs to be present to supervise it.

[15] Q: And why would that be, sir?

[16] A: It's generally because at that moment [17] staff does not trust them to use them safely.

[18] Q: Because they present a risk to themselves [19] of violence?

[20] A: Or to others. Or it may be part of some [21] kind of program they're on; I don't know. It [22] usually means there's a risk.

[23] Q: Referring to page 656 of Exhibit 18, do [24] you see the entry, sir, where it says after

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[1] November 25, in that same line, four lines from the [2] top –

[3] A: After what date?

[4] Q: November 25. 11/25, page 656.

[5] A: Okay.

[6] Q: "Suicidal thoughts but favorable outcome, [7] not a decision to commit suicide, not actively [8] suicidal"?

[9] A: Yes.

[10] Q: That is reporting on the patient's [11] condition several months before she takes [12] fluoxetine?

[13] A: Correct.

[14] Q: And then jumping down about six or eight [15] lines you see the entry dated 4/22, sir?

[16] A: Yes.

[17] Q: And the next line says "suicidal [18] ideation, jumping in front of train"?

[19] A: Yes.

[20] Q: "Looking more depressed and irritable"?

[21] A: Yes.

[22] Q: "Purging"?

[23] A: Yes.

[24] Q: "Suicidal ideation turned out to be

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[1] chronic"?

[2] A: Correct.

[3] Q: That is a description of the patient [4] about ten days before she's on Prozac for the first [5] time on May 2. Correct? (Pause) We earlier [6] agreed based on page 657 where the asterisk was in [7] the left margin that she was started on Prozac 5/2, [8] 20 milligrams.

[9] A: Yes. Okay.

[10] Q: So, sir, am I correct that that is a [11] statement about the patient's condition about eight [12] or ten days prior – Let me finish my question. [13] That the entry dated 4/22 referring to "Suicidal [14] ideation, jumping in front of train, looking more [15] depressed and irritable, purging, suicidal ideation [16] turned out to be chronic" is a statement of her [17] condition about ten days prior to starting [18] fluoxetine?

[19] A: The way I understand that is that that [20] statement when they said suicidal ideation turned [21] out to be chronic meant that it then went on for [22] the next several months.

[23] Q: As of April 22?

[24] A: Yes.

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[1] Q: Prior to when this patient began [2] fluoxetine the description appears "suicidal [3] ideation, jumping in front of train, looking more [4] depressed and irritable, purging, suicidal ideation [5] turned out to be chronic." Correct?

[6] A: Which, again, "turned out to be," meaning [7] she continued to have suicidal ideation for several [8] months thereafter.

[9] Q: And approximately ten days prior to [10] starting fluoxetine this patient had thoughts of [11] jumping in front of a train?

[12] A: Yes.

[13] Q: And the entry 4/28, which is again prior [14] to when she begins fluoxetine, has an entry [15] "chronic suicidality always an issue" before the [16] statement "begins fluoxetine"?

[17] A: Yes.

[18] Q: Now, sir, patient number 3 was commented [19] on by one of the peer reviewers who reviewed your [20] article in 1990. Correct?

[21] A: You would have to show me.

[22] Q: I believe you produced it as MHT00800. [23] While we're getting it out let me just read to you [24] the references that this reviewer said, quote,

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[1] "Case 3 is an example where some of the adverse [2] effects (akathisia) are also probably due to the [3] metabolic potentiation of Perphenazine." Do you [4] recall that?

[5] A: I don't disagree with you. I don't have [6] a good recall for something I read six years ago or [7] seven years ago.

[8] Q: I am showing you what has been identified [9] as MHT00800. That is a letter that you received, [10] sir, as a peer-review comment upon submission of [11] your article –

[12] A: Yes.

[13] Q: – to the American Journal?

[14] A: Yes.

[15] Q: In the third paragraph, you see where [16] I was reading from?

[17] A: Yes.

[18] Q: Now, sir, do you believe that that is a [19] possibility, that in case 3's situation some of the [20] adverse effects are probably due to the metabolic [21] potentiation of Perphenazine with fluoxetine?

[22] MR. GREENWALD: Objection to the form [23] of the question.

[24] A: Well, I think it is a – The argument by

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[1] the peer reviewer has a little bit of substance but [2] not a lot of substance. The data that does not [3] support the reviewer's contention is, first, that [4] "it worsened even though the Perphenazine dose was [5] lowered. Second, when fluoxetine was discontinued, [6] even though she was still on Perphenazine, the [7] suicidality seemed to largely abate. And finally, [8] she was on a combination of I believe nortriptyline [9] and Perphenazine, and nortriptyline potentiates [10] Perphenazine in much the same way as fluoxetine by [11] raising blood levels and she did not have it on [12] that combination. So although I can't dismiss that [13] explanation categorically, it doesn't seem to be a [14] good accounting for the facts.

[15] Q: Doctor, would you agree with the classic [16] sort of definition of akathisia that it requires [17] both a subjective and objective report of motor [18] restlessness?

[19] A: The traditional definition is a [20] disturbing sense of inner restlessness usually [21] accompanied by motor signs of agitation and [22] restlessness.

[23] Q: And it requires a report by the patient [24] as well as the clinician's objective appraisal?

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[1] A: In the clinical assessment of akathisia [2] in clinical practice you want to find both. You [3] would like to see both components, yes.

[4] Q: Doctor, are there any case control [5] studies that you are aware of that demonstrate that [6] patients who develop akathisia become suicidal?

[7] A: There is a literature on akathisia and [8] suicide but I am not aware of well-done case [9] control studies that would specifically address [10] that. I would say that at this juncture it is [11] reasonably well accepted in the field.

[12] Q: Largely based on case reports?

[13] A: Yes.

[14] Q: You are not aware of any prospective case [15] control trial which has demonstrated that the [16] presence of akathisia induces suicidality or [17] contributes to suicidality?

[18] A: Yes.

[19] MR. GREENWALD: Objection. I'm not [20] sure I understand your question.

[21] MS. GUSSACK: But Dr. Teicher did.

[22] MR. GREENWALD: I understand that. [23] But I want to understand it too. Just talk simply [24] for me so I can understand what you're saying.

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[1] BY MS. GUSSACK:

[2] Q: Your answer was "yes," Doctor, there is [3] no such study that you're aware of?

[4] A: Let me think for a second.

[5] Q: Patient number –

[6] A: I'm still –

[7] Q: Yes, I know, you're still thinking.

[8] A: I'm still thinking.

[9] MR. GREENWALD: The man has a right [10] to think.

[11] A: Can I ask you, since we need to be on the [12] same wavelength, how do you define a case control [13] study?

[14] Q: Well, sir, it is not important how I do. [15] How do you?

[16] MR. GREENWALD: For the purposes of [17] your question I think he needs to know what you're [18] talking about.

[19] MS. GUSSACK: I'm going to adopt the [20] doctor's definition. So why don't we have the [21] doctor define it?

[22] A: I would usually define a case control [23] study as one in which patients are recruited and [24] studied over time and that it would be a blind

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[1] assessment. And as the question becomes: Would [2] you include in the definition of a case control [3] study rechallenge studies?

[4] Q: No, sir, I am distinguishing between the [5] two.

[6] A: That is often also considered a case [7] control study.

[8] Q: For my purposes when I ask the question [9] I am not referring to rechallenge studies. I am [10] referring to prospective randomized controlled [11] trials.

[12] A: Then I am not aware of a prospective [13] randomized controlled trial which has shown that [14] akathisia can produce, did you say suicidal [15] ideation or suicidal attempts?

[16] Q: Both.

[17] A: Yeah, I'm not aware of a prospective [18] controlled trial.

[19] Q: Doctor, can you turn to page 689 of [20] Exhibit 18. On that page of Exhibit 18, page 689, [21] you will see that there is an entry dated 2/12 [22] referring to case number 5?

[23] A: Yes.

[24] Q: It says "2/12 fluoxetine started"?

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[1] A: Yes.

[2] Q: And then you will see several lines above [3] "January 5, '88, got fired/transferred." Correct?

[4] A: Yes.

[5] Q: That would be a fairly significant life [6] stressor for patient number 5, wouldn't it, getting [7] fired?

[8] MR. GREENWALD: Objection.

[9] A: Well, she actually got transferred.

[10] Q: How do you know, sir, looking at "got [11] fired/transferred"?

[12] A: Because that's what I recall happened.

[13] Q: But would that be a significant stressor [14] for her?

[15] MR. GREENWALD: What? Getting [16] transferred?

[17] MS. GUSSACK: Yes.

[18] MR. GREENWALD: Well, there were two [19] things you were asking. I want to be sure which [20] one you're asking him.

[21] BY MS. GUSSACK:

[22] Q: Would the change in her job status have [23] been a stressor for her, sir? Was it?

[24] A: It certainly had some impact. Had some

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[1] both good and bad impact.

[2] Q: Let me refer you to the entry above it [3] dated December '87, where it says "insecure at [4] work, not working as well, feels others aren't [5] pleased and doesn't feel on top of things." That [6] is a description of this patient not feeling good [7] about what's going on in her worklife. Correct?

[8] A: Right. And part of that was alleviated [9] by being transferred.

[10] Q: That was a stressor at the time?

[11] A: Right.

[12] Q: And on February 23, sir, there is an [13] entry again that problems she feels at work [14] continue. That's after the entry of January 5, [15] '88, where you believe she was transferred. [16] A month and a half later she's reporting that [17] problems she feels at work continue. Correct?

[18] A: That is certainly what's indicated in [19] this synopsis of the notes. What I am not exactly [20] sure of right now is what that means. My [21] impression is it means that she's having some [22] difficulty concentrating at work. It is not [23] specifically referring to what she was experiencing [24] on 12/87 in terms of insecurity. The 12/87 with

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[1] the insecurity was the insecurity that one felt [2] when they knew that they weren't functioning up to [3] standards and they were going to get transferred to [4] a less difficult position. So that was her [5] insecurity. She was perceptive enough that others [6] weren't pleased with her work performance and it [7] resulted in a transfer to a less busy office.

[8] And so that's what happened with [9] those two notes. And then 2/23, one of her [10] problems in treatment was that she sometimes had [11] difficulty concentrating at work, and I think [12] that's what is being referred to on 2/23.

[13] Q: So in your article when you say that you [14] looked for issues such as loss and abandonment, [15] sir, you considered these complaints by patient [16] number 5 and determined that they were not [17] significant?

[18] A: Right.

[19] Q: This patient suffered a seizure on the [20] day before March 1st. Do you see the entry on 689?

[21] A: Yes, "seizure previous day."

[22] Q: And she reports "very depressed, apathy, [23] having relationship struggles"?

[24] A: It doesn't say having relationship what?

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[1] Q: I'm sorry. At the bottom of that page, [2] March 8, "depressed, having problems with [3] relationship"? Do you see the last line on page [4] 689?

[5] A: Yes.

[6] Q: And then again on page 690 under the [7] entry for March 18, you see "problems with [8] relationships, struggles" again referenced?

[9] A: Yes.

[10] Q: "Not able to do anything but work," so [11] this patient is now able to work?

[12] A: Excuse me?

[13] Q: This patient is now able to focus on [14] work?

[15] A: Well, she's not able to do anything but [16] work. I'm not saying – It is not a comment that [17] she's able to work. It is a comment that she's not [18] able to do anything else. She was attending; she [19] was showing up at her job and doing her work. I'm [20] not indicating how good her performance was.

[21] Q: Patient number 5 was an epileptic, sir?

[22] A: She has basically some psychomotor type [23] seizures. As indicated in here she suffered from [24] temporal lobe epilepsy, psychomotor seizures.

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[1] Q: So she was an epileptic?

[2] A: I would not use the term. I would say [3] that she had psychomotor seizures. You know, it [4] was not associated with loss of consciousness; she [5] didn't wear an epilepsy badge. She had episodic [6] paroxysmal disturbances in cognition and [7] concentration that were seizure phenomena.

[8] Q: That were?

[9] A: Seizure phenomena. I just don't like to [10] use the word epileptic in that – Basically when [11] epileptic is used in lay language it usually [12] indicates somebody who actually has seizures with [13] loss of consciousness.

[14] Q: So she had a seizure on March 1st but you [15] don't believe she had a loss of consciousness?

[16] A: No, she didn't.

[17] Q: Sir, in your draft which you submitted to [18] Dr. Baldessarini on page 6, Exhibit 19, you have [19] made reference to patient number 5. Correct?

[20] A: Which page again? I'm sorry.

[21] Q: Page 6.

[22] A: (Pause) Yes.

[23] Q: I believe it says there on page 6 that an [24] early attempt to resume isocarboxazid therapy after

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[1] patient discontinued Prozac led to intolerable side [2] effects?

[3] A: Yes.

[4] Q: Do you know what those intolerable side [5] effects were?

[6] A: (Pause) It says on 5/14 "Marplan, but [7] got nauseous and bad headache, very frustrated."

[8] Q: Is there a reason that you didn't [9] describe those in the case report on patient number [10] 5?

[11] A: In the article?

[12] Q: Yes.

[13] A: Just space.

[14] Q: Just space requirements?

[15] A: Yes.

[16] Q: Sir, you mentioned yesterday that you [17] have been sued for malpractice. Is that correct?

[18] A: Yes.

[19] Q: More than one occasion?

[20] A: Yes.

[21] Q: On one occasion the malpractice suit was [22] brought by patient number 6 in your case series. [23] Correct?

[24] MR. GREENWALD: Objection.

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[1] A: Yes.

[2] Q: What was the other circumstance in which [3] you were sued?

[4] MR. GREENWALD: Objection.

[5] MS. GUSSACK: Do you want a [6] continuing line of objections to this subject area?

[7] MR. GREENWALD: Okay.

[8] MS. GUSSACK: Sure.

[9] THE WITNESS: I'm free to answer it?

[10] MR. GREENWALD: Well, I can't [11] instruct you. I am not your attorney, so you have [12] to use your own judgment. Or if you have an [13] attorney giving you instructions, follow those. [14] But I am not your lawyer so I can't instruct you.

[15] A: The other case in which I was sued for [16] malpractice regarded a patient of mine who was in [17] the hospital, who escaped from the hospital and [18] committed suicide.

[19] Q: That was a patient under your care?

[20] A: Yes.

Q: For whom you were responsible?
A: Yes.
Q: Had you predicted that patient was at risk for suicide?

