



**I N D E X**

**MONDAY, MAY 14, 2001..... 2: 5593: 3**  
**1: 45 P.M ..... 2: 5593: 7**

**WITNESS**  
**MACE BECKSON**

**DIRECT EXAMINATION BY MR. CARLTON..... 2: 5594: 3**

**EXHIBITS**

**I. D. 11108 - DEMONSTRATIVE..... 2: 5651: 12**

1 CASE NUMBER: BC 226593  
 2 CASE NAME: BOEKEN V. PHILIP MORRIS  
 3 LOS ANGELES, CALIFORNIA MONDAY, MAY 14, 2001  
 4 DEPARTMENT 308 HON. CHARLES W MC COY, JUDGE  
 5 APPEARANCES: (AS NOTED ON TITLE PAGE.)  
 6 REPORTER: LINDA STALEY, CSR NO. 3359, RMR, CRR  
 7 TIME: 1:45 P. M

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THE COURT: OKAY.

OUR JURY PANEL IS WITH US; COUNSEL ARE PRESENT  
AS WELL; WITNESS IS ON THE STAND.

SIR, IF YOU WOULD PLEASE FACE MY CLERK.

RAISE YOUR RIGHT HAND AND BE SWORN AS A WITNESS  
IN THIS MATTER.

MACE BECKSON,  
CALLED AS A WITNESS BY THE DEFENDANTS, HAVING BEEN FIRST DULY  
SWORN, TESTIFIED AS FOLLOWS:

THE CLERK: HAVE A SEAT.

SIR, IF COULD YOU STATE YOUR FIRST AND LAST  
NAME AND SPELL YOUR LAST NAME, PLEASE.

A. MACE, M-A-C-E, BECKSON, B-E-C-K-S-O-N.

THE CLERK: THANK YOU VERY MUCH.

THE COURT: MR. CARLTON.

MR. CARLTON: THANK YOU, YOUR HONOR.

1 THE COURT: YES, SIR.

2

3 DIRECT EXAMINATION

4 BY MR. CARLTON:

5 Q. GOOD AFTERNOON, DOCTOR.

6 A. GOOD AFTERNOON.

7 MR. CARLTON: GOOD AFTERNOON, EVERYONE.

8

9 (CHORUS OF GOOD AFTERNOON' S. )

10

11 Q. BY MR. CARLTON: CAN YOU TELL US WHAT YOUR  
12 OCCUPATION IS?

13 A. I' M A PSYCHIATRIST.

14 Q. AND DO YOU HAVE AN AREA IN WHICH YOU  
15 SPECIALIZE?

16 A. YES, I DO.

17 Q. WHAT IS THAT?

18 A. ADDICTION PSYCHIATRY.

19 Q. WHERE DO YOU PRACTICE?

20 A. HERE IN LOS ANGELES.

21 Q. AND HAVE YOU BEEN ASKED TO RENDER AN OPINION OR  
22 OPINIONS IN THIS CASE REGARDING THE PLAINTIFF RICHARD BOEKEN?

23 A. YES, I HAVE.

24 Q. WITHOUT GETTING INTO THE SUBSTANCE OF YOUR  
25 OPINIONS, CAN YOU TELL US WHAT TYPE OF OPINIONS YOU' RE  
26 PREPARED TO RENDER HERE?

27 A. WHETHER MR. BOEKEN HAD THE CAPACITY TO QUIT  
28 SMOKING, IF HE SO CHOSE; IF THERE' S ANY REASON TO BELIEVE

1 THAT THERE MIGHT HAVE BEEN ANY FACTOR WHICH WOULD HAVE  
2 INTERFERED WITH MR. BOEKEN'S CAPACITY TO UNDERSTAND AND  
3 ASSIMILATE ANY INFORMATION PERTAINING TO RISK ASSOCIATED TO  
4 SMOKING.

5 Q. ALL RIGHT. WELL, BEFORE WE GET TO THAT, MAYBE  
6 YOU SHOULD TELL US A BIT ABOUT YOUR BACKGROUND.

7 HOW ABOUT YOUR PROFESSION -- OR I'M SORRY --  
8 YOUR EDUCATION -- CAN YOU START THERE -- WITH COLLEGE?

9 A. SURE. I ATTENDED HARVARD COLLEGE. I MAJORED  
10 IN BIOCHEMICAL SCIENCES. I GRADUATED IN 1980.

11 I THEN ATTENDED MEDICAL SCHOOL AT CORNELL  
12 UNIVERSITY MEDICAL COLLEGE. I GRADUATED IN 1985. I THEN DID  
13 AN INTERNSHIP.

14 Q. IF YOU COULD JUST STOP THERE.

15 A. SURE.

16 Q. YOU WENT TO CORNELL MEDICAL SCHOOL.

17 AND DID YOU THEN -- WHEN YOU GRADUATED, YOU GOT  
18 A MEDICAL DEGREE?

19 A. THAT'S CORRECT. AN M.D.

20 Q. OKAY. AND ANY PARTICULAR AREA OR IS THIS A  
21 GENERAL MEDICAL DEGREE?

22 A. IT'S A GENERAL DEGREE.

23 Q. ALL RIGHT. AFTER CORNELL MEDICAL SCHOOL, WHAT  
24 DID YOU DO TO CONTINUE YOUR TRAINING?

25 A. THE NEXT STAGE WAS TO COMPLETE AN INTERNSHIP,  
26 BECAUSE THE STANDARD PROGRESSION IS, ONCE YOU'VE COMPLETED  
27 YOUR MEDICAL STUDIES AND HAVE YOUR DEGREE, YOU'RE STILL NOT A  
28 LICENSED PHYSICIAN UNTIL YOU'VE SUCCESSFULLY COMPLETED AT

1 LEAST ONE YEAR OF TRAINING AFTERWARD, WHICH IS CALLED AN  
2 INTERNSHIP.

3 I DID THAT YEAR AT NEW YORK HOSPITAL AND  
4 MEMORIAL SLOAN-KETTERING CANCER CENTER.

5 AFTER THAT, I BECAME A LICENSED PHYSICIAN AND  
6 THEN CHOSE TO PURSUE SPECIALTY TRAINING.

7 Q. OKAY. WAS YOUR INTERNSHIP SPECIALIZED IN ANY  
8 WAY?

9 A. TECHNICALLY, IT WAS BEING SPONSORED BY THE  
10 PSYCHIATRY DEPARTMENT AT CORNELL UNIVERSITY, BUT IT ACTUALLY  
11 CONSISTED OF ROTATIONS THROUGH PEDIATRICS, NEUROLOGY,  
12 MEDICINE, AS WELL AS PSYCHIATRY.

13 Q. SO YOU COVERED A WIDE RANGE OF AREAS?

14 A. CORRECT.

15 Q. NOW, YOU'VE TOLD US THAT AFTER YOUR INTERNSHIP,  
16 YOU DECIDED TO SPECIALIZE A BIT MORE?

17 A. CORRECT.

18 Q. WHAT DID YOU CHOSE TO SPECIALIZE IN?

19 A. GENERAL PSYCHIATRY.

20 Q. AND WHERE DID YOU GO TO DO THAT?

21 A. UCLA.

22 Q. WHAT DID YOU DO AT UCLA TO FURTHER YOUR  
23 TRAINING IN PSYCHIATRY?

24 A. WELL, I COMPLETED THE THREE-YEAR PSYCHIATRY  
25 RESIDENCY TRAINING PROGRAM WHICH TAKES YOU THROUGH A VARIETY  
26 OF SETTINGS, SEEING A VARIETY OF DIFFERENT TYPES OF PATIENTS,  
27 BEING INVOLVED IN DIFFERENT TYPES OF TREATMENT. AND IN THE  
28 LAST YEAR, SERVED AS A CHIEF RESIDENT AT THE NEUROPSYCHIATRIC

1 INSTITUTE AND GRADUATED AT THAT POINT. YOU WOULD BE REFERRED  
2 TO AS A BOARD-ELIGIBLE PSYCHIATRIST.

3 Q. THIS IS IN, WHAT, 1989, SOMETHING LIKE THAT?

4 A. THAT'S TRUE.

5 Q. UM-UM BOARD-ELIGIBLE PSYCHIATRIST.

6 DID YOU CONTINUE TO RECEIVE TRAINING AFTER YOU  
7 COMPLETED YOUR THREE-YEAR RESIDENCY AT UCLA?

8 A. ACTUALLY, I DID CHOOSE TO DO ADDITIONAL  
9 TRAINING. DURING THE RESIDENCY PROGRAM I HAD DEVELOPED A  
10 PARTICULAR INTEREST IN PHARMACOLOGY OR HOW DIFFERENT  
11 MEDICATIONS AND DRUGS INTERACT IN THE HUMAN BRAIN AND DECIDED  
12 THAT I WANTED TO SPEND SOME TIME SPECIFICALLY LEARNING ABOUT  
13 THE BRAIN AND ITS RELATIONSHIP TO BEHAVIOR.

14 SO IN THAT LIGHT, I APPLIED AND WAS ACCEPTED TO  
15 A BEHAVIORAL NEUROLOGY FELLOWSHIP, ALSO AT UCLA WHICH LASTED  
16 FOR TWO ADDITIONAL YEARS.

17 Q. WHAT IS BEHAVIORAL NEUROLOGY?

18 CAN YOU TELL US A LITTLE BIT ABOUT THAT?

19 A. IT'S A FAIRLY SPECIALIZED AREA AT THE BORDER OF  
20 NEUROLOGY, THE SPECIALTY THAT LOOKS AT DISORDERS OF THE  
21 NERVOUS SYSTEM AND PSYCHIATRY, WHICH LOOKS GENERALLY AT  
22 BEHAVIORAL DISORDERS. AND IT SPECIFICALLY LOOKS AT  
23 BEHAVIORAL DISTURBANCES THAT ARE RELATED TO DIFFERENT TYPES  
24 OF BRAIN DAMAGE.

25 Q. OKAY. SO SPECIFICALLY RELATING BEHAVIOR TO THE  
26 PHYSICAL PATHWAYS OF THE BRAIN?

27 A. CORRECT.

28 Q. OKAY. HAVE YOU BEEN INVOLVED IN ANY RESEARCH

1 RELATED TO ADDICTION?

2 A. YES, I HAVE. ACTUALLY, QUITE A BIT.

3 FOLLOWING THE BEHAVIORAL NEUROLOGY FELLOWSHIP,  
4 THERE WAS AN OPPORTUNITY TO PARTICIPATE IN A NEW RESEARCH  
5 PROGRAM THAT THE NATIONAL INSTITUTE ON DRUG ABUSE WAS  
6 CREATING AT A FEW CENTERS AROUND THE COUNTRY, AND LUCKILY,  
7 FOR ME, ONE OF THEM WAS AT THE V. A. MEDICAL CENTER IN  
8 WEST LOS ANGELES.

9 Q. BEFORE YOU GO ANY FURTHER.

10 YOU'VE MENTIONED THE NATIONAL INSTITUTE FOR  
11 DRUG ABUSE.

12 IS THAT ALSO KNOWN AS NITA?

13 A. THAT IS THE ACRONYM, YES.

14 Q. WHAT IS THAT?

15 A. IT'S ONE OF SEVERAL NATIONAL INSTITUTES OF  
16 HEALTH RUN BY THE GOVERNMENT, FUNDED BY CONGRESS, TO DEVELOP  
17 RESEARCH PROGRAMS, UNDERSTANDING AND TREATMENT FOR PRETTY  
18 MUCH ALL THE DIFFERENT DISEASES DEPENDING ON THE INSTITUTE.

19 NITA FOCUS IS ON DRUG ABUSE ISSUES.

20 Q. AND WHAT WAS IT THAT YOU DID IN RELATION TO  
21 THIS NITA PROGRAM YOU WERE BEGINNING TO TELL US ABOUT?

22 A. WELL, I SPLIT MY TIME BETWEEN CLINICAL  
23 TREATMENT OF SUBSTANCE ABUSE PATIENTS AND ALSO ENGAGED IN A  
24 RESEARCH PROGRAM WHERE WE WERE TRYING DIFFERENT MEDICATIONS  
25 FOR THE TREATMENT OF DIFFERENT TYPES OF DRUG ABUSE.

26 WE ACTUALLY DID ONE OF THE FINAL STUDIES  
27 REQUIRED BY THE FDA TO MAKE LONG-ACTING METHADONE MEET THE  
28 STANDARD FOR APPROVAL IN CLINICAL USE. WE ALSO DID A NUMBER

1 OF MEDICATION TRIALS FOR THE TREATMENT OF CRACK COCAINE  
2 DEPENDENCE WHICH WAS, PERHAPS, THE FOCUS OF THAT NITA  
3 PROGRAM

4 AND I ALSO SERVED AS THE ASSOCIATE DIRECTOR OF  
5 THE BRAIN IMAGING PROGRAM WITHIN THE MEDICATION DEVELOPMENT  
6 UNIT, WHICH WAS THE NITA-SPONSORED UNIT, AND THERE, WE LOOK  
7 AT EVIDENCE OF BRAIN DAMAGE IN CRACK COCAINE ADDICTS AS WELL  
8 AS BEHAVIORAL ABNORMALITIES.

9 Q. HOW LONG DID THIS PROGRAM GO ON -- OR HOW LONG  
10 DID YOUR INVOLVEMENT IN IT GO ON?

11 A. MY INVOLVEMENT PRETTY MUCH WENT ON AS LONG AS  
12 IT EXISTED AT THE WEST LOS ANGELES V. A. , WHICH WAS BETWEEN  
13 '91 AND THE END OF '97. I STILL AM INVOLVED IN SOME RESEARCH  
14 THAT CAME OUT OF THAT ORIGINAL WORK. AND SO IT'S NOT THAT  
15 I'VE STOPPED DOING RESEARCH, BUT THAT'S BECOME A MUCH SMALLER  
16 PART OF MY ACTIVITIES.

17 Q. TELL US A LITTLE BIT ABOUT THAT RESEARCH THAT  
18 YOU'RE CONTINUING TO DO?

19 A. THE RESEARCH, ESSENTIALLY, LOOKS AT HOW CRACK  
20 COCAINE, WHICH IS PERHAPS THE MOST POTENT FORM OF COCAINE,  
21 WHICH IS A VERY POWERFUL STIMULANT, MIGHT CREATE SPECIFIC  
22 BRAIN DAMAGE THAT YOU CAN SEE IN THE HUMAN BRAIN, AS WELL AS  
23 LOOK FOR BEHAVIORAL EVIDENCE.

24 SO WE HAVE FOUND, FOR EXAMPLE, THAT CRACK  
25 COCAINE ADDICTS WHO'VE USED CRACK COCAINE OVER A LONG PERIOD  
26 OF TIME HAVE PROBLEMS WITH THEIR MUSCLE MOVEMENT. THEY TEND  
27 TO LOOK LIKE PEOPLE WHO HAVE HAD DAMAGE TO THEIR BASAL  
28 GANGLIA, WHICH IS THE PART OF THE BRAIN INVOLVED IN

1 PARKINSON' S DISEASE.

2 WE' VE ALSO DEVELOPED A DATABASE IN WHICH WE SEE  
3 THAT LONG-TERM CRACK COCAINE ADDICTS HAVE EVIDENCE OF SMALL  
4 STROKES THROUGHOUT THEIR BRAIN THAT ARE SUBCLINICAL, MEANING  
5 THAT THEY NEVER KNEW THEY HAD IT AND NO DOCTOR WAS EVER  
6 TELLING THEM THAT THEY HAD IT.

7 WE ALSO HAVE LOOKED AT THAT LONG-TERM USERS OF  
8 CRACK COCAINE HAVE PROBLEMS IN THE WAY THEY THINK, THEIR  
9 MEMORY. THEY HAVE DIFFICULTY IN ANALYZING AND MAKING  
10 DECISIONS. AND THAT' S BEEN DEMONSTRATED ALONG WITH  
11 BEHAVIORAL TASKS.

12 SO PART OF THE GOAL IS TO -- AND WE' VE ALSO  
13 STARTED LOOKING AT OUTCOME DATA, TRYING TO COME UP,  
14 ULTIMATELY, WITH A TYPE OF HOLY GRAIL, WHICH IS THE ABILITY  
15 TO DO A BRAIN IMAGE, LIKE USING AN MRI SCAN, WHICH IS LIKE A  
16 CAT SCAN, AND BEING ABLE TO KNOW WHETHER THIS PERSON HAS A  
17 VARIETY OF PROBLEMS, WHAT THEIR LIKELIHOOD OF SUCCESS WOULD  
18 BE BASED ON THE AMOUNT OF BRAIN DAMAGE.

19 AND SO THAT RESEARCH IS ACTUALLY IN SYNC WITH  
20 WHERE BRAIN RESEARCH AND ADDICTIONS IS GOING TODAY.

21 Q. OKAY. NOW, ASIDE FROM THE NITA PROGRAM YOU' VE  
22 TOLD US ABOUT AND THIS RESEARCH, ARE YOU INVOLVED IN ANY  
23 OTHER PROGRAMS RELATED TO ADDICTION?

24 A. WELL, DURING THE ENTIRE TIME I WAS INVOLVED AS  
25 A NITA RESEARCHER, I BASICALLY SAW PATIENTS WITH ADDICTIVE  
26 DISORDERS OF ALL TYPES, ALCOHOL, COCAINE, HEROIN, PILLS. AND  
27 AFTER ABOUT SIX MONTHS, I WAS ASKED TO DIRECT THE ALCOHOL AND  
28 DRUG TREATMENT PROGRAM

1                   AND THEN OVER THE SUBSEQUENT YEARS, I WAS ASKED  
2 TO DEVELOP NEW PROGRAMS THAT WOULD OFFER SERVICES THAT HADN' T  
3 BEEN OFFERED IN THAT PARTICULAR WAY IN AN OUTPATIENT SETTING  
4 IN THE V. A.

5                   Q.       LET' S JUST MAKE SURE WE' RE CLEAR HERE.

6                   YOU WERE ASKED TO HEAD UP THE ALCOHOL AND DRUG  
7 TREATMENT PROGRAM WHERE?

8                   A.       AT THE V. A. MEDICAL CENTER IN WEST LOS ANGELES.

9                   Q.       ALL RIGHT. SO YOU CONTINUED TO WORK THERE?

10                  A.       YES. I HAD A STAFF OF ABOUT 40 PSYCHOLOGISTS,  
11 SOCIAL WORKERS, ALCOHOL AND DRUG COUNSELORS, NURSING STAFF.

12                  Q.       OKAY. I' M SORRY TO INTERRUPT, BUT YOU WERE  
13 TELLING US ABOUT THESE ADDICTION-RELATED PROGRAMS THAT YOU' RE  
14 INVOLVED IN.

15                  A.       SURE. LOS ANGELES HAS, AS YOU KNOW, BOTH A  
16 LARGE VETERAN POPULATION AND A LARGE PUBLIC SUBSTANCE ABUSE  
17 PROBLEM, AND A LOT OF PEOPLE SUFFERING FROM CRACK COCAINE  
18 ADDICTION AS WELL AS OTHER TYPES OF ADDICTION WOULD GO TO THE  
19 WEST LOS ANGELES V. A. FOR HELP. SO THOSE WERE OUR PATIENTS.