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A: At very high risk for suicide.
Q: The person was at very high risk for suicide?
A: Yes.
Q: And the patient's family sued you?
A: Yes.
Q: For not preventing the suicide?
A: Right.
Q: Now, patient number 6 was a patient of yours for, what, six years?
A: I'm happy to discuss what's here in the case, what's here in these notes. My attorney Mr. William Daley has instructed me not to discuss any details of this case.
Q: Well, sir, I am going to ask you questions because whether you want to or not, you have injected yourself into this litigation, and patient number 6 is a patient reported on in your article and it is relevant here. Mr. Daley is not counsel of record in this matter and has no authority here. So I am going to ask you the questions and I ask you to give me your best answers, sir.
A: To the extent that he has instructed me

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not to discuss the details of the case, I will not discuss the details of the case.
Q: Why don't we take it one question at a time and see where we go.
Patient number 6 was a patient of yours for six years?
MR. GREENWALD: Objection.
BY MS. GUSSACK:
Q: Is that right, sir?
A: His instructions to me were not to discuss the case, and I think that –
Q: I am going to ask you to listen to my question, Dr. Teicher, very closely.
A: Yes, and anything that I've written that is available on this I will verify and will discuss. But to the extent that you're asking information that is not here, additional information, I am going to refuse to answer.
Q: Doctor, if you would let me ask my questions and if you would listen to them closely, we'll see what you can answer and then we can decide what we're going to disagree about.
A: I heard your question about the six years. I don't see any data here that would

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independently indicate that she was my patient for six years.
Q: Doctor, would your notes of your treatment of patient number 6 that you have brought with you reflect how long you treated this patient?
A: I do not believe they would.
Q: So you are unable to state here in this litigation, referring to patient number 6 on whom you have published a case report, how long you treated this patient?
MR. GREENWALD: Are we now having a speech or a question?
MS. GUSSACK: That's a question.
MR. GREENWALD: It sounds like a speech.
A: I am willing to –
Q: I asked you, are you unable to?
A: I am unwilling to.
Q: You have stated that patient number 6 was the plaintiff in a malpractice suit brought against you. Correct, sir?
A: Yes.
Q: And that malpractice suit has been settled. Correct?

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A: Correct.
Q: And it has been reported that $500,000 was paid to settle that case.
MR. GREENWALD: Objection.
BY MS. GUSSACK:
Q: Is that an accurate statement, sir?
MR. GREENWALD: I assume I have my continuing line of objections that we started about, what, eight or nine questions before?
MS. GUSSACK: Oh, certainly. To the subject with regard to the malpractice with regard to patient number 6?
MR. GREENWALD: I think it was with regard to all malpractice issues. But since we have already passed that, I think you asked me if I wanted a continuing objection when you asked the first malpractice question and I believe I said I did. So I believe we have agreed that I don't have to say "objection" after every question that you ask here because the reporter will understand that I am making one. Or if you want me to start in again and make objections, I will.
MS. GUSSACK: Your objections are recognized.

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MR. GREENWALD: Thank you.
BY MS. GUSSACK:
Q: Dr. Teicher, is it accurate that you settled the lawsuit brought against you by patient number 6 for $500,000?
A: There's a confidentiality agreement regarding the settlement and I have been asked and instructed and agreed as part of that not to discuss it
Q: Did you make an independent promise, sir, not to discuss it, not to disclose the amount?
A: I think that was part of the confidentiality agreement, yes.
Q: Are you aware that in the December 13, 1994 Boston Globe the amount of the settlement was disclosed as an estimated $500,000?
A: Yes, I am aware of that.
Q: Did you write The Globe to tell them that that was an inaccurate statement?
A: I did not write The Globe to tell them all of their statements were inaccurate.
Q: Is that an inaccurate statement, that this case was settled for an estimated $500,000?
MR. GREENWALD: I think he's said he

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is not going to talk about it.
A: I've told you I feel I cannot discuss that.
Q: So you have a secret settlement in the lawsuit brought by patient number 6 which you believe precludes you from telling us how much you paid in settlement of the action?
A: Yes.
MR. GREENWALD: I believe he said it was a confidentiality agreement. Now, can I just make an observation? If that confidentiality was breached and you have information by someone who breached the confidentiality agreement, I think we have a right to know that. At least the doctor has a right to know that. Is that the case? Ms. Gussack? Has somebody breached his confidentiality agreement by providing you with information?
MS. GUSSACK: I asked a question. I got an answer.
MR. GREENWALD: No. I asked a question and I was looking for an answer.
MS. GUSSACK: I will discuss it with you privately after the deposition.

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MR. GREENWALD: Because I think he has a right to know that if someone has breached the confidentiality agreement.
MS. GUSSACK: Could we please have

that marked.

(Teicher Deposition Exhibit 40 marked for identification.)

BY MS. GUSSACK:

Q: Doctor, I am putting before you what's been identified as Teicher Exhibit 40, which is a complaint that is captioned Jane Doe and John Doe v. Martin Teicher, M.D., sir, and ask you is this the complaint that describes the allegations made by patient number 6 against you?

MR. GREENWALD: We still have our continuing objection?

MS. GUSSACK: Yes.

A: I believe that it is.

Q: Now, sir, in the course of the malpractice lawsuit brought by patient number 6 against you, you were deposed, were you not?

A: Yes.

Q: You told us that took place on three separate days, I think. Right?

A: Yes.

Q: And patient number 6, Jane Doe in that malpractice lawsuit, was also deposed in that action. Correct?

A: Yes.

Q: Have you reviewed her deposition testimony in that case?

A: Yes, I have.

Q: And, sir, have you reviewed your own deposition testimony in that case?

A: At some point in time, yes.

Q: Do you believe, sir, that in that deposition testimony there is information about patient number 6 that is of interest with regard to her medical status and the issues of evaluating her reaction to fluoxetine?

MR. GREENWALD: Objection.

A: In my deposition or in her deposition?

Q: In your deposition.

MR. GREENWALD: I'm confused. Can I ask you a question for clarification?

MS. GUSSACK: Could I first hear from the doctor whether he understands the question?

MR. GREENWALD: Do you understand the

question? Because I'm confused by it.

MS. GUSSACK: We can do it the easy way or we can do it the hard way.

BY MS. GUSSACK:

Q: Do you understand my question, Doctor?

A: I understand your question.

Q: Can you answer it, sir?

A: I guess you need to clarify the question. I think you said "of interest."

Q: Of significance; of clinical significance. How's that clarification? Is there information contained in your deposition testimony in the malpractice lawsuit that is clinically significant in evaluating patient number 6's response to fluoxetine?

A: I would have to look at that more carefully with that specific question in mind.

Q: Okay. Doctor. May I ask you to return to page MHT00664 of Exhibit No. 18 that is before you.

A: Yes, I have it.

Q: On page 664 of Exhibit 18 there is the entry that reflects that this patient, patient number 6, was started on fluoxetine on February 2. Correct?

A: Yes.

Q: Now, sir, these are your notes of patient number 6. Correct?

A: They are either my notes or Dr. Glod's notes but probably my notes.

Q: You see in the fourth line, and correct me if I read this inaccurately, these notes reflect that patient number 6 had a history of intermittent suicidal ideation and has made three significant suicide gestures, first age 17, and though had significant suicidal ideation episodically during last five years, made no action since daughter's birth five years ago. Is that correct?

A: Yes.

Q: On page 664 as well there is a reference in October 1987 that a brief trial of Surmontil occurred but was discontinued due to dysphoric mania?

A: 10/87, brief trial Surmontil, yes.

Q: I have read that accurately?

A: Yes, you have.

Q: And on this same page, sir, in January '88 the patient is identified as hypomanic?

A: When?

Q: January '88.

A: Yes.

Q: Then the entry for February 2, the day this patient is first given Prozac, sir, could you read the entry that appears there?

A: For February 2?

Q: Yes.

A: "Intense anxiety, progressed in past to nearly housebound, coming down" and should be "from hypomania, self-loathing, suicide ideation," I guess, doesn't say, "but no plan or intention. Feels exhausted, like giving up, hopeless, empty."

Q: Could you read the entry for March 1 now, sir?

A: "Felt shaky, DES plus high."

Q: What does that mean?

A: That I think is the dissociative experience scale. That measures the degree of dissociation. "In pain, restless, buzzy with nervous energy, dizzy, internal akathisia and agitation."

Q: And could you read the medications that she was on, sir?

A: "Meds, 4 milligram Haldol," looks like

2 comma 5 but should be probably "2.5 milligrams of clonidine, 800 milligrams Tegretol, 250 of Synthroid, 40 of Valium, 40 milligrams fluoxetine, and 100 milligrams of Benadryl."

Q: Of the medications that you read, sir, some of those are neuroleptics. Correct?

A: The Haldol is.

Q: And that is classically associated with akathisia?

A: Yes.

Q: I think you told us yesterday that when this patient became intensely suicidal in a manner that you attributed to her use of fluoxetine you were away. Is that correct?

MR. GREENWALD: He was what?

MS. GUSSACK: Away; out of town.

A: Part of that episode.

Q: What do you mean by part of that episode?

A: I was away for a brief period of time out of that episode. I wasn't away for the entire episode. If I recall, I was away for a day and a half and had come back that evening and there was a problem earlier in that day; I was back that evening. And that was probably March 31.

Q: Sir, in your 1990 article you say that patient number 6's self-destructiveness continued to intensify, she planned a lethal overdose and put a loaded gun to her head.

A: Yes.

Q: Were you available in your office to patient number 6 when she planned this lethal overdose and put a loaded gun to her head?

A: No.

Q: Did you speak to her at the time that she did that?

A: I spoke to her later that day but not at the time.

Q: At the time she did that Nurse Glod spoke with her?

A: Yes.

Q: And Nurse Glod was the person to whom she reported how she was feeling at that time?

A: Yes.

Q: And then you believe you spoke with her later that day?

A: Yes, I did, that evening.

Q: Did patient number 6 know that you were going to be away at the time?

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A: Oh, yes, and that Nurse Glod or Dr. Glod as she now is was covering. And she also knew I would be back that evening.

Q: Are you able to read, please, the entry for March 24 on MHT665?

A: Yes. March 24?

Q: Yes.

A: "Sinking, barely hanging on. No difficulty with DC, detached and withdrawn."

Q: Do you know what DC means?

A: It means discontinuation, but

Q: Discontinuation of what?

A: I don't know what it's referring to here.

Q: Okay.

A: If I can check this for a second.

Q: Well, Doctor, if you refer back to page 664 you see the entry on March 22 –

A: Oh, it says DC fluoxetine, right.

Q: So on March 22 the entry says "severely dissociated and much more so, therefore discontinue fluoxetine"?

A: Right. So it says then no difficulty with DC, so she's not having any physical reactions to discontinuing the medication.

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"Detached and withdrawn. I wish I were dead. I feel like I am dead. If not dissociated and attached, then suicidal panic and with voices inside shouting at me to commit suicide, Joan came out one voice wants" – I wish that wasn't there – "wants Doe to die because she's fat, ugly and" –

MR. GREENWALD: Excuse me. For the sake of continuity, can we redact that from this document and ask the court reporter to just put Doe in its place? For the preservation of confidentiality. I think Dr. Teicher would feel a lot better about that.

MS. GUSSACK: All right. Let the record reflect that at counsel's request we are redacting the reference to "[BLANK]" in the March 24 entry on Exhibit No. 18 and changing it to "Doe." Referring to patient number 6. Correct, Doctor?

THE WITNESS: Yes.

MR. GREENWALD: The problem with that is we still have "[BLANK]" in the record. What we're trying to do is get "[BLANK]" out of the record, so instead of saying "[BLANK]" why don't we

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just say we have redacted a name on 00665 and changed it to "Doe." We all know what we're talking about, but there will never be a record that has the word "[BLANK]" in it. That's what I am trying to achieve.

MS. GUSSACK: That's fine. And we will fix that at the end of the session today. We'll go back to the record and with the agreement of counsel we'll make that change in the record. Okay?

MR. GREENWALD: And the reporter can make a note in the record that by the agreement of counsel a name on page 00665 was redacted and changed to "Doe," and that way it will never appear in the record. Which is what the doctor would like. Okay?

BY MS. GUSSACK:

Q: Is this the first time, Doctor, March 24, that you were aware that patient number 6 had multiple personalities?

A: No.

Q: So were you aware prior to March 24, this entry, that patient number 6 had multiple personalities in which one of the personalities

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wanted another personality to die? (Pause) Do you have my question in mind, Doctor?

A: Yes, I'm thinking. I'm trying to see if there's any specific statement to that here.

Q: And you are referring to Exhibit 10?

A: Yes.

Q: What about in your notes summarizing patient number 6 that you have before you?

A: There's no mention in this material of the voice inside or the multiple personality presence shouting at her to die. And I can't say with certainty whether it had ever occurred at any time before this.

Q: Your process notes would reflect whether it had. Correct, sir?

A: They may. What the process notes would reflect is whether she told me it did.

Q: Sir, would you say that patient number 6 was an accurate historian?

A: I'm sorry. I would like to help but I think that leads to my discussing details of the case that are not in this material.

Q: Well, sir, you have answered me with respect to patient number 2 and told me that you

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thought there were problems with him as a historian. Correct?

A: Yes, I did.

Q: He was not forthright and candid with you. You told us that.

A: Yes.

Q: Now, with respect to –

A: I feel free to discuss case number 2 because I have not been instructed by my attorney not to discuss case number 2. I have been instructed by my attorney not to discuss the details of case number 6.

Q: Case number 6 and the lawsuit that was brought against you we have agreed has concluded. Correct?

A: Yes.

MR. GREENWALD: Objection.

BY MS. GUSSACK:

Q: Why is it that you believe you have some inhibition about discussing the subject matter of patient number 6 with respect to that lawsuit?

A: Because there is an ongoing legal matter regarding the Board of Registration in Medicine.

Q: That is the licensing board in

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Massachusetts?

A: Yes.

Q: And there is an ongoing proceeding against you, sir, in which patient number 6 is making allegations?

A: Yes.

Q: Can you answer the question, sir, whether you believe patient number 6 is an accurate historian?

MR. GREENWALD: I am going to object. That really puts him in a box in the sense of the other issue, because it goes to the issue of credibility. I think that that at this point would be an improper question and I object to it.

MS. GUSSACK: Andy, and Dr. Teicher, let me explain what I'm going to do here.

[17] I don't think there's any question [18] that the information that I am seeking about [19] patient number 6 is directly relevant to the [20] matters that are at issue in this case, including [21] specifically your case report reporting on patient [22] number 6, an article that you have placed at the [23] center of this litigation by virtue of your expert [24] report. The fact that you have a disciplinary

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[1] proceeding pending before the Board [2] of Registration [2] of the Commonwealth of Massachusetts does not make [3] patient number 6, her history and your involvement [4] with that patient, any less significant or relevant [5] here.

[6] Now, you may have objections, and [7] I understand that, but I am going to ask these [8] questions; and if the doctor does not want to [9] answer, he is going to have to tell me that and we [10] are going to go to the judge - when I'm finished [11] you can tell me what you want to tell me, okay? - [12] and I am going to seek an order compelling [13] Dr. Teicher to answer these questions. Because [14] while Dr. Teicher may have legal problems in his [15] personal life, they are not relevant here with [16] respect to patient number 6. He has voluntarily [17] injected himself into this litigation and these [18] issues are relevant.

[19] When we go before the judge and I ask [20] for the order compelling Dr. Teicher to return and [21] answer these questions, I am going to ask that he [22] be compelled at his expense, paying for my costs [23] incurred in returning for these questions.

[24] Now, I would like for the convenience

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[1] of the court reporter and the parties present that [2] if you're going to make objections, either make a [3] standing objection or simply state, Dr. Teicher, [4] that you're unable to testify, so that we may [5] create a record that we can go to Judge Penn with. [6] And I think that's a fair and reasonable way of [7] proceeding. Would you agree?

[8] MR. GREENWALD: If Dr. Teicher is not [9] going to answer a question, he should explain to [10] you why he is not answering. He has explained to [11] you that he has been instructed by his attorney - [12] that's obviously not me - not to discuss these [13] issues. We have agreed that I have a continuing [14] objection to this whole line of questioning.

[15] And I disagree with your position [16] about the relevance of this issue because I don't [17] think that the 1990 article is the centerpiece that [18] you think it is with respect to this case. So [19] I disagree with that issue with respect to [20] relevance. And I think it is now 4:30 of the [21] second day of Dr. Teicher's deposition where he has [22] been asked an incredible amount of questions about [23] the 1990 article, about all of the case reports in [24] it, about his notes, and all other issues relating

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[1] to it, and the doctor has repeatedly testified that [2] the 1990 article only created a hypothesis, which [3] you have discussed with him.

[4] And for that reason and other reasons [5] that we can discuss I disagree with you on what you [6] believe to be the extreme relevance of the 1990 [7] article.

[8] So if you wish to ask the judge for [9] an order compelling, you certainly have the right [10] to do that and we will take the appropriate action [11] if and when you decide to do that and the court [12] will make a decision one way or the other. But [13] I think that Dr. Teicher is within his rights, if [14] he is following the advice of his private counsel, [15] to do so. And thoughts about expense and all of [16] that stuff I don't think is appropriate to try to [17] get the doctor to - Are you listening?

[18] MS. GUSSACK: Go ahead.

[19] MR. GREENWALD: To try to get the [20] doctor to not follow his attorney's advice simply [21] for fear that he may have to pay somebody's plane [22] fare. So that is, I think, a kind of unfair [23] threat. But I understand why you've said it.

[24] MS. GUSSACK: I am not threatening,

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[1] I am simply stating my intent and my goal.

[2] MR. GREENWALD: Fine.

[3] MS. GUSSACK: My comments were simply [4] directed to explain that I am going to ask these [5] questions. For the sake of convenience here, [6] I would suggest if Dr. Teicher is not going to [7] answer, that he simply say so and tell us why he [8] says so. But for purposes of creating my record, [9] I am going to ask every question which I believe [10] I am entitled to an answer to. Okay?

[11] Now, may I have the last question [12] read back.

[13] (The reporter read back as follows:

[14] "Question: Can you answer the [15] question, sir, whether you believe patient [16] number 6 is an accurate historian?")

[17] MR. GREENWALD: And I objected.

[18] MS. GUSSACK: I am going to recognize [19] your continuing objection to this entire line of [20] questions.

[21] THE WITNESS: And had I responded?

[22] MR. GREENWALD: He answered the [23] question. The doctor answered the question. He [24] said "This relates to the issue that my attorney

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[1] has instructed me not to answer." He's already [2] answered that question.

[3] MS. GUSSACK: I'm trying to clarify [4] for my sake where we are.

[5] MR. GREENWALD: I understand. But [6] when you say what was the last question, he's [7] answered the question. He stated he wasn't going [8] to answer it.

[9] BY MS. GUSSACK:

[10] Q: Doctor, is that your position, you are [11] unable to respond to the question whether patient [12] number 6 is an accurate historian?

[13] A: Yes.

[14] Q: And that is on the advice of your [15] malpractice counsel Mr. Daley?

[16] A: Yes.

[17] Q: Who is representing you in an ongoing [18] proceeding before the Board of Registration in the [19] Commonwealth of Massachusetts?

[20] A: Correct.

[21] Q: A proceeding which puts your license at [22] issue?

[23] A: Possibly.

[24] Q: You may lose your license to practice

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[1] medicine in the commonwealth of Massachusetts?

[2] A: That's a possibility.

[3] Q: Doctor, do you have any recollection [4] sitting here today whether patient number 6 ever [5] told you prior to March 24 that she had [6] personalities that were encouraging other [7] personalities to die?

[8] MR. GREENWALD: Let me make one other [9] observation. Dr. Teicher doesn't understand, [10] I think, or wouldn't, because he's not a lawyer, [11] any issues about waiver when he testifies; and his [12] lawyer is not here.

[13] I would assume that if he does answer [14] some questions for you that he feels he can answer, [15] you will not use that as an argument that he has [16] waived his right to follow his attorney's advice. [17] That doesn't go into the issue of whether the [18] advice is appropriate or not. Is that correct?

[19] MS. GUSSACK: I am not giving [20] advisory opinions. I'm asking questions and I'm [21] looking for answers.

[22] MR. GREENWALD: If you are going to [23] argue that whatever answer he gives is a waiver of [24] what he said

before, then he ought to consider that

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[1] before he answers anything at all.

[2] BY MS. GUSSACK:

[3] Q: Doctor, do you have a recollection [4] sitting here today of any prior occurrence before [5] March 24 in which patient number 6 told you that [6] one of her personalities wanted another personality [7] to die?

[8] MR. GREENWALD: Excuse me. I think [9] he has a right to understand what waiver means. If [10] you are going to argue at some point waiver, [11] I think he has a right to know that.

[12] MS. GUSSACK: Neither you nor I are [13] his counsel, Andy, and I am not giving him legal [14] counsel today.

[15] MR. GREENWALD: I am not giving him [16] legal counsel either, but I think the man has a [17] right to know that by answering some questions you [18] may argue that he has waived his right not to [19] answer others.

[20] MS. GUSSACK: Can we continue, [21] please?

[22] BY MS. GUSSACK:

[23] Q: Dr. Teicher, can you answer the question?

[24] A: I thought I already had.

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[1] Q: You said you might have notes. I'm [2] asking you today sitting here, do you have a [3] recollection one way or the other –

[4] A: And I thought I had answered that the [5] material is not contained here and since it is not [6] contained in this and in that, the materials that [7] I submitted, I would have to decline answering the [8] question for the reasons that we've just discussed.

[9] Q: The reasons you've just discussed being [10] what?

[11] A: The advice of my attorney.

[12] Q: Mr. Daley?

[13] A: Yes.

[14] MR. GREENWALD: Can we agree that the [15] attorney is Mr. Daley so we don't have to keep [16] repeating that?

[17] MS. GUSSACK: I don't want there to [18] be any confusion about who's doing what here.

[19] MR. GREENWALD: Good.

[20] BY MS. GUSSACK:

[21] Q: On page 665 of Exhibit No. 18, Doctor, [22] you have a reference "back to baseline in terms of [23] suicidal thoughts." Correct?

[24] A: Yes.

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[1] Q: What was baseline for suicidal thoughts [2] for patient number 6?

[3] A: Intermittent suicidal thoughts and with [4] no intention to act on them.

[5] MR. GREENWALD: Doctor, where are you [6] reading from?

[7] THE WITNESS: Reading from case 6 [8] description.

[9] MR. GREENWALD: But what exhibit are [10] you reading from?

[11] THE WITNESS: I am reading that from [12] Exhibit 10.

[13] BY MS. GUSSACK:

[14] Q: Doctor, it is true, isn't it, that [15] throughout the time that you treated patient number [16] 6 she was taking Valium?

[17] A: As I wrote in Exhibit 10, she was on [18] diazepam, 40 milligrams, Valium 40 milligrams per [19] day, and during the duration of the chronology that [20] we've described in this case she was on Valium.

[21] Q: Was she on Valium, sir, throughout the [22] six years of treatment that you provided to her?

[23] MR. GREENWALD: Objection. He never [24] said he treated her for six years.

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[1] A: Again, I will decline answering that [2] question on the advice of my attorney.

[3] Q: Now, sir, in your deposition testimony [4] taken in the case of Jane Doe versus Martin Teicher [5] you in fact provided information, didn't you, about [6] patient number 6's medical history? Correct?

[7] MR. GREENWALD: Objection.

[8] A: On the advice of counsel I will not [9] discuss the deposition testimony.

[10] Q: Well, sir, I am going to put before you [11] the deposition of Martin Teicher taken on October [12] 20, 1993, and ask you to refer to pages starting [13] at 97.

[14] MR. GREENWALD: Is this the whole [15] thing?

[16] MS. GUSSACK: Yes.

[17] BY MS. GUSSACK:

[18] Q: Doctor, before you look at page 97, can [19] you describe for me the allegations made against [20] you by patient number 6 in this malpractice [21] complaint?

[22] MR. GREENWALD: I'm sorry. I missed [23] the question completely. I'm sorry.

[24] BY MS. GUSSACK:

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[1] Q: Can you describe for me the allegations [2] that Jane Doe, patient number 6, made against you [3] in the malpractice complaint?

[4] MR. GREENWALD: Objection.

[5] A: On the advice of counsel I will not.

[6] Q: Well, sir, you would agree that she [7] complained that you were negligent in your [8] prescribing of multiple medications for her at the [9] same time. Correct?

[10] MR. GREENWALD: Objection.

[11] A: I have indicated I will not discuss this.

[12] Q: Sir, did she also allege in her complaint [13] and in her deposition that you had engaged in [14] multiple acts of sexual relations with her?

[15] MR. GREENWALD: Objection.

[16] A: Again, I will not discuss this on advice [17] of counsel.

[18] Q: Now, Doctor, let me be clear. You are [19] again not answering these questions on advice of [20] counsel because of the pending matter before the [21] Board of Registration?

[22] A: Correct.

[23] MR. GREENWALD: Can we shorten this [24] by having him say that's the reason he's not going

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[1] to answer all of the questions? Unless he has a [2] different reason, he will provide one. So we don't [3] have to –

[4] MS. GUSSACK: I'm understanding him [5] pretty well. Okay?

[6] BY MS. GUSSACK:

[7] Q: Could you refer to page 97 of your [8] deposition of October 20, 1993, Doctor, please.

[9] MR. GREENWALD: This deposition says [10] at the top of it "confidential." May I ask how it [11] was obtained if it's confidential?

[12] MS. GUSSACK: I will be glad to [13] discuss that with you after the deposition.

[14] BY MS. GUSSACK:

[15] Q: Could you refer to page 97, sir.

[16] A: Yes, I see the deposition.

[17] Q: Now, sir, you see where the question is [18] asked "Have you been with Jane Doe in any hotels, [19] motels or inns?" Do you see that question?

[20] MR. GREENWALD: Objection.

[21] A: On the advice of counsel I will not [22] discuss this.

[23] Q: Your answer at that time on page 97 was [24] "No." Is that correct?

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[1] MR. GREENWALD: Objection.

[2] A: It is the advice of counsel that I not [3] discuss this matter.

[4] Q: Doctor, is it accurate to state that on [5] October 20, 1993, in your deposition you described [6] Jane Doe as suffering from, from being diagnosed as

[7] a grand hysteric during her first hospitalization [8] at McLean?

[9] MR. GREENWALD: Objection.

[10] A: Again, I will not discuss this.

[11] Q: And, Doctor, on page –

[12] MR. GREENWALD: I am going to move [13] when you're done to strike all of this based on [14] what I perceive to be the use of a confidential [15] document.

[16] BY MS. GUSSACK:

[17] Q: Doctor, on page –

[18] MR. GREENWALD: As well as the other [19] reasons we've talked about.

[20] Q: On page 98 of your deposition taken in [21] this malpractice case, is it accurate to state that [22] you identified a grand hysteric as someone who [23] would make up all sorts of things for attention?

[24] MR. GREENWALD: Objection.

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[1] A: Again, I will not discuss that.

[2] Q: You stated during this deposition, didn't [3] you, that she remained a grand hysteric during the [4] entire time that you treated her?

[5] MR. GREENWALD: Objection.

[6] A: Again, I am not able to discuss that.

[7] Q: She was treated for this disorder of [8] grand hysteric but did not do very well. Correct, [9] sir?

[10] MR. GREENWALD: Objection.

[11] A: I am not able to discuss that.

[12] Q: Doctor, it is true, isn't it, referring [13] to page 99 of the deposition, that patient number 6 [14] suffered delusions the entire time that you were [15] treating her because you described it as a chronic [16] problem?

[17] MR. GREENWALD: Objection.

[18] A: I am not able to discuss that.

[19] Q: Doctor, referring to page 101 of the [20] deposition, you stated that patient number 6 had [21] serious problems with reality testing, [22] distinguishing fantasy from reality in all areas. [23] Correct?

[24] MR. GREENWALD: Objection.

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[1] A: I am not able to discuss it.

[2] Q: Doctor, it is true, isn't it, that when [3] you first began treating patient number 6 in 1986, [4] that Nurse Glod told you that she was, quote, one [5] of the sickest patients she's ever encountered, end [6] quote?

[7] MR. GREENWALD: Objection.

[8] A: I am not able to discuss that.

[9] Q: You can't discuss whether Nurse Glod told [10] you that in the initial course of your treatment [11] with patient number 6?