20                         AND INITIALLY, WE WERE DOING FAIRLY STANDARD  
21 TREATMENT USING A 21-DAY INPATIENT PROGRAM AND OVER THE  
22 COURSE OF THE '90' S, THERE' S BEEN NO EMPHASIS ON BECOMING  
23 MORE EFFICIENT, USING OUTPATIENT SERVICES INSTEAD OF  
24 INPATIENT SERVICES.

25                         AND RESEARCH HAS COME OUT DEMONSTRATING THAT IF  
26 YOU CAN TREAT PEOPLE IN SOME TYPE OF OUTPATIENT SETTING --  
27 THE ONE WE CHOSE WAS WHAT YOU CALL DAY HOSPITAL; A PERSON  
28 COMES IN THE MORNING, SPENDS THE WHOLE DAY, THEN GOES

1 HOME -- IF YOU TREAT PEOPLE IN THAT MANNER, THEY TEND TO DO  
2 BETTER LONG TERM BECAUSE THEY CAN WORK WITH YOU AROUND THE  
3 CHALLENGES THEY'RE FACING OUT IN THE REAL WORLD AS OPPOSED TO  
4 BEING SIMPLY CLOISTERED FOR SOME PERIOD OF TIME AND THEN  
5 HAVING TO FACE ALL THE CHALLENGES PRECIPITOUSLY. THERE'D  
6 BEEN NO DAY HOSPITAL WHICH PARTICIPATED IN THE V. A. SYSTEM  
7 SO ACTUALLY, WE, IN CONVERTING FROM ONE TYPE TO ANOTHER, WAS  
8 LOOKED AT THROUGHOUT THE SYSTEM AS A MODEL.

9 Q. HAVE YOU SERVED IN ANY CAPACITY AS A  
10 CONSULTANT?

11 A. YES. I'VE DONE CONSULTING WORK. SOME HAS BEEN  
12 IN ADDICTION.

13 I'M THE PSYCHIATRIC CONSULTANT FOR THE SEXUAL  
14 RECOVERY INSTITUTE IN LOS ANGELES. THE FOCUS THERE IS  
15 TREATING SEXUAL ADDICTION.

16 I ALSO, OUT OF SUBSEQUENT ACTIVITIES INVOLVING  
17 WORKING WITH DANGEROUS PATIENTS, HAVE CONSULTED TO THE  
18 VENTURA COUNTY SHERIFF'S DEPARTMENT ON HOW POLICE MIGHT BEST  
19 INTERACT WITH MENTALLY ILL SUSPECTS.

20 Q. ALL RIGHT. NOW, A LITTLE WHILE AGO, YOU TOLD  
21 US THAT AT SOME POINT, YOU BECAME A BOARD-ELIGIBLE  
22 PSYCHIATRIST.

23 ALONG THE WAY, DID YOU BECOME A BOARD CERTIFIED  
24 IN ANY FIELD?

25 A. I BECAME BOARD CERTIFIED THROUGH EXAMINATION.  
26 AFTER YOU'RE BOARD ELIGIBLE, YOU COMPLETED AN ACCREDITED  
27 TRAINING PROGRAM IN PSYCHIATRY. YOU CAN THEN SIT FOR  
28 PHASE I, WHICH IS A WRITTEN EXAM IF YOU PASS THAT, YOU CAN

1 SIT FOR PHASE II, WHICH IS AN ORAL EXAMINATION. AND HAVING  
2 PASSED THOSE, I BECAME BOARD CERTIFIED IN GENERAL PSYCHIATRY.

3 AS A RESULT OF SUBSPECIALTY INTERESTS AND MY  
4 EXPERIENCES, I ACTUALLY ALSO PASSED THE EXAMINATIONS AND  
5 BECAME BOARD CERTIFIED IN ADDICTION PSYCHIATRY AND FORENSIC  
6 PSYCHIATRY AS WELL AS GERIATRICS PSYCHIATRY.

7 Q. ALL RIGHT. DO YOU BELONG TO ANY PROFESSIONAL  
8 ORGANIZATIONS?

9 A. YES, I DO. I BELONG --

10 Q. TELL US A LITTLE BIT ABOUT THAT.

11 A. I BELONG TO A FAIRLY LARGE NUMBER.

12 BASIC ONE BEING THE AMERICAN PSYCHIATRIC  
13 ASSOCIATION.

14 I'M ALSO A MEMBER OF THE AMERICAN ACADEMY OF  
15 ADDICTION PSYCHIATRISTS; .

16 THE AMERICAN SOCIETY OF ADDICTION MEDICINE; .  
17 THE NATIONAL COUNCIL ON SEXUAL ADDICTION AND  
18 COMPULSIVITY.

19 BECAUSE OF THE FORENSIC INTERESTS I HAVE, I  
20 ALSO BELONG TO THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW  
21 AND THE ASSOCIATION OF THREAT ASSESSMENT PROFESSIONALS.

22 Q. DO YOU TEACH ANYWHERE?

23 A. YES. I'VE ALWAYS BEEN A FULL-TIME FACULTY  
24 MEMBER AT UCLA SCHOOL OF MEDICINE. BETWEEN 1991 AND '97, I  
25 WAS RUNNING THE SUBSTANCE ABUSE TRAINING FOR PSYCHIATRY  
26 RESIDENTS AT THE UCLA NEUROPSYCHIATRIC INSTITUTE AND HARBOR  
27 UCLA MEDICAL CENTER.

28 I'VE CONTINUED WITH THAT TO THE PRESENT IN MY

1 CAPACITY AS MEDICAL DIRECTOR OF THE PSYCHIATRIC INTENSIVE  
2 CARE UNIT. AND THERE, I'M IN CHARGE OF RUNNING THE TRAINING  
3 FOR THE NEUROPSYCHIATRIC INSTITUTE AND THE V. A. SEPULVEDA  
4 OLIVE VIEW MEDICAL CENTER PSYCHIATRY TRAINING PROGRAM AND  
5 THAT'S IN FORENSIC PSYCHIATRY AND INTENSIVE CARE PSYCHIATRY.

6 Q. ALL RIGHT. NOW, IN ADDITION TO THE THINGS  
7 YOU'VE JUST TOLD US ABOUT, DO YOU HAVE A CLINICAL PRACTICE?  
8 DO YOU SEE PATIENTS?

9 A. YES. IN ADDITION TO MY FULL-TIME POSITION AT  
10 THE V. A. , WHICH RUNS MONDAY THROUGH FRIDAY AND IS OVER BY 430  
11 IN THE AFTERNOON, I HAVE A PRIVATE CLINICAL PRACTICE WHERE I  
12 SEE MY OWN CLINICAL PATIENTS IN THE LATE AFTERNOONS AND EARLY  
13 EVENINGS DURING THE WEEK AND ON SATURDAYS.

14 Q. CAN YOU TELL US, IF YOU HAVE AN ESTIMATE, WHAT  
15 PROPORTION OF YOUR TIME IS SPENT ACTUALLY SEEING PATIENTS?

16 A. WELL, THE VAST MAJORITY OF WHAT I DO IS PATIENT  
17 RELATED. THEIR -- DEPENDING ON WHAT PARTICULAR WEEK OR  
18 MONTH, I ALSO DO SOME FORENSIC CONSULTING AND THERE,  
19 TECHNICALLY, IF YOU'RE INVOLVED WITH SOMEONE, THAT PERSON'S  
20 NOT GOING TO BE YOUR PATIENT, AND I WOULD SAY PROBABLY A GOOD  
21 80 PERCENT OF WHAT I DO HAS TO DO WITH TREATING PATIENTS.

22 Q. OKAY.

23 A. MAYBE MORE.

24 Q. NOW, YOU'VE TOLD US YOU'RE A PSYCHIATRIST, AND  
25 JUST TO MAKE SURE WE ALL UNDERSTAND, CAN YOU TELL US WHAT'S  
26 THE DIFFERENCE BETWEEN A PSYCHIATRIST AND A PSYCHOLOGIST?

27 A. THAT'S CERTAINLY A SOURCE OF CONFUSION FOR MOST  
28 PEOPLE AND A QUESTION I GET ASKED A LOT.

1                   PSYCHIATRISTS HAVE GONE TO MEDICAL SCHOOL, DONE  
2 THEIR MEDICAL STUDIES, AND THEN FOCUSED ON BEHAVIORAL AND  
3 EMOTIONAL PROBLEMS AND HOW TO TREAT THEM   THEY USUALLY HAVE  
4 A MORE BIOLOGICAL BRAIN-BASED APPROACH TO EMOTIONAL AND  
5 BEHAVIORAL DISORDERS.   THEY CAN PRESCRIBE MEDICATION FOR THE  
6 TREATMENT OF BEHAVIORAL DISORDERS.

7                   PSYCHOLOGISTS HAVE SPECIALIZED A BIT EARLIER  
8 ON.   THEY HAVEN'T DONE ANY MEDICAL TRAINING, PER SE, BUT  
9 THEY'VE GONE TO A GRADUATE PROGRAM IN PSYCHOLOGY AND HAVE  
10 EARNED, GENERALLY, A PH. D. DEGREE AND BECOME LICENSED TO  
11 TREAT PATIENTS AS A PSYCHOLOGIST.   NO MEDICATIONS ARE  
12 PRESCRIBED.

13                Q.        OKAY.   AND YOU'VE ALSO -- YOU'VE TOLD US THAT  
14 YOU HAVE A SPECIALTY IN ADDICTION PSYCHIATRY.

15                           AND CAN YOU TELL US A BIT ABOUT THAT?

16                           WHAT IS THAT SPECIALTY?

17                A.        ADDICTION PSYCHIATRY IS A SPECIALIZED PART OF  
18 PSYCHIATRY THAT FOCUSES ON THE DIAGNOSIS AND TREATMENT OF  
19 PEOPLE WHO HAVE SUBSTANCE ABUSE PROBLEMS AND BEHAVIORAL  
20 DISORDERS OF AN ADDICTIVE TYPE.