[12] A: I have been instructed not to discuss the [13] details of the case. If it's in the article, if [14] it's in these notes, I'm happy to discuss it. If [15] it's not there, I think that that goes against my [16] attorney's advice.

[17] Q: Sir, you have testified, haven't you, at [18] page 110 of the deposition taken on October 20, [19] 1993, that Nurse Glod told that you there was much [20] greater transference under the surface than you [21] were picking up in the therapy sessions and you [22] should be very careful and that Nurse Glod [23] encouraged you to, quote, "maintain as rigid [24] boundaries as I can," end quote. Isn't that right,

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[1] sir?

[2] MR. GREENWALD: Objection.

[3] A: I am unable to discuss that.

[4] Q: It is not that you are unable to discuss [5] it, you have chosen not to discuss it, sir. [6] Correct?

[7] MR. GREENWALD: Objection.

[8] BY MS. GUSSACK:

[9] Q: You are unwilling to discuss this?

[10] A: Unwilling, unable.

[11] MR. GREENWALD: I think he said he's [12] following his counsel's advice.

[13] BY MS. GUSSACK:

[14] Q: Turning to page 185, sir, of the [15] deposition, you stated that patient number 6 was [16] physically dependent but not addicted to Valium [17] throughout the time that you treated her. Correct?

[18] MR. GREENWALD: Objection.

[19] A: I am unable to, unwilling to discuss it.

[20] Q: Do you know whether your notes reflect [21] that, sir, the ones that you have before you?

[22] A: The notes that are present do not refer [23] to the entire period that I was treating her.

[24] MR. GREENWALD: Is this an extra

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[1] copy?

[2] MS. GUSSACK: No. That is my only [3] complete copy.

[4] MR. GREENWALD: Are you making this [5] an exhibit?

[6] MS. GUSSACK: I haven't decided yet.

[7] BY MS. GUSSACK:

[8] Q: Doctor, referring to page 190 to 191, [9] I want to direct you to your testimony where you [10] said that Jane Doe would call you at home. Isn't [11] that right?

[12] A: I am unwilling to discuss that.

[13] Q: She called you at home throughout the [14] course of the time that you were treating her. [15] Correct?

[16] A: I am unwilling to discuss that.

[17] Q: You have testified in your malpractice [18] deposition –

[19] MR. GREENWALD: I don't know why [20] I keep saying objection. I have a continuing [21] objection.

[22] MS. GUSSACK: Right.

[23] Q: – referring to page 190 to 191, that [24] throughout the time that you treated patient number

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[1] 6 she was often very suicidal at night after her [2] husband went to sleep. Correct?

[3] A: I am unwilling to discuss that.

[4] Q: She had a great deal of difficulty at [5] night, that was the worst part of the day for her. [6] Correct?

[7] A: I am unwilling to discuss that.

[8] Q: She was, quote, "very lonely, very [9] frightened, often very suicidal after her husband [10] had gone to sleep." Sir, is that accurate?

[11] A: I am unwilling to discuss that.

[12] Q: You would admit, wouldn't you, sir, that [13] you have stated in the second part of your [14] deposition in this case, taken on June 30, 1994 –

[15] MR. GREENWALD: Is this the whole [16] thing?

[17] Q: – on page 175 that during a large part [18] of the time that patient number 6 was a patient of [19] yours, she was at risk of suicide. Correct, sir?

[20] MR. GREENWALD: Wait a second. What [21] page are you on?

[22] MS. GUSSACK: Page 175.

[23] MR. GREENWALD: That's not what my [24] page says.

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[1] MS. GUSSACK: I am in Volume 2, June [2] 30, 1994.

[3] MR. GREENWALD: Is this the whole [4] deposition or is there another one of these?

[5] MS. GUSSACK: This is day two of [6] Dr. Teicher's deposition, on page 175.

[7] MR. GREENWALD: My 175 says [8] "Mr. Daley: I am going to instruct the witness [9] not to answer."

[10] MS. GUSSACK: That's Volume 2. You [11] must have Volume 1 in front of you.

[12] MR. GREENWALD: That's why I asked [13] you, is this the whole thing?

[14] MS. GUSSACK: Well, that's the whole [15] thing for the first day and this is the whole thing [16] for the second day.

[17] MR. GREENWALD: Well, when I said [18] whole thing I meant the whole

brought with him? Because we know it's not in the article.

MR. GREENWALD: Wait a minute. Now I'm confused. You are not talking about the

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article?

MS. GUSSACK: Is it in Exhibit 18 anywhere? That's my question.

MR. GREENWALD: I hate to ask this, but while he's looking through that, can we take a two-minute break? I need to do that.

MS. GUSSACK: Sure.

(In recess 4:55 p.m. to 5:05 p.m.)

MS. GUSSACK: I am going to have marked as Exhibit 41 Volume 1 of –

MR. GREENWALD: Now, I want to say something I have noticed in skimming some of this that this person's name appears in these depositions.

MS. GUSSACK: Off the record, if you would, for a second.

MR. GREENWALD: Off the record.

(Discussion off the record.)

MS. GUSSACK: One thing at a time. I will mark this as Exhibit 41.

MR. GREENWALD: What is it?

MS. GUSSACK: It is the order lifting the confidentiality by the judge in the case.

(Teicher Deposition Exhibit 41 marked

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for identification.)

BY MS. GUSSACK:

Q: Let me show you Exhibit 41, Doctor, which has on the side the handwritten notation "Allowed after hearing on the record, the court not having been persuaded that good cause exists for impoundment, Impoundment Rule 7." Have you ever seen that before is my question.

A: No, I haven't seen it.

MS. GUSSACK: Let's have marked as Exhibit 42 Volume 1 of the deposition of Martin Teicher in Civil Action No. 92-0947. In fact, let's make Exhibit 42 all three volumes.

(Teicher Deposition Exhibits 42-A, 42-B and 42-C marked for identification.)

MR. GREENWALD: Can I ask you a question? Off the record.

MS. GUSSACK: Yes.

(Discussion off the record.)

BY MS. GUSSACK:

Q: Doctor, I have had marked as 42-A the first day of your deposition taken in Jane Doe on October 20, 1993. 42-B is the second day of your deposition taken on June 30, 1994. And 42-C is

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the third day of your deposition, taken on July 6, 1994. And let me just ask you if you would, sir, can you identify this as the transcripts of your deposition testimony which you have previously reviewed reflecting your testimony in the malpractice action brought by patient number 6?

MR. GREENWALD: I am going to object because it would require him to read every single page to determine whether that's his testimony. And you have probably – I don't know – five hundred pages here. More than five hundred pages.

BY MS. GUSSACK:

Q: Doctor, can you answer my question?

A: Skimming the record, it looks like more or less like that material. It looks a lot like it but I haven't read every word to verify it's accurate.

Q: I understand you haven't read every word, sir, but it certainly looks like your deposition testimony that you have previously reviewed in the case of Jane Doe or patient number 6 versus Martin Teicher. Correct?

A: Yes.

Q: Thank you, sir.

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MR. GREENWALD: And I know you are marking them as exhibits to the deposition but I am objecting to them. I think they are irrelevant and we can argue the issues –

MS. GUSSACK: You have that continuing objection. All right?

MR. GREENWALD: Yes. But it also includes the marking of these deposition transcripts as well as the impoundment order, Exhibit No. 41 that you just marked.

BY MS. GUSSACK:

Q: Doctor, is it true that during a large part of the time that patient number 6 was a patient of yours she was at risk of suicide?

MR. GREENWALD: I still have my continuing objection?

MS. GUSSACK: Yes, sir.

MR. GREENWALD: To every question on patient number 6 that the doctor feels he cannot answer?

MS. GUSSACK: Yes.

MR. GREENWALD: Okay.

A: What I can say is that from the material provided in Exhibit 10, from the case description,

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the answer to that question is yes.

Q: And, sir, she remained a suicide risk at the end of 1990 when you stopped treating her?

MR. GREENWALD: Objection. Did he testify that he stopped treating her in 1990? I don't think so.

BY MS. GUSSACK:

Q: Did you stop treating patient number 6 in 1990?

A: I am unwilling to answer that question.

Q: Did she continue to remain suicidal, sir, or a suicide risk throughout 1990?

A: I am unwilling to answer that key.

Q: Did she remain at risk for suicide from the time that you published this case report, sir, until 1990?

A: The case report was published in 1990.

Q: I'm sorry. From the time that you submitted it for publication until it was published.

A: I am unwilling to answer the question. She remained a risk during the period of time that I described the case. It was more intense when she was on fluoxetine; it was less intense during the

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period I described after the fluoxetine was abandoned. But certainly the risk did not go away.

Q: Was the risk after patient number 6's use of fluoxetine different than her risk for suicide prior to her use of fluoxetine?

A: No. It was about the same.

Q: Now, sir, is it correct that patient number 6 suffered from a depressive form of manic-depressive illness with periods of dysphoric mania which were drug-induced?

A: I indicate in Exhibit 10 that she had bipolar disorder, which is a manic-depressive illness.

Q: Was it a predominantly depressive form of manic-depressive illness?

A: (Pause) I indicate in Exhibit 18 again that she had a history of bipolar disorder and indicate a period of hypomania and indicate a period of dysphoric mania.

Q: Which were drug-induced?

A: I indicate that the brief trial of Surmontil was discontinued due to dysphoric mania, but I did not indicate in this specifically whether it was drug-induced.

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enchilada.

BY MS. GUSSACK:

Q: Doctor, is that an accurate statement?

MR. GREENWALD: Wait a minute now.

A: I have been advised not to answer.

MR. GREENWALD: May I say for the record that this is also marked "confidential" and

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I have the same concerns that I expressed with regard to the first volume.

BY MS. GUSSACK:

Q: Doctor, there was a confidentiality impoundment order entered in the Jane Doe v. Teicher matter. Is that right?

MR. GREENWALD: I'm sorry. I totally missed that question.

BY MS. GUSSACK:

Q: Was there an impoundment order, a confidentiality order entered in the case, do you know?

A: To the extent I understand these legal questions, I believe so.

Q: And are you also aware that that order was lifted by the judge at the conclusion of the case at the request of The Boston Globe?

A: I believe so.

Q: Doctor, could I refer you to page 175 of day 2 of your transcript in the case and ask you to confirm for us that you have testified that during a large part of the time that Jane Doe was a patient of yours, she was at risk of suicide. Is that correct, sir?

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A: I am unable to answer that.

Q: Well, Doctor, based on your treatment notes and your records before you, can you answer that?

MR. GREENWALD: He has just said he's not going to answer.

A: According to item 10, case report 6. I indicated that the patient had - Specifically, intermittent suicidal thoughts had continued during the past five years is something that I indicated at the beginning, and then at the end I indicated the severity of her suicidal and destructive thoughts and her need to act on them had abated.

Q: Well, sir, is intermittent -

MR. GREENWALD: Wait a minute. Can I just ask, what were you just reading from, Doctor?

THE WITNESS: I said item 10.

MR. GREENWALD: You mean Exhibit 10?

THE WITNESS: Exhibit 10. Excuse me.

BY MS. GUSSACK:

Q: Is intermittent suicidal ideation consistent with your testimony in the malpractice case that this patient was suicidal on a nightly

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basis and frequently called you about it?

A: I am unwilling to answer that.

Q: So you cannot tell me whether a statement in Exhibit 10, your 1990 case report series, is consistent with a statement that you have made under oath in a deposition?

A: Correct. It is correct that I am unwilling or unable based on counsel's advice to answer that question.

Q: Doctor, it is true, isn't it, that you prescribed Buprenex for patient number 6?

A: I am unwilling to answer that question.

Q: Well, is it in your treatment records that you have before you? Not just the article reporting on it but Exhibit 18.

A: I'll check Exhibit 18. (Pause)

Q: While you're looking, Doctor, can you tell me, what is Buprenex?

A: Buprenex is a Schedule 5 opioid analgesic.

Q: Is it a controlled substance?

A: Schedule 5. That means it's sort of in the same category as Lomotil. It is not considered to pose any significant risk of addiction or

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dependence as opposed to, say, like Tylenol No. 3 or something, which would be a Schedule 2 drug.

I can't see any mention of Buprenex in Exhibit 18 or Exhibit 10, so I can't answer your previous question.

Q: Sir, you prescribed Buprenex to patient number 6 in late 1987 or early 1988 in an injectible form. Correct?

A: I can't answer that question.

Q: Doctor, what is polypharmacy?

A: It refers to prescribing multiple medications.

Q: You prescribed Buprenex for patient number 6 for drug detoxification, pain control, and because she was addicted to Percocet. Correct?

A: I can't answer that question. I am unwilling to answer the question.

Q: You have testified to that in your deposition in the malpractice case, haven't you?

A: I am unwilling to answer the question.

Q: Do you have the deposition transcript in front of you?

MR. GREENWALD: Which volume?

MS. GUSSACK: Volume 2, June 30,

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1994.

MR. GREENWALD: Volume 2 is right here.

BY MS. GUSSACK:

Q: You have seen that transcript before, Doctor?

A: Yes, I have.

Q: Can you tell me whether what I am describing about the testimony in the transcript is accurate or not?

A: Unwilling to discuss it.

Q: This is your testimony, isn't it, that we have before you, June 30, 1994?

MR. GREENWALD: Let me object and say you have provided a document marked confidential which states Jane Doe and John Doe, Plaintiffs, versus Martin Teicher and purports to be a deposition taken on June 30, 1994.

BY MS. GUSSACK:

Q: Doctor, could you look at that deposition and tell me if you have any question as to whether that is your testimony in the case Jane Doe v. Martin Teicher?

MR. GREENWALD: I am going to object.

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I think he would have to read the entire deposition to be sure whether it was his testimony or not.

A: Without reading the entire testimony, it looks like it.

Q: It looks like your testimony in the malpractice action brought by patient number 6?

A: Yes.

Q: Now, sir, is it true that patient number 6 was injecting herself as many as four times a day during 1988 or 1989 when she was using Buprenex?

A: Unwilling to answer.

Q: Is it true, sir, that patient number 6 had a history of cocaine abuse?

A: Unwilling to answer.

Q: Is that contained in your treatment records on the patient that you've brought with you? It is not reported in your article.

MR. GREENWALD: The question is, is it in the case reports? Is that the question?

MS. GUSSACK: No. Is it in the records, his detailed synopses that he's

Q: Do you believe it to be drug-induced?