21                Q.        SO DOES YOUR PRACTICE, THEN, INCLUDE TREATING  
22 PEOPLE WHO ARE ADDICTED TO HARD DRUGS, LIKE HEROIN AND  
23 ALCOHOL?

24                A.        ALMOST MY ENTIRE PRACTICE OF PRIVATE PATIENTS  
25 THAT I SEE IN MY PRIVATE PRACTICE ARE ADDICTED AND A VERY  
26 LARGE PERCENTAGE OF THE PATIENTS THAT I SEE IN THE  
27 PSYCHIATRIC INTENSIVE CARE UNIT ARE ADDICTED.

28                Q.        DO YOU SEE PEOPLE WHO WANT TO STOP SMOKING?

1           A.       I DO.

2           Q.       AND DO YOU TREAT THEM FOR THAT?

3           A.       I DO QUITE A BIT OF TREATMENT OF NICOTINE  
4 WITHDRAWAL. I DO SOME SMOKING CESSATION WITH MOTIVATED  
5 PATIENTS, EITHER AT THE V. A. HOSPITAL OR IN MY PRIVATE  
6 PRACTICE.

7           Q.       DO PEOPLE GENERALLY COME TO YOU SPECIFICALLY  
8 FOR HELP IN QUITTING SMOKING?

9           A.       NOT SPECIFICALLY FOR THAT REASON. I THINK THAT  
10 MOST PEOPLE, WHEN THEY THINK ABOUT QUITTING SMOKING, DON'T  
11 THINK THAT THEY HAVE SOME MENTAL DISORDER OR ARE MENTALLY ILL  
12 AND NEED TO SEE A SHRINK. THAT'S JUST NOT WHAT PEOPLE THINK  
13 ABOUT. A LOT OF PEOPLE DON'T SEEK MEDICAL ATTENTION ANYWAY.  
14 BUT IF THEY WERE, THEY'D PROBABLY SEE THEIR FAMILY DOCTOR IF  
15 THE COMPLAINT WAS THAT THEY WANT TO QUIT SMOKING.

16                   SMOKING IS VERY PREVALENT, MUCH MORE THAN IN  
17 THE GENERAL POPULATION, AMONG THE PATIENTS I TREAT, PEOPLE  
18 WITH MENTAL ILLNESS AND PEOPLE WHO ARE ADDICTED TO OTHER  
19 DRUGS. SO THERE'S A VERY HIGH PREVALENCE OF SMOKING IN THE  
20 PATIENTS I TREAT. AND FREQUENTLY, WHEN SOMEONE HAS A SENSE  
21 THAT THEY'RE READY TO -- AND IT MAY BE AFTER THEY'VE STOPPED  
22 USING A DIFFERENT DRUG -- THEY MAY DECIDE TO ACTUALLY ENGAGE  
23 IN THE PROCESS OF QUITTING.

24                   SO I WILL DEVISE A PROGRAM WITH THEM AND  
25 GENERALLY PRESCRIBE A NUMBER OF MEDICATIONS AND WORK WITH  
26 THEM TO QUIT.

27                   AT THE V. A. HOSPITAL, YOU HAVE A LOT OF  
28 TREATMENT OF NICOTINE WITHDRAWAL, OR AT LEAST LOOKING FOR

1 NICOTINE WITHDRAWAL, BECAUSE YOU HAVE PEOPLE WHO MAY BE HEAVY  
2 SMOKERS COMING INTO A SMOKE-FREE FACILITY, AND THAT'S KIND OF  
3 INTERESTING TO SEE HOW HEAVY SMOKERS COPE WITH SUDDENLY BEING  
4 DEPRIVED OF THEIR CIGARETTES.

5 Q. ALL RIGHT. NOW, YOU'VE MENTIONED THAT AMONG  
6 THE AREAS IN WHICH YOU'RE BOARD CERTIFIED IS FORENSIC  
7 PSYCHIATRY.

8 A. THAT'S CORRECT.

9 Q. WHAT IS THAT?

10 A. FORENSIC PSYCHIATRY IS, AGAIN, A SPECIALIZED  
11 AREA WITHIN PSYCHIATRY THAT FOCUSES ON PROVIDING HELP TO THE  
12 COURT OR TO A JURY IN UNDERSTANDING MENTAL HEALTH ISSUES IN A  
13 LEGAL SETTING.

14 Q. OKAY. ARE YOU INVOLVED IN -- WELL, DO YOU GET  
15 INVOLVED IN COURT PROCEEDINGS AS A FORENSIC PSYCHIATRIST?

16 A. WELL, FORMALLY, I WOULD SAY THAT SPECIFICALLY  
17 AS A FORENSIC PSYCHIATRIST THAT MOST OF THE WORK I DO IS  
18 CONSULTING TO ATTORNEYS WHERE I NEVER WILL EVEN APPEAR IN  
19 COURT. I HAVE TESTIFIED A FEW TIMES AS A FORENSIC  
20 PSYCHIATRIST.

21 ALTHOUGH, IF YOU TAKE A BROADER OUTLOOK, I'M IN  
22 DEPARTMENT 95 OF THE SUPERIOR COURT FREQUENTLY THROUGHOUT THE  
23 YEAR TESTIFYING ABOUT THE PATIENTS ON THE PSYCHIATRIC  
24 INTENSIVE CARE UNIT. THOSE ARE MY PATIENTS, THOUGH. I HAVE  
25 NOT BEEN ASKED BY AN ATTORNEY TO CONSULT IN A COURTROOM

26 Q. SO YOU APPEAR IN VARIOUS KINDS OF COURT  
27 PROCEEDINGS REGULARLY?

28 A. YES.

1 Q. AND HOW MANY TOBACCO-RELATED CASES HAVE YOU  
2 BEEN DESIGNATED IN AS AN EXPERT WITNESS IN?

3 A. I BELIEVE IT WOULD BE APPROXIMATELY HALF A  
4 DOZEN.

5 Q. AND WHEN WAS YOUR EARLIEST INVOLVEMENT WITH A  
6 TOBACCO-RELATED CASE?

7 A. BACK IN '99.

8 Q. HOW MANY HAVE YOU ACTUALLY TESTIFIED IN COURT  
9 IN?

10 A. JUST ONE PREVIOUS ONE. I BELIEVE IT WAS JUST A  
11 LITTLE MORE THAN A YEAR AGO.

12 Q. CAN YOU TELL US -- I THINK YOU MAY HAVE  
13 MENTIONED JUST BRIEFLY SOME OF THE TYPES OF COURT PROCEEDINGS  
14 THAT YOU'VE TESTIFIED IN -- I WANT TO EMPHASIZE -- ASIDE FROM  
15 YOUR TOBACCO-RELATED WORK, ASIDE FROM YOUR FORENSIC  
16 PSYCHIATRY WORK, WHAT KINDS OF COURT PROCEEDINGS DO YOU  
17 APPEAR IN?

18 A. WELL, THEY FLOW FROM WHAT THE PSYCHIATRIC  
19 INTENSIVE CARE UNIT DOES. AND I THINK IT WOULD BE IMPORTANT  
20 TO UNDERSTAND THAT FOR ME TO GIVE YOU A GOOD ANSWER --

21 Q. THIS IS THE PSYCHIATRIC INTENSIVE CARE UNIT AT  
22 THE WEST LOS ANGELES VETERANS HOSPITAL?

23 A. YES. ACTUALLY, IT SERVES THE ENTIRE VETERANS  
24 ADMINISTRATION GREATER LOS ANGELES HEALTHCARE SYSTEM WHICH  
25 COVERS AN AREA FROM BAKERSFIELD DOWN TO LONG BEACH AND FROM  
26 THE OCEAN OUT TO ABOUT RIVERSIDE.

27 AND MANY DIFFERENT OUTPATIENT FACILITIES  
28 THROUGHOUT SOUTHERN CALIFORNIA WILL FEED INTO THIS UNIT FOR

1 PARTICULAR TYPES OF PATIENTS. THE UNIT IS SPECIFICALLY  
2 DESIGNED FOR DANGEROUS PATIENTS. THESE ARE PEOPLE WHO,  
3 BECAUSE OF A MENTAL ILLNESS OR DRUG ADDICTION PROBLEM, ARE  
4 DANGERS TO THEMSELVES, MAY BE SUICIDAL, OR HAVING TRIED TO  
5 KILL THEMSELVES OR DANGEROUS TO OTHERS, POTENTIALLY. AND  
6 WE'VE HAD NUMEROUS CASES OF STALKERS, PEOPLE MAKING TERRORIST  
7 THREATS, THREATS AGAINST THE PRESIDENT.

8 SO WE INTERACT WITH LAPD THREAT MANAGEMENT  
9 UNIT, THE SECRET SERVICE, THE FBI, THE D. A. STALKING UNIT,  
10 BECAUSE OF THE DANGEROUSNESS OF THE PATIENTS.

11 WHEN THESE PATIENTS ARE HOSPITALIZED  
12 INVOLUNTARILY, I. E. , AGAINST THEIR WILL, THEN THERE ARE A  
13 NUMBER OF COURT PROCEEDINGS TO REVIEW THE HOSPITALIZATION,  
14 WHETHER A PERSON SHOULD TAKE MEDICATION, WHETHER THE PERSON  
15 SHOULD OR SHOULDN'T BE RELEASED AT ANY JUNCTURE.

16 AND GENERALLY, I'M ASKED TO TESTIFY ABOUT  
17 WHETHER THE PERSON HAS A MENTAL DISORDER, WHETHER THE PERSON  
18 IS A DANGER TO HIMSELF OR OTHERS, WHETHER THE PERSON HAS THE  
19 CAPACITY TO MAKE AN INFORMED DECISION ABOUT MEDICATION.  
20 THOSE SORT OF ISSUES.