A: I am unwilling to answer that.

Q: Sir, it is true, isn't it, that as early as July of 1984 patient number 6 was having problems or symptoms of akathisia?

A: If it is not in this material, I am unwilling to answer that.

Q: Well, sir, do you have a recollection that that's true about patient number 6?

A: I am unwilling to answer that. I am not willing to discuss details of the case that are not presented in the details I've given you, on advice of counsel.

Q: Doctor, is it accurate that during the time that you treated patient number 6, whatever that period of time was, that you prescribed to her as many as fifty different medications?

A: Unwilling to answer that.

Q: It is true, isn't it, sir, that patient number 6 experienced akathisia and restlessness at various times during the time that you were treating her?

A: There is, I believe, a mention of akathisia in case 6 on March 3.

Q: What about episodes of akathisia prior to March 3 as reported in your records on patient number 6?

A: It looks to me that the earliest report of akathisia in the material available here that I've made available in this indicates March 3, and I am unwilling to answer about material that predates what's here.

Q: So, sir, it is not that she didn't experience akathisia prior to March 3, it is simply that you are unwilling to answer as to whether she did in fact experience akathisia prior to that date?

A: Correct.

Q: And you are unwilling to provide that information based upon advice from counsel?

A: Yes.

Q: Sir, is it true that beginning in 1987 but becoming more serious in 1988 patient number 6 and her husband were facing significant financial problems?

A: Unwilling to answer.

Q: Well, were her financial problems one of those life stressors that you considered in

evaluating whether her suicidality was attributable to her use of fluoxetine?

A: What I will say is in all of the cases that we reported we considered life circumstances and the significance and severity of life circumstances in evaluating the phenomena for all cases.

Q: Specifically with respect to patient number 6 did you consider the financial difficulties that she was experiencing in 1987 and then more seriously in 1988 as life stressors that would provide the alternate explanations that you said were significant in evaluating whether there is a causal link between the use of fluoxetine and suicidality?

A: I am unwilling to confirm or deny that there were financial difficulties at this juncture.

Q: Doctor, did patient number 6 pick up a gun to threaten someone who was threatening a lawsuit against her husband?

A: I am unwilling to answer that.

Q: Her husband was sued, wasn't he?

A: I am unwilling to answer that.

Q: Well, Doctor, you have testified, haven't

you, on the third day of your deposition in the malpractice proceeding that patient number 6 picked up a gun to threaten the person who was suing her husband?

A: Unwilling to answer that.

Q: Now, did that event occur prior to the time that patient number 6 took fluoxetine?

A: I am unwilling to answer that.

Q: Do you think it is significant, sir, in determining whether patient number 6's hostile or aggressive acts either towards others or herself are related to her use of fluoxetine?

A: I am unwilling to answer that.

Q: So, Doctor, is it fair to say that there is information that you are unwilling to provide us that may be clinically significant in evaluating patient number 6 and the claim that you make in your article or the observation that you make in your article that her obsessive preoccupation with suicide was induced by fluoxetine?

MR. GREENWALD: Could you run that by me one more time?

(The reporter read the question.)

MR. GREENWALD: Wait a second.

MS. GUSSACK: You have a standing objection.

MR. GREENWALD: I know, but I just want to think about what the question was for a second.

BY MS. GUSSACK:

Q: Doctor, do you have my question in mind?

A: Yes. I am unwilling to answer it.

Q: Doctor, is there information that you are unwilling to provide that would be clinically significant in evaluating that issue with respect to patient number 6?

A: You just changed the question now. The first time you said that may be and now you said that would be

Q: Yes.

MR. GREENWALD: I still have my continuing objection on these questions. Right?

MS. GUSSACK: Mm-hmm.

MR. GREENWALD: Is that mm-hmm a yes?

MS. GUSSACK: Yes.

A: I am unwilling to answer that question.

Q: You can't tell us whether there is

information that you are unwilling to provide that is clinically significant?

A: Correct.

Q: And you can't tell us because you believe you are operating at the direction of your counsel representing you before the disciplinary board?

A: Yes.

Q: Doctor, you testified, didn't you, on the third day of your deposition in the malpractice case that in 1988 patient number 6's personality Joan desperately wanted patient number 6 to die. Correct?

A: Unwilling to answer the question.

Q: And although in 1986 it is true, isn't it, that these personalities were yelling at her less often to kill herself but there were times when they still would yell at her to kill herself. Correct?

A: Unwilling to answer that.

Q: Now, Doctor, it is true, isn't it, that in the course of the malpractice suit brought by patient number 6, patient number 6 alleges that you had sexual relations with her starting in the fall of 1984. Correct?

A: I am unwilling to answer that.

Q: And she further testified, sir, didn't she, that you had sexual relations with her at the Battle Green Hotel. Correct?

A: I am unwilling to answer that.

Q: Doctor, are you denying those allegations?

[8] MR. GREENWALD: That is an unfair [9] question. He said he's not going to discuss any of [10] this. By asking him questions to make it appear [11] like he is giving answers I think is unfair.

[12] MS. GUSSACK: I am not suggesting [13] that he is giving answers. I'm asking him if –

[14] MR. GREENWALD: Just a minute. If [15] you want to put your question on the record, you [16] have every right to do that, but –

[17] MS. GUSSACK: That's my question.

[18] MR. GREENWALD: – to ask him [19] questions that are in a sense trick questions to [20] him, like the last one, I think is inappropriate [21] and unfair. The man has said on advice of counsel [22] he is not going to discuss anything except what's [23] in the papers that he has produced.

[24] BY MS. GUSSACK:

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[1] Q: No trick intended, sir. Do you [2] understand my question? Can you deny those [3] allegations?

[4] A: I understand your question, but I believe [5] I have to refuse to answer the question.

[6] Q: So you are not able sitting here to deny [7] those claims by patient number 6?

[8] MR. GREENWALD: Just a minute. [9] That's not what he said. What he said is he is not [10] going to discuss it on advice of counsel. And [11] that's an unfair representation of what you think [12] he just said or what you've made up that he just [13] said.

[14] BY MS. GUSSACK:

[15] Q: Doctor?

[16] A: You know, I would love to answer the [17] question, but I would really love to speak to my [18] attorney about whether I can answer that question [19] or not.

[20] Q: Should I ask it this way? Doctor, do you [21] deny that – No, strike that. Let me ask it even [22] more precisely. Have you denied, sir, in your [23] testimony in the malpractice case brought by [24] patient number 6 that you had any inappropriate

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[1] touching or kissing with patient number 6?

[2] MR. GREENWALD: And, again, the [3] documents speak for themselves. Whatever's in his [4] deposition is in his deposition. He said he can't [5] tell you and on advice of counsel he's not going to [6] discuss the subject matter. So it is an unfair [7] kind of insinuation that whatever he answers he's [8] really not denying something, when in fact he is [9] not saying that; he's saying he can't tell you [10] whether he's denying anything.

[11] MS. GUSSACK: It seems to me the [12] doctor has made very clear that his answers to [13] these questions are either yes with information or [14] no with information or "I can't answer that because [15] my counsel has advised me not to."

[16] BY MS. GUSSACK:

[17] Q: I am asking you, sir, and the objection [18] is noted, have you denied in the context of the [19] malpractice suit brought by patient number 6 her [20] testimony and allegation that you had inappropriate [21] touching and kissing with patient number 6?

[22] MR. GREENWALD: And again I think [23] you're doing the same thing to him.

[24] MS. GUSSACK: Can we go ahead,

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[1] please?

[2] MR. GREENWALD: Even though I have a [3] continuing objection I am still compelled to say [4] so.

[5] A: The information is there, but under the [6] advice of counsel I am unwilling to answer the [7] question.

[8] Q: And when you say the information is [9] there, sir, are you referring to your deposition [10] testimony in the lawsuit?

[11] A: Yes.

[12] Q: It is true, isn't it, sir, that in the [13] course of the deposition of patient number 6 in [14] this lawsuit she testified that sexual relations [15] occurred between you on multiple times. Correct?

[16] A: I am unwilling to answer the question.

[17] Q: She testified, didn't she, sir, that on [18] three or four occasions she had sexual relations [19] with you at your home. Correct?

[20] A: I am unwilling to answer the question.

[21] MS. GUSSACK: Off the record.

[22] (Discussion off the record.)

[23] MR. GREENWALD: I just want to put [24] one thing on the record. My concern with your

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[1] questions is that the way many of them are phrased, [2] they may tend to give the impression that the [3] doctor has not denied something by the way he has [4] answered when in fact he is not responding to the [5] question at all on advice of counsel. And I don't [6] want the record to appear that when you say "Are [7] you denying," that because his answer is on advice [8] of counsel it would appear that he therefore is not [9] denying something.

[10] I want it to be clear that he's not [11] answering at all on advice of counsel.

[12] THE WITNESS: Would it be better to [13] say I am unwilling to answer on the advice of [14] counsel? Would that be better?

[15] MR. GREENWALD: That's fine.

[16] MS. GUSSACK: That's fine, Doctor. [17] I just want to make sure that you understand – let [18] me finish – that you're clear about my position, [19] which is that I want you to give me as complete an [20] answer as you can. And those questions that you [21] feel you are unwilling or unable to answer because [22] of the advice of counsel, you simply need to say [23] so. Okay?

[24] THE WITNESS: Yes.

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[1] MR. GREENWALD: And you understand [2] that we earlier tried to discuss with you the [3] concept of waiver and how it would affect answers [4] with respect to some that the doctor might give or [5] not give, and you did not wish to get into that [6] kind of a discussion on how you would react to [7] that. Therefore, we're proceeding as we are [8] proceeding, so go ahead.

[9] BY MS. GUSSACK:

[10] Q: Doctor, you are aware, aren't you, that [11] patient number 6 has alleged that you engaged in [12] oral sex, intercourse and anal intercourse with you [13] on a number of occasions –

[14] MR. GREENWALD: I'm sorry. Can we go [15] off the record for a second? No, never mind. Go [16] ahead.

[17] Q: – on a number of occasions during the [18] period that you treated her. Right?

[19] A: I am unwilling to answer on the advice of [20] counsel.

[21] MR. GREENWALD: I still have my [22] continuing objection. Right?

[23] MS. GUSSACK: Yes.

[24] BY MS. GUSSACK:

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[1] Q: It is true, isn't it, Doctor, that you [2] saw patient number 6 at your home. Correct?

[3] A: Unwilling to answer on the advice of [4] counsel.

[5] Q: It is also true, sir, isn't it, that [6] patient number 6 is the only patient that you have [7] ever seen at your home for psychiatric care?

[8] A: Unwilling to answer on the advice of [9] counsel.

[10] Q: It is true, sir, isn't it, that you don't [11] maintain an office for psychiatric care at your [12] home, do you?

[13] A: Unwilling to answer on the advice of [14] counsel.

[15] Q: Now, sir, is it true that you had sexual [16] relations with patient number

6 in your office?

A: Unwilling to answer on the advice of counsel.

Q: Are you aware, sir, that patient number 6 has testified that you had sexual relations with her in your office countless times?

A: Unwilling to answer on the advice of counsel.

Q: Sir, is it true that you provided

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psychiatric care in one of your sessions with patient number 6 while you were working at the Charles River Hospital?

A: Unwilling to answer on the advice of counsel.

Q: And is it true, sir, that on occasion you had patient number 6 assist you in the preparation of some work or slides that you were preparing?

A: Unwilling to answer on the advice of counsel.

Q: Sir, is it accurate that considering the office visits that patient number 6 had with you between 1984 and 1990, on 65 to 70 percent of those visits you engaged in sexual relations with patient number 6?

A: Unwilling to answer on the advice of counsel.

Q: Now, sir, you have admitted, haven't you, that you have given gifts to patient number 6?

A: Unwilling to answer on the advice of counsel.

Q: You gave her an artificial plant, didn't you?

A: Unwilling to answer.

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Q: You gave her a pair of earrings, sir? Is that right?

A: Unwilling to answer.

Q: You sent her birthday cards on a number of occasions signed "Love, Marty." Isn't that right?

A: Unwilling to answer.

Q: Throughout the time that you were treating patient number 6 you gave her various books, didn't you?

A: Unwilling to answer.

MR. GREENWALD: Various what?

MS. GUSSACK: Books.

A: Unwilling to answer.

Q: Isn't it true, sir, that you sent patient number 6 a card at some point during the time that you were treating her in which you said, quote, "I love you greatly, your smile is the brightest and most beautiful smile in the world"?

A: Unwilling to answer.

Q: Did you provide patient number 6 with a copy of a book called How To Be Your Own Best Friend?

A: Unwilling to answer.

Q: Did you give her a book of Monet pictures?

A: Unwilling to answer.

Q: Did you insubscribe in the book "To my special friend"?

A: Unwilling to answer.

Q: Have you admitted doing these things, sir, in your deposition testimony in the malpractice case?

A: I am unwilling to answer that.

Q: So if I put before you your deposition testimony in which you have in fact admitted it, you would be unwilling to answer those questions?

A: I believe so.

Q: Just for the record, so that we save ourselves time, if I gave you page and line references –

A: Yes, yes.

Q: Let me finish. – to each place where you have testified about giving patient number 6 an

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artificial plant, a foldout fan, earrings, birthday cards or holiday cards signed "Love, Marty," copies of books, including How To Be Your Own Best Friend, The Tao Of Pooh, The Courage To Heal, or Monet, or cassette tapes of music or a necklace, you would be unwilling to answer the questions as to whether you in fact admit to doing so. Correct?

A: Correct.

Q: Doctor, you have accepted gifts from patient number 6 throughout the time that you were treating her, didn't you?

A: Unwilling to answer.

Q: Sir, if I direct your attention to page 213 of your deposition testimony taken in the malpractice case, would you be able to confirm for me that you have testified that you accepted a cardholder, letter opener from patient number 6?

A: Unwilling to answer.

Q: Now, sir, I think you have told me that this case was settled. Correct?

MR. GREENWALD: He didn't say that.

MS. GUSSACK: He did say that.

MR. GREENWALD: No, he didn't say that.

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BY MS. GUSSACK:

Q: Did you say that, sir?

MR. GREENWALD: No, he did not. He told you there was a confidentiality agreement and you said there was an article in The Boston Globe.

MS. GUSSACK: I am going to let the record speak for itself.

BY MS. GUSSACK:

Q: But, Doctor, do you believe that you told me the case was settled?