21 Q. WELL, IT SOUNDS LIKE YOU'VE GOTTEN A LOT OF  
22 BALLS IN THE AIR.

23 CAN YOU TELL US JUST VERY BRIEFLY -- JUST  
24 SUMMARIZE HOW WOULD YOU SPEND A TYPICAL WEEK, WHAT KINDS OF  
25 THINGS DO YOU DO IN THE COURSE OF A WEEK?

26 A. I CAN TELL YOU HOW THINGS HAVE BEEN, YOU KNOW,  
27 OVER THE PAST TWO, THREE YEARS. MAYBE THIS IS A TRANSITIONAL  
28 STATE, BECAUSE I'VE BEEN WORKING 60 OR 70 HOURS A WEEK

1 MINIMUM, AND PART OF THAT HAS BEEN BECAUSE I LIKE ALL OF THE  
2 DIFFERENT PIECES OF THE PIE THAT I'M INVOLVED IN AND HAVEN'T  
3 WANTED TO GIVE UP THE PSYCHIATRIC INTENSIVE CARE UNIT AND  
4 TEACHING THE PSYCHIATRY RESIDENTS OR GIVE UP MY PRIVATE  
5 PRACTICE OR GIVE UP FORENSIC WORK.

6 SO TYPICALLY, MONDAY THROUGH FRIDAY, IT'S A  
7 FIVE-DAY WORK WEEK, ENDS AT 4:30. THAT'S RUNNING THE  
8 PSYCHIATRIC INTENSIVE CARE UNIT. THEN I GO OVER TO MY OFFICE  
9 IN WEST LOS ANGELES, AND I WILL SEE PATIENTS USUALLY FROM  
10 4:30 TO 8:30. SOMETIMES, IF THERE'S A NEW EVALUATION, IT MAY  
11 GO, YOU KNOW, UNTIL 10 O'CLOCK.

12 AND THEN I GENERALLY SEE PATIENTS ON SATURDAYS,  
13 AT LEAST IN THE MORNING; SOMETIME, IN THE AFTERNOON. AND  
14 THEN I'LL TRY TO FIT IN FORENSIC WORK ON TOP OF THAT. MAYBE  
15 SATURDAY AFTERNOON I'LL DO A FORENSIC EVALUATION OR, IF  
16 NECESSARY, I'LL TAKE A VACATION DAY FROM THE V. A. IN ORDER TO  
17 DO A FORENSIC EVALUATION.

18 Q. OKAY. WHAT I'D LIKE TO DO NOW IS TURN TO THE  
19 TOPIC OF ADDICTION, IF WE COULD.

20 A. OKAY.

21 Q. AND SPECIFICALLY, I WANT TO TALK ABOUT HOW YOU  
22 GO ABOUT TREATING PEOPLE FOR ADDICTION, IF YOU CAN DO THAT.

23 AND LET ME ASK YOU THIS: DO YOU FEEL IT'S  
24 NECESSARY TO ASSESS EACH PERSON YOU TREAT INDIVIDUALLY?

25 A. OH, ABSOLUTELY. AS ANY PHYSICIAN WOULD FOR ANY  
26 KIND OF MEDICAL PROBLEM

27 Q. AND WHAT IS IT THAT YOU TRY TO LEARN ABOUT EACH  
28 PATIENT THAT YOU TREAT?



1           A.       WELL, THAT WAS THE SUBJECT OF YEARS OF  
2 TRAINING, I SUPPOSE. LET ME BREAK IT DOWN INTO -- THERE ARE  
3 BASICALLY TWO PARTS.

4                    ONE HAS TO DO WITH MY FACE-TO-FACE INTERACTIONS  
5 WITH THE PERSON. MAY INVOLVE FACE-TO-FACE INTERACTIONS WITH  
6 SIGNIFICANT OTHERS AND FAMILY MEMBERS. BUT JUST STICKING  
7 WITH THE INDIVIDUAL PATIENT WHO COMES TO ME, I'M GOING TO GET  
8 A DETAILED HISTORY BASED ON MY UNDERSTANDING OF THE DISORDER,  
9 OTHER DISORDERS THAT TEND TO RUN IN FAMILIES ASSOCIATED WITH  
10 IT.

11                   I'LL ALSO DO A MENTAL STATUS EXAMINATION, WHICH  
12 MEANS, I'M GOING TO ASK QUESTIONS TO DETERMINE HOW THE PERSON  
13 CAN THINK AND CONCENTRATE, WHETHER THEY HAVE ANY UNUSUAL  
14 EXPERIENCES. AND THEN FOLLOWING THAT, THERE MAY BE PENCIL  
15 AND PAPER TESTING, INCLUDING PSYCHOLOGICAL TESTING.

16           Q.       PENCIL AND PAPER TESTING. WHAT DO YOU MEAN BY  
17 THAT?

18           A.       WELL, AS A BEHAVIORAL NEUROLOGIST, YOU DO A LOT  
19 OF PAPER AND PENCIL TESTING, IF YOU HAVE SUSPICION THAT  
20 SOMEONE HAS PROBLEMS WITH HOW THEIR BRAIN IS WORKING. SO IT  
21 COULD BE HAVING PEOPLE DRAW FOR YOU, COPY CIRCLES AND SQUARES  
22 AND MORE COMPLEX DIAGRAMS, TEST THEM HALF AN HOUR LATER TO  
23 SEE IF THEY REMEMBERED WHAT THEY DREW OR COULD THEY PICK IT  
24 OUT OF A MULTIPLE CHOICE SETTING. TESTING THEIR ABILITY TO  
25 PERFORM CALCULATIONS, CONCENTRATE AND SO FORTH. EVEN THINGS  
26 AS BASIC AS LANGUAGE, WHETHER THEY CAN UNDERSTAND THINGS,  
27 WRITE FOR YOU, FOLLOW COMMANDS. THAT'S ALL PART OF YOUR  
28 BASIC NEUROLOGICAL MENTAL STATUS EXAM IF YOU NEED TO GO

1 THROUGH EVERYTHING.

2 AND AGAIN, YOU DO AS MUCH AS YOU NEED TO DO TO  
3 GET TO A POINT WHERE YOU FEEL COMFORTABLE THAT YOU UNDERSTAND  
4 WHERE THINGS ARE. AND SOMETIMES, YOU MIGHT REFER TO OTHER  
5 PEOPLE, LIKE A NEUROPSYCHOLOGIST, WHO WILL SPEND TWO OR THREE  
6 DAYS DOING PENCIL AND PAPER TESTS.

7 SO IT REALLY FLOWS FROM THE PATIENT.

8 Q. OKAY. YOU ALSO MENTIONED PSYCHOLOGICAL  
9 TESTING. IS THAT SOMETHING DIFFERENT THAN THE KINDS OF  
10 PENCIL AND PAPER TESTING YOU'VE JUST BEEN TELLING US ABOUT?

11 A. THE PENCIL AND PAPER TESTING THAT I'M TALKING  
12 ABOUT IS SOMETIMES CALLED BEDSIDE TESTING, BECAUSE IT'S  
13 SOMETHING THAT YOU CAN DO AT THE BEDSIDE OR DO IN YOUR  
14 OFFICE. IT DOESN'T NEED TO BE SCORED. IT WILL GIVE YOU THE  
15 GENERAL IDEA OF WHAT'S WORKING AND WHAT'S NOT WORKING.

16 BUT PSYCHOLOGICAL TESTING USES TOOLS THAT HAVE  
17 BEEN STUDIED AND USED FOR YEARS WHICH CAN TELL YOU, THIS  
18 PERSON IS IN THE TOP THOUSAND OF PEOPLE WHEN IT COMES TO  
19 ARITHMETIC, AND THIS PERSON IS IN THE BOTTOM THIRD WHEN IT  
20 COMES TO LANGUAGE COMPREHENSION.

21 SO PSYCHOLOGICAL TESTING WILL GIVE YOU SPECIFIC  
22 NUMBERS COMPARING THE PERSON BEING TESTED TO PEOPLE THEIR AGE  
23 AND SEX. AND ALSO, THERE ARE PERMIT TESTS THAT HAVE BEEN  
24 USED FOR DECADES WHICH CAN GIVE YOU A SENSE OF SOMEONE'S  
25 PERSONALITY TRAITS AS WELL AS MORE SERIOUS PROBLEMS. AND  
26 SOMETIMES, THAT'S USEFUL.

27 YOU'RE MEETING SOMEONE WHO MAY OR MAY NOT WANT  
28 TO BE SHOWING THEIR GOOD SIDE OR EMPHASIZING THEIR BAD SIDE,

1 AND YOU WANT TO GET A SENSE SORT OF WITH A BLANK SCREEN HOW  
2 THE PERSON'S GOING TO ANSWER QUESTIONS. AND THEN THE PATTERN  
3 OF ANSWERS IS LOOKED AT AND COMPARED TO A HUGE AMOUNT OF DATA  
4 COLLECTED OVER DECADES, AND THEN THE LIKELY PATTERN, HOW IT'S  
5 RELATED TO PERSONALITY FEATURES MIGHT COME UP IN THE REPORT.

6 Q. ARE THERE NAMES FOR THESE PERSONALITY TESTS  
7 THAT YOU'VE JUST DESCRIBED?

8 HOW DO YOU REFER TO THEM?

9 A. THE OLDEST AND MOST COMMON ONE THAT'S USED IS  
10 CALLED THE MMPI, WHICH STANDS FOR THE MINNESOTA MULTIPHASIC  
11 PERSONALITY INVENTORY, WHICH HAS BEEN AROUND FOR A GOOD  
12 40 YEARS.