A: If I understand the question, I think you asked if the case was settled and I think I responded in the affirmative.

Q: Okay. Now, Doctor, is the disciplinary proceeding that is ongoing before the Board of Registration the only disciplinary proceeding that you have ever been involved in?

A: Yes.

Q: In the aftermath of the malpractice action brought by patient number 6, were your privileges at McLean limited in any manner?

A: No.

Q: Were you required to have a senior physician review your cases or your patients?

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MR. GREENWALD: Objection.

A: The answer to that is that that was not part of a disciplinary process. That was part of a hospital investigation, so it was an assessment to see if there were any problems, at which point none were found and no discipline took place.

Q: Did this assessment occur at or around the time that the malpractice proceeding was pending?

A: It took place, I believe, afterwards.

MS. GUSSACK: I am going to mark this as Exhibit No. 43.

A: Wait a second. What did we call this again? You said did this something take place at around the time of the – ?

Q: I used your word, "this assessment."

A: This assessment, okay.

Q: Was there something else you wanted to call it, Doctor?

A: No. I was just thinking that you called it something else and I had agreed to you calling it something else.

(Teicher Deposition Exhibit 43 marked for identification.)

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BY MS. GUSSACK:

Q: I am placing before you and counsel, Doctor, a document captioned In The Commonwealth Of Massachusetts, Board Of Registration In Medicine, In the Matter of Martin H. Teicher, M.D. Have you seen this document before, sir?

MR. GREENWALD: I am going to object to Exhibit No. 43. I think it is irrelevant and I think it is solely for the purpose of harassing the witness. I move to strike it.

MS. GUSSACK: Just for the record, I am going to I think state the obvious, which is Dr. Teicher's professional standing, qualities, training, experience, and status are all relevant and appropriate areas of inquiry for an expert witness who has voluntarily elected to inject himself in this litigation, holding himself out as an expert in psychiatry, psychopharmacology, suicidology, I believe he said, and there might even be other areas. So I recognize your objection and you've heard me on the subject.

MR. GREENWALD: Good.

BY MS. GUSSACK:

Q: Have you seen this document before,

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Doctor?

A: Yes. It's what we've been referring to, right?

Q: Exhibit No. 43?

A: Yes.

MR. GREENWALD: You asked him if he had seen it before. That was the question.

BY MS. GUSSACK:

Q: What did you mean when you said this is what we had been referring to?

A: When we talked about the matter regarding the Board of Registration in Medicine, this is the matter regarding the Board of Registration in Medicine.

Q: Now, isn't it true, sir, that there was a prior proceeding before the Commonwealth of Massachusetts Board of Registration in Medicine that was brought and then dismissed?

A: It was the same case.

Q: Was it a separate proceeding?

MR. GREENWALD: Do you know what she's talking about, first of all? I don't know that he understands what you're talking about.

MS. GUSSACK: But he is going to tell

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me if he doesn't because he is a very, very smart fellow.

BY MS. GUSSACK:

Q: Do you know what I'm referring to, Doctor?

A: Yes.

Q: Was there a prior proceeding that was dismissed by the Board of Registration in Medicine in the Commonwealth of Massachusetts?

A: I am not sure about the meaning, the legal word –

MR. GREENWALD: If you don't understand –

A: – proceeding.

MR. GREENWALD: Hold it. If you don't understand what she's asking, you have a right to ask her to explain. And if you don't understand the legal ramifications of what she might be asking, then you obviously can't answer.

MS. GUSSACK: Are you acting as his counsel now, Attorney Greenwald?

MR. GREENWALD: No.

MS. GUSSACK: Thank you.

MR. GREENWALD: I am acting as a

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person sitting here next to a person who is being asked legal questions without them being explained to him, and I think in all fairness he has a right to know what you're talking about. That's the kind of person I'm acting as.

BY MS. GUSSACK:

Q: Doctor, I want you to tell me any time you don't understand a question I asked.

A: That's why I asked about the word "proceeding."

Q: Okay.

Are you aware of any other charge brought against you regardless of whether it is the same charging party prior to this statement of allegations marked as Exhibit 43?

A: That's why I was trying to get clarification, because –

MR. GREENWALD: Objection.

A: – I would use "statement" in that they're allegations and that it is a case of allegations, I would say, and that the terminology that I believe has been used is that the case was reopened. So I would consider them to be one and the same. Dismissed once, reopened a second time.

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Q: Okay, thank you, Doctor, for that clarification.

Are you aware of another document which has a statement of allegations that is different from Exhibit 43?

A: Not that I am aware of.

Q: Now, Exhibit 43 represents a statement of allegations brought by the Board of Registration in Medicine. Correct, Doctor?

MR. GREENWALD: I am going to object. You're free to look at this, Doctor. I've kind of taken it out of your hands for a minute.

BY MS. GUSSACK:

Q: Can you answer the question?

MR. GREENWALD: What's the question?

BY MS. GUSSACK:

Q: This is a statement of allegations brought by the Board of Registration in Medicine. Correct?

MR. GREENWALD: I'm going to object. 43 is whatever it says it is.

BY MS. GUSSACK:

Q: Is that right, sir?

A: Unwilling to answer.

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Q: The Board of Registration in Medicine has issued a statement of allegations against you in which they state they have reason to believe that Martin H. Teicher, M.D. has engaged in conduct which calls into question his competence to practice medicine, sexual misconduct, boundary violations and improper termination with a psychiatric patient between 1984 and 1990. Correct?

MR. GREENWALD: I am going to object. I assume I still have my continuing objection to all of this.

MS. GUSSACK: Yes, you do.

MR. GREENWALD: But I also object additionally. This document is whatever it says it is, purportedly. And as you well know, anybody can make any allegation against anybody.

MS. GUSSACK: Well, we're not talking about anybody, Attorney Greenwald.

BY MS. GUSSACK:

Q: We're talking about the Board of Registration in Medicine has issued a statement of allegations. Is that correct, sir?

MR. GREENWALD: Continuing objection.

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A: I am unwilling on advice of counsel to discuss this pending legal matter.

Q: Just so there is no confusion about the prior matter that you thought was closed or reopened, it is your understanding, Doctor, that this statement of allegations brought against you

by the Board of Registration in Medicine is an [8] ongoing proceeding?

[9] MR. GREENWALD: Objection.

[10] A: There is an ongoing proceeding.

[11] Q: Sir, have you testified in that [12] proceeding?

[13] A: Yes. I have.

[14] Q: Has patient number 6 testified in that [15] proceeding?

[16] A: Unwilling to discuss that.

[17] Q: Who else has testified in the proceeding?

[18] MR. GREENWALD: Same objection.

[19] A: I think on advice of counsel I'm [20] unwilling to discuss aspects of this pending, [21] ongoing legal proceeding.

[22] Q: Well, Doctor, can you tell me what is [23] your understanding of when this proceeding will be [24] concluded?

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[1] A: It may well be concluded by the end of [2] next month.

[3] Q: Pardon?

[4] A: End of November.

[5] Q: You are not an expert, sir, in [6] psychiatric ethics, are you?

[7] MR. GREENWALD: I'm sorry?

[8] Q: You are not an expert in psychiatric [9] ethics, are you?

[10] MR. GREENWALD: Is that a question or [11] a statement?

[12] MS. GUSSACK: A question.

[13] MR. GREENWALD: What does that mean? [14] I don't understand.

[15] BY MS. GUSSACK:

[16] Q: Do you consider yourself, as we discussed [17] yesterday, an authority on psychiatric ethics?

[18] A: I would say that I am not what I would [19] regard as an authority on psychiatric ethics. If [20] you asked if I was an expert in the way that [21] I understand, not being a lawyer, that "expert" is [22] used, that is, somebody having more knowledge than [23] the average person, then I would have to say [24] I certainly have more knowledge about psychiatric

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[1] ethics than the average person. And whether you [2] would say that any board-certified psychiatrist has [3] expertise in psychiatric ethics that would be [4] suitable to be called an expert, I don't know.

[5] I would say that if that's the case, [6] then I certainly do.

[7] Q: Do you recognize Spencer Eth as an expert [8] in psychiatric ethics?

[9] MR. GREENWALD: Objection.

[10] A: Yes.

[11] Q: That means he has greater authority in [12] this subject area than you do?

[13] A: He's a board-certified psychiatrist.

[14] Q: Yes, but I'm drawing on the distinction [15] that you made. Does Dr. Eth have greater knowledge [16] and authority in the area of psychiatric ethics [17] than you do?

[18] MR. GREENWALD: Objection.

[19] A: I don't know. I haven't discussed it [20] with Dr. Eth.

[21] Q: Have you published any articles in the [22] area of psychiatric ethics?

[23] A: No, I have not.

[24] Q: Has Dr. Eth?

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[1] A: I don't know.

[2] Q: Doctor, is it accurate that during the [3] course of your care of patient number 6 you [4] admitted patient number 6 to McLean Hospital on [5] five occasions?

[6] A: I am unwilling to discuss that.

[7] Q: Now, is that reported in your case report [8] on patient number 6?

[9] A: I see no discussion in Exhibit 10, case [10] 6, of hospitalizations.

[11] Q: Doctor, let's be clear about something. [12] You are not answering questions about patient [13] number 6 because you believe she is the complaining [14] party behind the proceedings pending before the [15] Board of Registration?

[16] A: Correct.

[17] Q: So the reference to patient A in this [18] statement of allegations refers to patient number 6 [19] as far as you know. Correct?

[20] A: Right.

[21] MR. GREENWALD: Are you almost done? [22] Because it's ten to 6:00.

[23] BY MS. GUSSACK:

[24] Q: Now, Doctor, you have testified under

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[1] oath in the proceeding pending before the Board of [2] Registration. Correct?

[3] A: I am unwilling to discuss it.

[4] Q: You are unwilling to confirm whether you [5] have in fact testified under oath before the Board [6] of Registration in Medicine?

[7] MR. GREENWALD: I am going to object [8] again. You have refused to discuss with him the [9] issue of what you may argue is a waiver on certain [10] questions and in order to protect himself, as [11] I understand it, he is refusing to answer all these [12] questions on advice of counsel.

[13] MS. GUSSACK: No, that's not why he [14] has refused to answer.

[15] MR. GREENWALD: My impression is that [16] that has a lot to do with what's going on.

[17] BY MS. GUSSACK:

[18] Q: Doctor, are you concerned about waiver?

[19] A: Since it's been brought up, yes.

[20] Q: What is it that you are concerned about [21] with respect to waiver?

[22] A: That if I answer some of your questions, [23] that somebody would say that the cow is out of the [24] barn, you know, and that since some information is

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[1] divulged, that I would then be compelled to divulge [2] all information because I had established some sort [3] of precedent for producing information. So based [4] on that concern I believe I have to be very [5] cautious in not providing information that would be [6] used to compel me to produce other information that [7] I would not otherwise be required to produce, and [8] that my attorney has advised me not to discuss any [9] aspects of this case because of the pending [10] litigation.

[11] So I have chosen only to discuss [12] those aspects of the case that are published in [13] Exhibit 10 or that I had previously provided you as [14] part of the subpoena in Exhibit 19. And otherwise [15] I feel I cannot, based on advice of my attorney, [16] discuss it.

[17] Q: Doctor, is it true that patient 6's [18] medical history included a year of using cocaine on [19] a daily basis?

[20] MR. GREENWALD: I assume I have my [21] continuing objection, Nina, and I think this is [22] really at this point getting kind of oppressive and [23] harassing. I understand that you want to put [24] questions on the record, but you've been doing this

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[1] I think for probably over an hour and –

[2] MS. GUSSACK: Thank you. I have your [3] objection. Because of the concerns with time, [4] I would like to conclude.

[5] MR. GREENWALD: You know, under Rule [6] 30 I could say let's just stop and go to the judge.

[7] MS. GUSSACK: I don't think you can. [8] I don't think you can without very severe [9] consequences. And if you want to make that choice, [10] please do so.

[11] MR. GREENWALD: I am not suggesting [12] that I am doing that at this point. But I think it [13] is –

[14] MS. GUSSACK: I would like to finish [15] my questions of the doctor. We have some time [16] constraints here.

BY MS. GUSSACK:

Q: Doctor, is it true that patient 6's medical history included a year of using cocaine on a daily basis?

MR. GREENWALD: I object. You have already asked questions with respect to drug use of patient number 6. You have asked questions already with respect to cocaine use of patient number 6 and

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I believe you are now repeating questions. Because I recall your asking questions about cocaine use, about drug use, and I think those questions have already been asked and he has already indicated his position as eloquently stated just a minute ago when you asked him what he understood waiver to be. So if you have something new to ask, that's one thing, but to rehash I think is inappropriate.

BY MS. GUSSACK:

Q: Doctor, did patient 6's history of drug abuse complicate your ability to evaluate her limbic system damage?

A: Unwilling to answer.

Q: Doctor, did patient number 6 abuse cocaine and marijuana during the time that you treated her?

A: Unwilling to answer.

Q: Did you make any reference to patient number 6's substance abuse in Exhibit 10, your case report on patient number 6?

MR. GREENWALD: Again, I know I have my continuing objection to all of this. Right?

MS. GUSSACK: Yes. And I'll even give you a bigger objection if you just let me

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finish the questions because I could really be finished.

MR. GREENWALD: But the document says what it says. I mean, aren't we just wasting time?

A: There is no mention of substance abuse on case 6 in Exhibit 10.

Q: Doctor, is patient number 6 identified in the 1990 article as a borderline personality?

A: There's multiple personality but not borderline personality.

Q: Would you agree, sir, that she was a borderline personality?

A: Yes.

Q: And, sir, it is true that borderline personality disorder patients present a high risk for suicide. Correct?

MR. GREENWALD: That's a general question?

MS. GUSSACK: Yes.

A: Yes. And also my statement about borderline personality was derived from the fact that most patients with multiple personality disorder are borderline personality disorder

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patients.

Q: Is it a fair characterization of patient number 6 that she was very brittle in response to drugs?

A: Unwilling to answer.

Q: Is it your experience in the treatment of patient number 6 that during periods of depression when you would add a medication to alleviate the depression, it would push her into a state of dysphoric irritability?

A: I am unwilling to answer.

Q: Doctor, if I showed you your testimony that was provided in the context of the disciplinary proceeding on pages 583 and 584, would that enable you to answer the question?

A: Unwilling to discuss the case.