13 AND MORE RECENT, BUT AN EQUALLY RESPECTED ONE,  
14 IS THE MILLON CLINICAL MULTIAXIAL INVENTORY WHICH, AGAIN,  
15 DOES SIMILAR THINGS IN A DIFFERENT WAY BUT FOCUSES MORE ON  
16 RELATING TO DSM-IV DIAGNOSTIC LINGO. AND THAT'S THE LINGO  
17 USED BY PSYCHIATRISTS AND THE AMERICAN PSYCHIATRIC  
18 ASSOCIATION.

19 Q. IS THERE A SHORTHAND NAME FOR THIS LAST TEST?

20 A. IT'S ABBREVIATED MCM AS OPPOSED TO MMPI.

21 Q. ALL RIGHT. HAVE YOU CONDUCTED AN EVALUATION OF  
22 THE PLAINTIFF IN THIS CASE, RICHARD BOEKEN?

23 A. YES, I HAVE.

24 Q. AND HOW DID THAT COME ABOUT?

25 A. THAT CAME ABOUT, ESSENTIALLY, THROUGH MY  
26 REQUEST TO PERSONALLY EXAMINE MR. BOEKEN, IN ADDITION TO  
27 REVIEWING AS MUCH MATERIAL AS I COULD GET MY HANDS ON.

28 IN A NUTSHELL, I WAS ASKED TO CONSULT ON THE

1 CASE, AND AS PART OF THE PROCESS OF COMING TO ANY TYPE OF  
2 OPINION, IT'S MY PRACTICE -- IT'S THE ETHICAL PRACTICE OF  
3 AMERICAN FORENSIC PSYCHIATRISTS TO EXAMINE THE PERSON, IF  
4 THAT'S AT ALL POSSIBLE.

5 Q. NOW, YOU WERE ASKED TO CONSULT IN THIS CASE ON  
6 BEHALF OF PHILIP MORRIS, RIGHT?

7 A. THAT WOULD BE CORRECT.

8 Q. ALL RIGHT. WHAT INFORMATION -- WHAT MATERIALS  
9 DID YOU REVIEW IN RELATION TO YOUR EVALUATION OF MR. BOEKEN?

10 A. WELL, STARTING ABOUT SIX MONTHS AGO, I STARTED  
11 REVIEWING DEPOSITION TRANSCRIPTS. MR. BOEKEN GAVE A NUMBER  
12 OF DEPOSITIONS, AND I REVIEWED THE DEPTHS OF THOSE  
13 DEPOSITIONS, THE VIDEOTAPES OF THOSE DEPOSITIONS.

14 THERE HAVE BEEN DEPOSITIONS OF NUMEROUS OTHERS,  
15 FRIENDS, FAMILY, FAMILY PHYSICIAN.

16 I'VE REVIEWED MEDICAL RECORDS, INCLUDING THOSE  
17 OF HIS FAMILY PHYSICIAN.

18 I'VE ALSO REVIEWED PSYCHOLOGICAL TESTING.

19 I'VE REVIEWED THE EXPERT REPORT OF  
20 DR. MARTIN BLINDER, WHO WAS AN EXPERT WHO ALSO EXAMINED  
21 MR. BOEKEN.

22 AND I ALSO PERFORMED A PERSONAL EXAMINATION ON  
23 FEBRUARY 2ND AND FEBRUARY 8TH OF THIS YEAR.

24 I'VE ALSO REVIEWED SOME RELEVANT TRIAL  
25 TESTIMONY PERTAINING TO MR. BOEKEN.

26 Q. I WANT TO GET BACK TO YOUR PERSONAL INTERVIEWS  
27 WITH THE PLAINTIFF.

28 BUT DID YOU REVIEW AN MMPI, AN MCM?

1           A.       I REVIEWED ONE OF EACH, ACTUALLY.  OR AT LEAST  
2 I REVIEWED THE NARRATIVE REPORTS OF ONE OF EACH.

3           Q.       OKAY.  NOW, AS FAR AS YOUR INTERVIEW OF  
4 MR. BOEKEN, OR INTERVIEWS -- YOU MET WITH HIM TWICE?

5           A.       THAT' S CORRECT.

6           Q.       WHEN DID THOSE OCCUR?

7           A.       THOSE WERE IN EARLY FEBRUARY.  I BELIEVE IT WAS  
8 THE 2ND AND THE 8TH.

9           Q.       AND WHAT DID YOU -- WHAT WAS THE PURPOSE OF  
10 THOSE TWO MEETINGS?

11          A.       WELL, THE PURPOSE WAS TO, ESSENTIALLY, DO A  
12 DIAGNOSTIC EVALUATION OF MR. BOEKEN AND REALLY COME TO  
13 UNDERSTAND HIM  IT INVOLVED GOING OVER THE FINE POINTS OF  
14 THE HISTORY, LOOKING AT AREAS OF THE HISTORY WHICH HAD NOT  
15 BEEN COVERED BY ATTORNEYS WHO HAD QUESTIONED HIM, DOING SOME  
16 OBJECTIVE MENTAL STATUS EXAMINATION AND ADMINISTERING AN  
17 MMPI.

18          Q.       AND ABOUT HOW LONG DID YOU MEET WITH MR. BOEKEN  
19 ON EACH OF THESE OCCASIONS?

20          A.       WELL, IT WAS APPROXIMATELY TWO HOURS FACE TO  
21 FACE THE FIRST OCCASION.  THE SECOND OCCASION WAS ABOUT HALF  
22 AN HOUR FACE TO FACE, AND THEN FOR THE NEXT HOW HOUR, HE  
23 COMPLETED THE PAPER AND PENCIL TEST, THE MMPI.

24          Q.       AND DID YOU DEVELOP AN IMPRESSION ABOUT  
25 MR. BOEKEN JUST WITH YOUR PERSONAL MEETINGS WITH HIM?

26          A.       SURE.

27          Q.       WHAT IMPRESSION DID YOU GET?

28          A.       I FOUND MR. BOEKEN TO BE AN INTELLIGENT, AWARE,

1 IN CONTROL SORT OF INDIVIDUAL. HE WAS SURPRISINGLY INTACT AS  
2 FAR AS HIS MENTAL STATE WAS CONCERNED, AT LEAST AT THAT TIME.

3 I KNOW IT CAN BE VARIABLE, BUT I WAS CONCERNED  
4 THAT PERHAPS HE WOULD HAVE PROBLEMS WITH ATTENTION OR  
5 CONCENTRATION AND MEMORY. AND I WAS IMPRESSED, FIRST OF ALL,  
6 THAT HE FOUND MY OFFICE BY HIMSELF, WHICH A LOT OF MY  
7 PATIENTS HAVE TROUBLE DOING. AND HE NAVIGATED IT. HE FOUND  
8 IT. HE CAME BY HIMSELF. HE WAS VERY SHARP.

9 I GAVE HIM ONE OF MY STANDARD, FILL-THIS-OUT  
10 INFORMATION PACKET, AND HE TOLD ME, WELL, I WON'T BE NEEDING  
11 THIS -- WHICH IS THE DOCTOR-PATIENT AGREEMENT -- HE SAID, I  
12 WON'T BE NEEDING THIS BECAUSE I'M NOT YOUR PATIENT. I'M HERE  
13 JUST FOR, YOU KNOW, LEGAL PURPOSES.

14 SO HE CLEARLY KNEW THE DIFFERENCE THERE.  
15 ANSWERED ALL OF MY QUESTIONS. AND HE HAD A GOOD COMMAND OF  
16 THE DETAILS OF HIS TREATMENT, WHICH WAS IMPRESSIVE. AND SO I  
17 WAS ACTUALLY A BIT SURPRISED.

18 Q. I'D LIKE TO TURN FOR A BIT TO THE TERM  
19 "ADDICTION," IF WE COULD.

20 HOW HAS THAT TERM BEEN USED?

21 A. IT'S A TERM THAT'S BEEN USED IN A VARIETY OF  
22 WAYS OVER THE YEARS WITH DIFFERENT CONNOTATIONS, BOTH IMPLIED  
23 AND NOT IMPLIED.

24 IF WE BASICALLY GO BACK, SAY, HALF A CENTURY,  
25 AT THAT TIME, THERE ARE A COUPLE OF THEMES THAT WERE COMMON  
26 IN HOW THE WORD "ADDICTION" WAS USED.

27 ONE WAS A THEME OF STIGMA. AND I'M SORRY TO  
28 SAY, MY OWN AMERICAN PSYCHIATRIC ASSOCIATION, WHEN IT PUT OUT

1 ITS DIAGNOSTIC MANUAL IN 1952, LISTED DRUG ABUSE UNDER  
2 SOCIOPATHIC PERSONALITY DISTURBANCE, ALONG WITH SEXUAL  
3 DEVIANTS AND ANTISOCIAL BEHAVIOR. AND I THINK THAT THAT  
4 THERE WAS VERY PREVALENT, THEN, THAT ADDICTS ARE ANTISOCIAL  
5 PERSONALITY, THEY HARM SOCIETY, THEY WILL ROB YOU, LIE, CHEAT  
6 AND STEAL. AND THAT'S A STIGMA THAT'S NOT WHOLLY GONE, EVEN  
7 THOUGH WE FEEL THAT WE'RE MORE ENLIGHTENED NOW

8 INTERESTINGLY ENOUGH, THAT SAME CATEGORIZATION  
9 AS A SOCIOPATHIC PERSONALITY DISORDER WAS REPEATED IN THE  
10 1968 DIAGNOSTIC MANUAL.

11 Q. AND WHEN YOU REFER TO THE DIAGNOSTIC MANUAL,  
12 ARE YOU REFERRING TO SOME SORT OF SET OF STANDARDS OR  
13 GUIDELINES USED BY PSYCHIATRISTS?