MR. GREENWALD: May I see that a second? Can I see that, Nina?

(Document handed by Ms. Gussack to Mr. Greenwald.)

BY MS. GUSSACK:

Q: Doctor, are you aware that your testimony in the disciplinary proceeding is a public record?

A: Yes.

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Q: That is not a surprise to you?

MR. GREENWALD: I'm sorry? What was that last question?

BY MS. GUSSACK:

Q: That's not a surprise to you? You're aware of that?

A: Yes.

Q: Doctor, is it true that in 1985 patient number 6 became psychotic and delusional while using Nardil?

A: Unwilling to answer.

Q: Doctor, is it true patient number 6 was at a very high risk for suicide in 1984?

A: Unwilling to answer.

Q: Would you fairly characterize patient number 6 as somebody who had made numerous attempts earlier at suicide?

MR. GREENWALD: What does "earlier" mean? Earlier than what?

MS. GUSSACK: Prior to the 1990 article.

MR. GREENWALD: Okay. I just didn't know what "earlier" meant.

A: I indicated in item 10 that there were

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three significant attempts or three significant....

Q: So would you deny that there were more than three attempts?

A: I indicated that there were three.

Q: Do you have any record that would tell you whether there were more than three attempts?

A: This should be an accurate reflection of my records.

Q: Well, sir, if you've testified that there were numerous attempts at suicide, did you mean more than three?

A: I think three is subsumed under numerous.

Q: It is true, isn't it, Doctor, that as early as 1984 during your treatment of patient number 6 she was ruminating about suicide. Correct?

A: Unwilling to answer.

Q: Do you have a recollection, sir, of a frantic period in 1984 where patient number 6 had pills that she was thinking of overdosing on, she had a razor blade that she was cutting herself with and she wanted to take pills?

A: Unwilling to answer.

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Q: Now, sir, is it accurate that 1986 was a very risky year for patient number 6 in terms of suicide?

A: Unwilling to answer.

Q: Have you testified to that effect?

A: Unwilling to answer.

Q: Doctor, is it true that in your opinion patient number 6 presents a greater suicidal risk as her daughter grows older?

A: Unwilling to answer.

Q: Doctor, have you testified in the Board of Registration proceeding that between 1984 and 1987 hardly a session went by with patient number 6 in which you didn't ask her about her suicidal thinking and try to assess it?

A: Unwilling to answer.

Q: Doctor, what does "innumerable" mean to you? If numerous means three, what does innumerable mean?

A: I didn't say means three. I said numerous means any number. Three would be subsumed under numerous. Innumerable means too many to count; too numerous to count. And that depends on what you're counting.

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Q: On page 601 of your testimony before the Board of Registration, sir, you said, quote, "There were in-

numerable times in which she," referring to [4] patient number 6, "would call and tell me that she [5] was desperately suicidal. There were times when [6] her husband would call and tell me that she was [7] suicidal." Is that accurate, sir?

[8] A: I am unwilling to answer.

[9] Q: Doctor, between 1988 and 1989 was patient [10] number 6 experiencing grievous financial problems [11] at home that added a lot of stress to her [12] situation?

[13] MR. GREENWALD: You've already asked [14] that question.

[15] MS. GUSSACK: I asked a different [16] time period.

[17] MR. GREENWALD: You asked if he was [18] aware that financial problems were a stressor and [19] you went into that whole thing already. And even [20] though I have a continuing objection I would like [21] to compound my objection because we've now been [22] going at this since after 9:00 in the morning, it's [23] 6:00 p.m., and we are getting a whole lot of [24] repetitious questions here.

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[1] A: I am unwilling to answer.

[2] Q: You are unwilling to answer that, sir?

[3] A: Correct.

[4] Q: Doctor, do you believe that patient [5] number 6 threatened the family who was suing her [6] husband with a gun because of a reaction to the [7] financial stress that the family was experiencing?

[8] A: Unwilling to answer.

[9] Q: Doctor, is it true that borderline [10] personality syndrome generally involves feelings of [11] emptiness and aloneness which make patients [12] desperate and sometimes make them suicidal?

[13] MR. GREENWALD: Is this a general [14] question?

[15] MS. GUSSACK: Yes.

[16] A: To the extent it is a general question, [17] yes.

[18] Q: And was that true of patient number 6?

[19] A: Unwilling to answer.

[20] MR. GREENWALD: Are you making this [21] an exhibit, by the way?

[22] MS. GUSSACK: I don't know yet.

[23] BY MS. GUSSACK:

[24] Q: Doctor, did patient number 6 see your

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[1] bedroom?

[2] A: Unwilling to answer.

[3] Q: You have admitted, haven't you, that you [4] met patient number 6 at a motel?

[5] A: Unwilling to answer.

[6] Q: You have admitted, sir, in sworn [7] testimony that you gave patient number 6 a [8] Valentine's Day card with the message, quote, [9] "A simple card to let you know how much I care and [10] how wonderful and special you are," end quote?

[11] A: Unwilling to answer.

[12] Q: Doctor, you have admitted in testimony, [13] haven't you, taken before the Board of Registration [14] under oath that you have sent patient number 6 a [15] card with the message, quote, "I love you very much [16] and respect your courage. You are brave, daring [17] and wonderfully complex. Perhaps you are the most [18] interesting person I've ever met." Is that right?

[19] A: I am unwilling to answer.

[20] Q: What year was it, sir, that you sent [21] that?

[22] MR. GREENWALD: Objection.

[23] A: I am unwilling to answer.

[24] MR. GREENWALD: Have you stopped

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[1] beating your....

[2] BY MS. GUSSACK:

[3] Q: Was it your practice to give all of the [4] patients that you were seeing your phone number so [5] they could reach you when you were out of town?

[6] A: Unwilling to answer.

[7] Q: Did you give patient number 6 your phone [8] number so she could reach you when you were out of [9] town?

[10] A: Unwilling to answer.

[11] Q: Did you believe that these cards and [12] messages and gifts that you provided patient number [13] 6 were essential in terms of helping to keep her [14] alive?

[15] A: Unwilling to answer.

[16] Q: Doctor, you have admitted, haven't you, [17] giving patient number 6 a cassette recording of [18] Earl Klugh?

[19] MR. GREENWALD: Who?

[20] A: Unwilling to answer.

[21] Q: Doctor, if you would turn to Exhibit [22] No. 25, the 1993 article, I want to direct your [23] attention to the entry on Rhonda Hala. You see [24] that, sir?

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[1] A: I'm trying to find it. Yes, I've found [2] her name here.

[3] Q: Now, Doctor, you have previously [4] testified that you spoke with Mrs. Hala and with [5] Mr. Finz, her lawyer. Correct?

[6] A: Yes.

[7] Q: And you received from Mrs. Hala and [8] Mr. Finz, her lawyer, information that led to your [9] summary presented in your 1993 drug safety article?

[10] A: Yes.

[11] Q: Did you ever speak with any of [12] Mrs. Hala's doctors?

[13] A: No, I did not.

[14] Q: Are you familiar with Dr. Mitchell Banks [15] who treated Mrs. Hala?

[16] A: I am not familiar with him, no.

[17] Q: What page are you referring to, sir?

[18] A: This is page 197. Was I referring to [19] it?

[20] Q: With respect to Mrs. Hala.

[21] A: Yes.

[22] Q: And, Doctor, it is fair, isn't it, that [23] you state in your '93 article on page 197 that [24] "Mrs. Hala was initially treated for anxiety and

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[1] depression with fluoxetine and buspirone. Shortly [2] thereafter for the first time in her life she [3] purposefully and intentionally cut herself"?

[4] A: Yes.

[5] Q: Fluoxetine was discontinued thereafter, [6] Correct?

[7] A: Yes.

[8] Q: Sir, do you have any records with you [9] that would show the date on which Mrs. Hala was [10] first prescribed Prozac?

[11] A: No.

[12] Q: Let me refer you to Exhibit 16 at page [13] 643, one of your slides in which you report on [14] Mrs. Hala. Does that tell you, sir, when Mrs. Hala [15] was first prescribed Prozac?

[16] A: No, it doesn't.

[17] MS. GUSSACK: Let's have this marked [18] as Exhibit 44.

[19] (Teicher Deposition Exhibit 44 marked [20] for identification.)

[21] BY MS. GUSSACK:

[22] Q: Doctor, I am putting before you what's [23] been marked as Exhibit 44, which is a letter from [24] Dr. Mitchell Banks dated November 28, 1989,

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[1] regarding Rhonda Hala. Do you have that before [2] you, sir?

[3] A: Yes.

[4] Q: And you see in the first sentence, [5] Doctor – And, by the way, we can agree, sir, [6] can't we, that this letter was sent before the [7] publication of your 1990 article. Right?

[8] A: That this was sent before the publication [9] of the 1990 article?

[10] Q: Yes.

[11] A: It was sent to –

[12] Q: Metropolitan Life.

[13] A: It was dated November 28, '89. I don't [14] know whether it was dated, it isn't signed, so [15] I don't really know. Just the date that's on here [16] was before this article appeared, yes.

[17] Q: And, Doctor, it is true, isn't it, that [18] in Exhibit 43, the letter from Dr. Banks to the [19] Metropolitan Life Insurance Company, Dr. Banks [20] states that he has been seeing Mrs. Hala since [21] September 22, 1988, because of depression, self- [22] mutilating behavior, suicidal ideation, crying [23] spells, anhedonia, guilt, and low self-esteem. [24] Correct?

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[1] A: That's what it says.

[2] Q: And then Dr. Banks, whom you've never [3] spoken with – correct?

[4] A: Yes.

[5] Q: – says this condition has persisted for [6] approximately two years. Is that correct?

[7] A: Correct.

[8] Q: Two years, sir, would take us back before [9] the time that Prozac was available on the market?

[10] A: If that statement is true, yes.

[11] Q: And, sir, are you aware that at the time [12] of the letter it is referenced in paragraph 2 of [13] Exhibit 43 that Mrs. Hala was then on Prozac at 20 [14] milligrams. Correct?

[15] A: Yes.

[16] Q: Doctor, do you know whether Dr. Banks is [17] a psychiatrist?

[18] A: It says M.D. and I don't have any [19] specific information.

[20] Q: Okay. In paragraph 2 you will see that [21] Dr. Banks presents Mrs. Hala's diagnosis, which is [22] axis 1 major depression recurrent severe, axis 2 [23] borderline personality disorder. Correct?

[24] A: Yes. That's what he's written.

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[1] Q: Do either of these diagnoses appear in [2] your 1993 article in which you were describing [3] Mrs. Hala?

[4] A: The 1993 article? I have her under the [5] category borderline states of hostility and we're [6] discussing the postulation that certain patients [7] who do not suffer from borderline personality [8] disorder may have a drug-induced borderline state, [9] so that we are certainly in the framework of [10] borderline personality.

[11] Q: Well, Doctor, you state, don't you, on [12] page 197 of your 1993 article, quote, "She had no [13] known history of depression or borderline [14] personality and had never seen a mental health [15] professional"?

[16] A: What I said, to be very specific, was –

[17] Q: First, Doctor, is that in your article, [18] that sentence I just read?

[19] A: Yes. And that was referring to some [20] point in time, and that was referring before she [21] went on medication treatment, that's the [22] information I was presented with. So that up until [23] the time when she had her back injury she had been [24] free of known psychiatric problems including

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[1] depression and had not seen a mental health [2] professional. This would be in advance of her [3] seeing Dr. Banks.

[4] Q: You are reciting a history that is in [5] advance of seeing Dr. Banks?

[6] A: Yes.

[7] Q: What is the date that you are dating your [8] information from, sir?

[9] A: Oh, because what she's indicated is that [10] she had never seen a mental health professional, [11] that she had no history of depression or borderline [12] personality disorder. She then became depressed, [13] anxious, and at that point she did engage in [14] treatment. So the inference and what I believe to [15] be the case is that at that point she was seeing [16] Dr. Banks, after she became symptomatic.

[17] Q: Now, Doctor, when was Mrs. Hala's first [18] psychiatric admission?

[19] A: Admission? Where is that?

[20] Q: Do you have any records that would tell [21] you when Mrs. Hala was first admitted to a [22] psychiatric hospital?

[23] A: I don't have any information here that [24] would tell me that.

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[1] Q: Do you have any information before you [2] that would tell you when Mrs. Hala was first [3] prescribed Prozac?

[4] A: No, I do not.

[5] Q: So you wrote a case report summary of [6] this patient not knowing her psychiatric history [7] and not knowing when fluoxetine was started?

[8] A: Wait a second. You said do I have before [9] me any material. You didn't say if I had any [10] material or if I've seen any material. You asked [11] basically if I have any material before me. [12] I don't have any material before me. I have seen, [13] I have reviewed material, I did provide that [14] information.

[15] Q: I didn't mean to cut you off, Doctor. [16] What have you seen or reviewed with respect to [17] Mrs. Hala's care that you have not brought with you [18] today?

[19] A: I had been provided material by Attorney [20] Finz regarding Rhonda Hala's medical history.

[21] Q: So you have seen before, is it fair to [22] assume, sir, the psychiatric admission discharge [23] summary of Mrs. Hala to Brunswick Hospital Center [24] on July 24, '88, through September 14, '88? Can

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[1] you recall whether you have seen that before is my [2] question.

[3] A: I don't specifically recall seeing this [4] document. I have documents. Whether this is one [5] of them, doesn't look familiar.

[6] Q: Well, sir, can you tell by looking at [7] that document – Strike that. I am putting before [8] you a record from the Brunswick Hospital Center [9] entitled medication and treatment record for [10] Mrs. Hala, and I ask you to look at the entry where [11] it says Prozac, Doctor.

[12] MR. GREENWALD: While he's doing [13] that, can we go off the record?

[14] (Discussion off the record.)

[15] BY MS. GUSSACK:

[16] Q: Doctor, have you had a chance to review [17] the medication and treatment record from Brunswick [18] Hospital Center for Mrs. Hala?

[19] A: I see what you've handed me, yes.

[20] Q: And you see that that record in the [21] left-hand corner has a date stamped July 24, 1988?

[22] A: Correct.

[23] Q: Sir, calling upon your expertise as a [24] psychiatrist and one who sees patients in an

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[1] in-hospital setting, can you tell me looking at [2] this record when Prozac was first prescribed on [3] this record from Mrs. Hala?

[4] A: This record dated 7/24 would indicate [5] that Prozac was prescribed from 7/28 to 7/31. [6] I cannot tell if it was prescribed at any point [7] earlier than that.

[8] MR. GREENWALD: Was that three days?

[9] THE WITNESS: That's four days but [10] that's all that's on this particular sheet, and [11] I don't see any sheets that are dated earlier than [12] that.

[13] BY MS. GUSSACK:

[14] Q: Did Mr. Finz or Mrs. Hala tell you that [15] when she was admitted to the Brunswick Hospital [16] even before she was prescribed Prozac, Doctor, she [17] was on a suicide and assault watch from the [18] beginning of her admission?

[19] A: That was not any part of the history that [20] she related to me, and the material that was [21] provided to me by Attorney Finz did not reflect [22] that.

[23] Q: Doctor, did the material provided to you [24] by plaintiff's counsel Mr. Finz or Mrs. Hala

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[1] contain –

[2] A: Now, wait, can we go back up one second?

[3] Q: Sure.

[4] A: Do you have specific documentation of [5] suicide or assault precautions? Because I know [6] that in most hospitalizations patients who come in [7] are routinely placed on those for no reason during [8] the initial observation period, so that that is [9] often hospital policy, that until a patient is [10] known those precautions are instituted and have [11] nothing to do with her care and treatment.

[12] Q: Do you know that to be true of Brunswick [13] Hospital?

[14] A: No, no. I just know that that's a [15] standard operating policy in many hospitals, so [16] I would like to see some documentation as to [17] whether there were reasons given.

[18] Q: Sir, what psychiatric hospitals do you [19] have privileges at other than McLean?

[20] A: I have worked at a number of other [21] psychiatric hospitals.

[22] Q: That wasn't my question. What hospitals [23] do you have privileges at presently other than [24] McLean?

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[1] A: I imagine Mass. General Hospital.

[2] Q: Because it is affiliated with McLean?

[3] A: Yes.

[4] Q: Any others?

[5] A: Not to my knowledge.

[6] Q: Have you ever practiced medicine outside [7] the commonwealth of Massachusetts?

[8] A: No, I have not.

[9] Q: Doctor, did Mrs. Hala or Mr. Finz provide [10] you with information about Mrs. Hala's family [11] history of psychiatric illness?

[12] A: I don't recall.

[13] Q: Do you know that her father was diagnosed [14] as having a bipolar disorder?

[15] A: I don't –

[16] MR. GREENWALD: He just said he [17] didn't recall.

[18] MS. GUSSACK: Sometimes a more [19] precise question will cause a recollection.

[20] MR. GREENWALD: Are you insinuating [21] that you asked a more precise question?

[22] MS. GUSSACK: As I go along. [23] Tomorrow I'll be really good.

[24] MR. GREENWALD: Yeah, but

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[1] unfortunately you'll be looking in the mirror.

[2] BY MS. GUSSACK:

[3] Q: Now, Doctor, what information do you have [4] in your office about Mrs. Hala that you have not [5] produced to us? Can you describe it by category?

[6] A: I was sent information and records [7] regarding Ms. Hala but I haven't looked at them in [8] three, maybe four years, maybe longer, so I don't [9] have a clear recollection of what specifically the [10] categories are.

[11] Q: And these would be medical records [12] provided to you by Mr. Finz?

[13] A: Yes.

[14] MS. GUSSACK: Now, Doctor, if you [15] give me a two-minute break, I'll see if I have any [16] other questions for you.

[17] MR. GREENWALD: Good, because I need [18] one myself.

[19] (In recess 6:22 p.m. to 6:30 p.m.)

[20] (Teicher Deposition Exhibit 45 marked [21] for identification.)

[22] BY MS. GUSSACK:

[23] Q: Doctor, a few final questions and then [24] I think you can be on your way.

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[1] Generally speaking about borderline [2] personalities, would you say that these are people [3] who feel that out of sight is out of mind?

[4] A: Often, yes.

[5] Q: That they have great feelings of [6] alienation and isolation if people in their lives [7] are not sufficiently present and attentive to them?

[8] MR. GREENWALD: I'm sorry. You're [9] off all of the questions about 6?

[10] MS. GUSSACK: When I say 6 I'm going [11] to wake you up.

[12] MR. GREENWALD: Look, my client will [13] think I was asleep when you say that! I would move [14] to strike all of the 6 questions as they relate to [15] the administrative hearing and the board and the [16] malpractice case consistent with my continuing [17] objection that I had to all those questions. Go [18] ahead.

[19] THE WITNESS: I'm sorry. Can I hear [20] your question again just to be specific?

[21] BY MS. GUSSACK:

[22] Q: Tell me more what you mean by borderline [23] personalities feel that out of sight is out of [24] mind.

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[1] A: What we talk about with borderline [2] personality disorder is object permanence or object [3] impermanence. What it means is that they often [4] need continual assurances that people care about [5] them, are interested in them, are still their [6] friends, have positive regard for them, and that [7] sometimes after a period of absence when they [8] haven't heard from somebody, they can lose their [9] positive feelings; they can start to think [10] negatively of the individual. They can start to [11] feel that that person doesn't care, so forth.

[12] Q: Now, sir, that would be true of a [13] borderline personality's relationship with their [14] therapist as well. Correct?

[15] A: Yes.

[16] Q: And you have to be concerned with a [17] borderline personality patient that if they feel [18] they are losing connection with the therapist, this [19] could increase their sense of emptiness or [20] aloneness. Correct?

[21] A: Yes.

[22] Q: And that they may also feel by losing [23] connection with the therapist that they become more [24] desperate and in fact even suicidal. Correct?

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[1] A: They can, yes.

[2] Q: Now, sir, did you consider that about [3] patient number 6 when you evaluated her suicidal [4] act involving a gun while you were out of town?

[5] A: Yes, I did.

[6] Q: And did you find it to be significant [7] that patient number 6 made a suicidal attempt by [8] placing a gun to her head, I think you described in [9] the article –

[10] MR. GREENWALD: Is that in the [11] document?

[12] THE WITNESS: Yes, that's in the [13] document.

[14] Q: – when you were out of town?

[15] A: We thought about it, we discussed it. It [16] was my conclusion and the co-authors agreed that [17] since I had been out of town on many other [18] occasions and this hadn't happened, that it was not [19] a response to my being out of town. Plus, I did [20] come back that evening.

[21] Q: And, Doctor, was everything the same in [22] the patient's life in terms of their life stressors [23] at the time that patient number 6 made a suicide [24] attempt as there were on previous occasions when

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[1] you had gone out of town?

[2] A: I think it would be hard to say that [3] things were identical or the same. I think that [4] what's fair to say is that there didn't seem to be [5] an appreciable difference.

[6] Q: Doctor, you have identified in a letter [7] to the editor in the American Journal of Psychiatry [8] and I believe in your expert report in this case [9] what you called a transient imbalance theory of how [10] Prozac affects serotonin neurotransmitters. [11] Correct?

[12] A: Yes.

[13] Q: Doctor, is there any human clinical data [14] to support your theory of transient imbalance [15] caused by the administration of fluoxetine?

[16] A: I would have to check. I believe there [17] may be. I believe there is.

[18] Q: What are you thinking of?

[19] A: I'm referring to data on time course of [20] changes of CSF 5HIAA.

[21] Q: I just want to make sure I understand [22] your testimony, Doctor. Is it your view that the [23] data that you just referred to is supportive of [24] your views with regard to the effect of fluoxetine

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[1] on serotonergic transmission as described in your [2] September '91 letter to the editor in the American [3] Journal of Psychiatry?

[4] A: Could you show me the letter so I can see [5] it once again?

[6] Q: Yes. I want to direct your attention to [7] the second page of that where I believe you posit [8] your hypothesis about the effects of fluoxetine on [9] serotonergic transmission both excessively and the [10] decrease of neurotransmission. Correct? (Pause) [11] Do you have my question in mind, sir?

[12] A: Yes, I do. I have your question in mind [13] and I just had to read this to figure out what [14] I was saying in 1991.

[15] Q: Is the data that you referred to [16] previously the data that you believe is evidence in [17] clinical experience supportive of the theory you [18] identify in the September 1991 letter?

[19] A: I believe that there is human data that [20] is supportive of this. The data is derived [21] predominantly from animal studies. The human [22] studies available to date suggest that the animal [23] studies are valid to extrapolate to humans.

[24] Q: And my question is, could you just

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[1] identify for me what human data you're referring [2] to?

[3] A: As I mentioned, I'm referring to data on [4] the time course of the 5HIAA in the CSF.

[5] Q: Give me an author?

[6] A: I can't off the top of my head.

[7] Q: Is it with you today?

[8] A: It may be, it may not be. Do you want to [9] go through all this stuff? There's a whole bunch [10] of articles here.

[11] Q: If it is here today it is in the [12] collection of articles that you brought with you?

[13] A: Yes.

[14] Q: And you believe it is an article that [15] refers to human experience?

[16] A: Yes.

[17] Q: Is there any other human data you believe [18] you have that supports the animal experience that [19] you refer to with transient imbalance?

[20] A: I would have to check. Off the top of my [21] head I can't think of any additional, but there may [22] be. I would have to check.

[23] MS. GUSSACK: Let me make a request [24] for the record, which is if you can identify this,

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[1] because it apparently is of significance to your [2] opinion, sir, I ask that you identify it to [3] Attorney Greenwald so that he can provide it to us. [4] Okay?

[5] THE WITNESS: Sure.

[6] MS. GUSSACK: I want to make one [7] further statement for the record before we [8] conclude, which has a couple of points to it. One [9] is that I understand that Dr. Teicher today [10] declined to answer questions on the advice of his [11] counsel Mr. Daley, who is not counsel of record in [12] this matter. He did not assert a privilege for not [13] answering. He did not assert a Fifth Amendment [14] right. He simply declined to answer on the [15] suggestion of counsel representing him in a [16] professional disciplinary proceeding before the [17] Board of Registration.

[18] I am suspending this deposition, not [19] concluding it, for two reasons. One is for the [20] reasons I have previously stated, because I intend [21] to go before Judge Penn seeking an order compelling [22] Dr. Teicher to answer these questions. And also [23] because of an agreement between counsel that is [24] contained in correspondence between plaintiff's

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[1] counsel and myself confirming that in the event [2] that Lilly is successful in the pending motion to [3] compel the production of process records and [4] clinical records and other material reporting on [5] patients, we will be taking Dr. Teicher's [6] deposition again.

[7] And furthermore, as contained in a [8] letter that I have written to Attorney Greenwald, [9] we have also reserved our right to seek another day [10] of deposition from Dr. Teicher with respect to [11] materials that were identified to us for the first [12] time on Friday, October 25. With that statement, [13] I conclude my questioning.

[14] MR. GREENWALD: I would just like to [15] observe that for two days solid you have been [16] deposing Dr. Teicher. The record is abundantly [17] clear with respect to the innumerable questions [18] that have been asked about his 1990 article. In [19] fact, I would say the overwhelming percentage of [20] questions asked yesterday and today dealt with that [21] 1990 article.

[22] Mr. Pavsner I believe has responded [23] to your reservation, and we all know that [24] reservations don't always get you rooms. So the

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[1] fact that you reserve doesn't necessarily mean that [2] Dr. Teicher will be deposed. I believe you have [3] more than amply covered all of the issues, I won't [4] say ad nauseam but pretty close. I do know there [5] was an agreement you have with Mr. Pavsner with [6] respect to the other issue.

[7] I just have two questions I would [8] like to ask Dr. Teicher at this point before we run [9] out the door.

[10] EXAMINATION

[11] BY MR. GREENWALD:

[12] Q: The first question is, Doctor, your [13] reports –

[14] MR. GREENWALD: His reports are [15] exhibits to the deposition?

[16] MS. GUSSACK: Yes.

[17] BY MR. GREENWALD:

[18] Q: I am pretty sure this is in your report, [19] Doctor. But the opinions you've rendered in those [20] reports, do you hold those with reasonable medical [21] certainty?

[22] A: Yes.

[23] Q: And, secondly, yesterday in answer to a [24] question you discussed four reasons why you felt

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[1] that the warnings on Prozac in 1990 were [2] insufficient and inadequate. Do you remember you [3] were asked questions about that?

[4] A: Yes.

[5] MS. GUSSACK: Objection.

[6] BY MR. GREENWALD:

[7] Q: Based upon that, Doctor, do you have an [8] opinion with reasonable medical certainty as to [9] whether or not based on the warnings that existed [10] or the information disseminated in 1990,

whether [11] Prozac was an unreasonably dangerous medication?

[12] MS. GUSSACK: Objection.

[13] MR. GREENWALD: You can answer.

[14] A: Yes, I hold that opinion.

[15] Q: And is that with reasonable medical [16] certainty?

[17] A: Yes.

[18] Q: And is it based on the material you gave [19] yesterday in discussing the inadequacy of the [20] warnings?

[21] A: Yes.

[22] MR. GREENWALD: That's all I have.

[23] MS. GUSSACK: Thank you, Doctor.

[24] (Deposition concluded at 6:45 p.m.)

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DEPONENT'S ERRATA SHEET & SIGNATURE

The original of the Errata Sheet has been delivered to Andrew E. Greenwald, Esq. When the Errata Sheet has been completed by the deponent and signed, a copy thereof should be delivered to each party of record and the original thereof delivered to Nina M. Gussack, Esq., to whom the original deposition transcript was delivered.

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Commonwealth of Massachusetts)
County of Suffolk)

COURT REPORTER'S CERTIFICATE

I, J. Edward Varallo, RPR/RMR (Registered Professional Reporter, Registered Merit Reporter) and Notary Public in the Commonwealth of Massachusetts, hereby certify that there came before me on October 30, 1996, at the time and place specified above, Martin H. Teicher, M.D., Ph.D., the deponent herein, whose oath continued from a previous date, who was thereafter examined under oath by counsel.

I certify that the questions asked of the deponent and the answers given were taken down by me stenographically and thereafter transcribed by me using computerized translation software and printed (on laser printer) in typewritten transcript format; and that the foregoing is a true and accurate transcript of the deponent's testimony.

I certify further that I am neither attorney, counsel, or relative of any party litigant, nor otherwise interested in the event of this suit.

J. Edward Varallo, RPR/RMR
MY COMMISSION EXPIRES
JANUARY 11, 2002

DATED: _____

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