14 A. YES. IT'S A SET OF GUIDELINES FOR MAKING A  
15 DIAGNOSIS, WHICH IS USED BY PSYCHIATRISTS, PSYCHOLOGISTS,  
16 SOCIAL WORKERS, COUNSELORS, THERAPISTS AROUND THE WORLD. THE  
17 PURPOSE IS TO ALLOW PEOPLE TO TALK TO ONE ANOTHER AND KNOW  
18 WHAT THE OTHER PERSON IS SAYING, ESPECIALLY WHEN IT COMES TO  
19 A DIAGNOSIS. AND THERE HAVE BEEN SEVERAL EDITIONS OF THIS  
20 BEGINNING IN 1952.

21 Q. SO THE PURPOSE IS TO DEVELOP STANDARDIZED TERMS  
22 OF REFERENCE IN MAKING DIAGNOSES REGARDING PSYCHOLOGICAL  
23 DISORDERS?

24 A. CORRECT.

25 Q. AND ARE THESE BOOKS REFERRED TO AS DSM S?

26 A. THAT'S THE SHORTHAND FOR DIAGNOSTIC AND  
27 STATISTICAL MANUAL.

28 Q. OKAY.

1 A. DSM

2 Q. GETTING BACK TO THE TERM "ADDICTION. "

3 A. SURE. I HAD COVERED THAT ONE THEME.

4 THERE'S A SECOND THEME WHICH WAS TRUE AROUND  
5 THAT TIME, WHICH DIDN'T EXACTLY LEAVE US FOR QUITE A WHILE,  
6 AND THAT THEME WAS THAT ADDICTION INVOLVED INGESTING OR  
7 TAKING INTO YOUR BODY IN SOME WAY, SHAPE OR FORM AN  
8 INTOXICATING SUBSTANCE THAT WOULD MAKE YOU INTOXICATED.

9 YOU WOULD THEN USE MORE AND MORE OF IT BECAUSE  
10 IT WOULD HAVE LESS AND LESS OF AN EFFECT, AND AS YOU BECAME  
11 TOLERANT TO IT AND USED MORE AND MORE, THEN YOU'D BE HOOKED,  
12 AND YOU COULDN'T STOP. IF YOU DID, YOU COULD DIE FROM  
13 WITHDRAWAL THAT WOULD MAYBE HAVE YOU LOSE YOUR MIND OR  
14 PHYSICALLY BE DECEASED. AND THAT --

15 Q. WAS THAT --

16 A. -- THAT WAS A VERY COMMON MODEL IN MEDICINE ALL  
17 THE WAY, YOU KNOW, PROBABLY TO THE '80'S.

18 Q. SO WOULD WE, PERHAPS, REFER TO THAT DEFINITION  
19 AS THE MEDICAL DEFINITION OF ADDICTION?

20 A. IT HAS BEEN REFERRED TO AS SUCH.

21 Q. AND WAS THAT DEFINITION ESSENTIALLY EMBODIED IN  
22 THE 1964 SURGEON GENERAL'S REPORT ON SMOKING?

23 A. WELL, THE 1964 SURGEON GENERAL'S REPORT PRETTY  
24 MUCH ADOPTED THE DEFINITIONS USED BY THE WORLD HEALTH  
25 ORGANIZATION IN 1957, AND THAT WAS A DIVISION BETWEEN  
26 HABITUATING SUBSTANCES, ONES THAT CREATED A HABIT, AND  
27 ADDICTIVE SUBSTANCES, ONES THAT CAUSED ADDICTION.

28 AND THE MEDICAL MODEL TYPE DEFINITION WAS

1 ESSENTIALLY USED FOR ADDICTION. AND IF THE SUBSTANCE DIDN'T  
2 HAVE -- DIDN'T MAKE YOU INTOXICATED AND YOU DIDN'T HAVE THIS  
3 LIFE-THREATENING OR CLASSICAL WITHDRAWAL SYMPTOM, THEN IT  
4 COULDN'T BE ADDICTING; IT WAS, INSTEAD, HABITUATING. THAT'S  
5 WHY THE SURGEON GENERAL AT THAT TIME SAID THAT NICOTINE IS  
6 NOT ADDICTIVE, IT IS HABITUATING.

7 Q. ALL RIGHT.

8 A. AND THAT SPEAKS TO MORE OF A PSYCHOLOGICAL  
9 DEPENDENCE, WHICH IS WHERE THEY WERE GOING WITH THAT.

10 Q. WELL, LET'S LOOK AT PAGE 351 FROM THE SURGEON  
11 GENERAL'S REPORT FROM 1964.

12 THIS IS EXHIBIT 5634.

13 AND YOU'VE READ THIS BEFORE, HAVEN'T YOU?

14 A. SURE.

15 Q. THE LEFT-HAND COLUMN PRETTY MUCH SETS OUT THE  
16 CRITERIA THAT THE SURGEON GENERAL IN 1964 USED TO DEFINE DRUG  
17 ADDICTION, RIGHT?

18 A. THAT'S CORRECT.

19 Q. AND THERE WERE FOUR ESSENTIAL CHARACTERISTICS;  
20 IS THAT RIGHT?

21 A. YES.

22 Q. THEY HAVE AN OPENING STATEMENT, WHICH REFERS TO  
23 INTOXICATION, AND THEN THEY HAVE FOUR CHARACTERISTICS THAT IT  
24 SHOULD INCLUDE TO BE ADDICTIVE.

25 AND THOSE FOUR CHARACTERISTICS WERE -- I DON'T  
26 KNOW IF YOU CAN READ IT FROM WHERE YOU ARE.

27 A. WELL, I'LL READ IT FROM HERE.

28 ONE IS AN OVERPOWERING DESIRE OR NEED TO KEEP

1 TAKING THE DRUG AND TO OBTAIN IT BY ANY MEANS.

2 AND THAT BEGINS TO GET YOU THAT FLAVOR OF THE  
3 ANTISOCIAL PERSON.

4 A TENDENCY TO INCREASE THE DOSE.

5 THAT'S THE TOLERANCE ISSUE WHERE THE PERSON,  
6 HE'S TAKING MORE AND MORE.

7 AND THEN THE PERSON HAS A PSYCHOLOGICAL --  
8 MEANING, THEY REALLY FEEL THAT THEY NEED IT -- AND GENERALLY  
9 A PHYSICAL DEPENDENCE TO THE EFFECTS OF THE DRUG.

10 AND THAT PHYSICAL DEPENDENCE GENERALLY MEANS IF  
11 YOU STOP, YOU'RE GOING TO BE REAL SICK.

12 AND THEN THE FOURTH ONE IS THAT THE ADDICTION  
13 CREATES A DETRIMENTAL EFFECT ON THE INDIVIDUAL AND ON  
14 SOCIETY.

15 AND AGAIN, THAT GETS TO THAT ANTISOCIAL FLAVOR  
16 AGAIN. IT'S NOT JUST THAT THE PERSON IS KILLING THEMSELVES.  
17 IT'S THAT THEY'RE STEALING YOUR CAR STEREO.

18 Q. THIS SOUNDS LIKE IT'S SORT OF A BLEND BETWEEN  
19 THE OLD SORT OF SOCIAL STIGMA APPROACH TO ADDICTION AND THE  
20 MEDICAL CONCEPT OF ADDICTION?

21 A. I THINK, YOU KNOW, WHEN THEY CAME UP WITH THAT  
22 IN '57, IT WAS A PRETTY GOOD HYBRID OF THOSE TWO ASPECTS OF  
23 HOW ADDICTION WAS VIEWED.

24 Q. ALL RIGHT. BUT YOU SAID NICOTINE WASN'T  
25 CLASSIFIED AS AN ADDICTIVE SUBSTANCE UNDER THIS DEFINITION BY  
26 THE SURGEON GENERAL?

27 A. ACCORDING TO THE 1964 SURGEON GENERAL'S  
28 DEFINITIONS, NICOTINE FELL ON THE RIGHT-HAND SIDE AS DRUG

1 HABITUATION, NOT DRUG ADDICTION.

2 Q. AND THAT WAS BECAUSE IT WASN' T INTOXICATING?

3 A. IT WASN' T INTOXICATING.

4 THEN YOU HAVE, NO. 1, THEY FELT IT WAS A DESIRE  
5 BUT NOT A COMPULSION. THAT' S SOMEWHAT SEMANTIC, BUT I THINK  
6 THEY' RE GETTING AT, WELL, THE PERSON CONSUMING NICOTINE HAS  
7 AN IMPROVED STATE OF WELL-BEING. IT' S NOT THAT THE PERSON  
8 NEEDS TO GET IT QUITE THE WAY THE CLASSICAL DRUGS OF ABUSE  
9 WOULD INVOLVE.

10 THEN ON NO. 2, THERE WAS LITTLE OR NO TENDENCY  
11 TO INCREASE THE DOSE. AND I THINK THAT REFLECTED THAT MOST  
12 PEOPLE GET TO A CERTAIN LEVEL OF SMOKING AND TEND TO BE  
13 RELATIVELY CONSTANT AT THAT LEVEL.

14 NO. 3, THERE WAS PSYCHIC DEPENDENCE ON THE  
15 EFFECT OF THE DRUG; MEANING THAT, YOU KNOW, IT WAS A HABIT.  
16 PEOPLE USED TO TALK ABOUT KICKING THE HABIT BACK THEN. YOU  
17 KNOW, PEOPLE -- THERE WEREN' T NICOTINE ADDICTS IN THE 60' S.  
18 THERE WERE ONLY PEOPLE WHO HAD THAT NASTY HABIT OF SMOKING  
19 CIGARETTES. AND WHEN THEY WANTED TO QUIT, YOU KNOW, IT  
20 WASN' T TALKED ABOUT, REMISSION AND RELAPSE; IT WAS TALKED  
21 ABOUT IN A PERSON KICKS THE HABIT OR DOESN' T.

22 THEN YOU HAVE NO. 4, THE DETRIMENTAL EFFECTS  
23 ARE NOT ON SOCIETY, THEY' RE ON THE INDIVIDUAL.

24 AND AGAIN, THAT' S BECAUSE THE EFFECTS ON  
25 SOCIETY ARE BASICALLY CRIMINAL IN NATURE IN THE ADDICTION  
26 CATEGORY.

27 Q. DURING 1964, DID THE CONCEPT OF ADDICTION  
28 CONTINUE TO BE EXAMINED AND RECONSIDERED?

1           A.       CONCEPTUALLY, THE TERM ADDICTION HAS BEEN  
2 EVOLVING TO THE PRESENT DAY.

3           Q.       IN WHAT WAY?

4           A.       WELL, TWO WAYS.

5                    ONE IS THAT THERE HAVE BEEN SIMPLY CONCEPTUAL  
6 CHANGES, NOT NECESSARILY TIED INTO ANY GREAT SCIENTIFIC  
7 DISCOVERY, BUT RATHER, AFTER A PERIOD OF TIME AND ENOUGH  
8 PEOPLE THINKING ABOUT THE ISSUES AND TALKING ABOUT IT, THERE  
9 HAVE BEEN DECISIONS THAT, WELL, THAT'S NOT QUITE RIGHT. WE  
10 NEED TO MAKE A CHANGE.

11                    YOU KNOW, IT REALLY WASN'T, I THINK, UNTIL THE  
12 '60'S THAT PSYCHIATRY REALLY STARTED GETTING INVOLVED  
13 SERIOUSLY IN THE TREATMENT OF ADDICTION. BEFORE THE '60'S,  
14 PSYCHIATRISTS OFTEN FELT THAT ADDICTS WERE HOPELESS, YOU  
15 KNOW, HAD MORE PROGNOSIS. IT WAS ONLY IN THE '60'S THAT  
16 PSYCHIATRISTS REALLY STARTED GETTING INVOLVED. THERE'S BEEN  
17 A LOT OF THINKING ABOUT IT SINCE THAT TIME.

18                    FOR EXAMPLE, IN 1968, THEY SAID, WELL, WAIT A  
19 SECOND, YOU DON'T NEED THE CLASSICAL WITHDRAWAL, BECAUSE  
20 COCAINE DOESN'T CAUSE THAT LIFE-THREATENING WITHDRAWAL, BUT  
21 WE KNOW IT'S ADDICTIVE. SO THEY THREW THAT OUT.

22                    IN 1980, THEY DECIDED, WE'RE GOING TO USE THE  
23 TERM "DEPENDENCE," LIKE THE WORLD HEALTH ORGANIZATION, AND  
24 TRY TO GET SOME CLARIFY -- LIKE START ALL OVER AGAIN IN  
25 DEFINING THEM IN A CERTAIN WAY. AND THAT'S EVOLVED IN  
26 SUBSEQUENT EDITIONS. AND ALSO, THERE HAVE BEEN SOME  
27 DISCOVERIES ABOUT THE NATURE OF ADDICTION THAT HAVE CHANGED,  
28 YOU KNOW, HOW WE THINK ABOUT ADDICTION.

1 Q. NOW, THE SURGEON GENERAL REVISITED THIS ISSUE  
2 IN 1988 AS FAR AS NICOTINE WAS CONCERNED, RIGHT?

3 A. IN 1988, THE SURGEON GENERAL PRODUCED A REPORT  
4 CALLED, I THINK, "NICOTINE ADDICTION." AND WHAT THAT REPORT  
5 WAS WAS A COMPENDIUM OF DATA AND CONCLUSIONS LOOKING AT THE  
6 BIOLOGICAL OR PHARMACOLOGICAL ASPECTS OF NICOTINE. THAT  
7 REPORT DID NOT ADDRESS PSYCHOLOGICAL OR SOCIAL FACTORS IN  
8 ADDICTION. SO IT GAVE CONCLUSIONS BUT ONLY LOOKED AT A SLICE  
9 OF THE PIE.

10 Q. SO IN EVALUATING NICOTINE IN 1988, DID THE  
11 SURGEON GENERAL EXPRESSLY EXCLUDE PSYCHOLOGICAL AND SOCIAL  
12 FACTORS?

13 A. IT WAS CONTINUED BEYOND THE SCOPE OF THAT  
14 REPORT.

15 Q. OKAY. AND WHAT DID THEY LOOK AT, THEN, JUST  
16 BIOLOGICAL FACTORS?

17 A. THEY LOOKED AT ALL THE BIOLOGICAL DATA. THEY  
18 LOOKED AT SOME FACTORS ABOUT HOW PEOPLE SMOKED, EPIDEMIOLOGY;  
19 IN OTHER WORDS, WHAT THE PREVALENCE OF SMOKING IS AND QUIT  
20 RATES, THAT SORT OF THING. THEY LOOKED AT A LOT OF RAT  
21 RESEARCH. IT'S CLEAR THAT THAT 1988 REPORT WAS HEAVILY  
22 INCLUDED BY RAT EXPERIMENTS LOOKING AT SELF-ADMINISTRATION BY  
23 RATS OF DRUGS OF ABUSE.

24 Q. LET'S LOOK AT THE 1988 CRITERIA, IF WE COULD.  
25 ARE THESE THE CRITERIA THAT WERE APPLIED IN  
26 EVALUATING NICOTINE?

27 A. THIS WAS THE SURGEON GENERAL'S REPORT'S TAKE ON  
28 HOW TO DEFINE DRUG DEPENDENCE.

1 Q. JUST FOR THE RECORD, THIS IS PAGE 7 FROM THE  
2 1988 SURGEON GENERAL'S REPORT, EXHIBIT 5653.

3 I'M SORRY FOR INTERRUPTING.

4 A. SURE. IT'S WORTH NOTING, I THINK, THAT THIS IS  
5 REALLY THE ONLY PLACE THAT SUCH A DEFINITION APPEARS. IT WAS  
6 DERIVED FOR THE PURPOSE OF THE NICOTINE ADDICTION REPORT IN  
7 1988. AND IT HAS, OF COURSE, A TOTALLY DIFFERENT DEFINITION  
8 FROM THE '64 AS WELL AS A VERY DIFFERENT DEFINITION FROM WHAT  
9 WAS APPEARING IN THE DIAGNOSTIC MANUALS USED BY MENTAL HEALTH  
10 PROFESSIONALS.

11 Q. WELL, LET'S LOOK AT THESE CRITERIA JUST REAL  
12 QUICKLY HERE.

13 THERE ARE "PRIMARY CRITERIA"?

14 A. THAT'S CORRECT.

15 Q. (READING:)

16

17 "HIGHLY CONTROLLED OR  
18 COMPULSIVE USE, PSYCHOACTIVE EFFECTS, AND  
19 DRUG REINFORCED BEHAVIOR."

20

21 WHAT DOES ALL THAT MEAN?

22 A. WELL, I THINK IT MEANS LESS THAN IT LOOKS LIKE,  
23 BECAUSE "PSYCHOACTIVE EFFECTS" MEANS THAT IT HAS SOME EFFECT  
24 ON HOW YOU FEEL. THE SURGEON GENERAL DECIDED TO TOSS THE  
25 INTOXICATION ISSUE. IN OTHER WORDS, NO LONGER DID A DRUG OF  
26 ADDICTION HAVE TO MAKE YOU INTOXICATED OR MAKE YOU HIGH. AS  
27 LONG AS IT DID ANYTHING THAT WOULD AFFECT HOW YOU FEEL, THAT  
28 WOULD BE GOOD ENOUGH. SO THAT'S THE MIDDLE ONE.

1 THE "HIGHLY CONTROLLED OR COMPULSIVE USE,"  
2 THAT'S TRYING TO CAPTURE THE IDEA THAT THE PERSON FEELS  
3 DRIVEN TO DO THE BEHAVIOR.

4 "COMPULSIVE" IS A WORD THAT IS PROBABLY AS  
5 MESSY AS "ADDICTION," SO IT'S HARD TO KNOW EXACTLY WHAT THAT  
6 IS SUPPOSED TO MEAN, BUT I THINK, GENERALLY, IT MEANS THAT  
7 THE PERSON FEELS URGES AND A DRIVE TO USE.

8 AND THEN YOU HAVE "DRUG-REINFORCED BEHAVIOR,"  
9 WHICH MEANS THAT THE PERSON DOES THINGS IN ORDER TO USE THE  
10 DRUG, BECAUSE THE DRUG IS EXPERIENCED AS POSITIVE, WHICH KIND  
11 OF REPEATS THE PSYCHOACTIVE EFFECTS AND THE COMPULSIVE USE  
12 CRITERIA.

13 Q. NOW, DID THE SURGEON GENERAL IN THIS REPORT  
14 PRETTY MUCH EQUATE ADDICTION WITH DRUG DEPENDENCE AS DEFINED  
15 HERE?

16 A. HE DID.

17 Q. SO THE TWO TERMS ARE THE SAME, ESSENTIALLY?

18 A. RIGHT. SO NOW, YOU HAVE DIFFERENT CRITERIA,  
19 NOT JUST FOR ADDICTION, BUT YOU HAVE DIFFERENT CRITERIA FOR  
20 DRUG DEPENDENCE COMPARING THE '88 REPORT WITH ALL THE DSM  
21 MANUALS THAT CAME OUT.

22 Q. AND THE SURGEON GENERAL FOUND UNDER THIS  
23 CRITERIA NICOTINE WAS A DEPENDENCE-PRODUCING DRUG OR AN  
24 ADDICTIVE DRUG?

25 A. CORRECT.

26 Q. WAS THERE ANYTHING -- WAS THERE ANY NEW  
27 INFORMATION ABOUT THE ADDICTIVE QUALITIES OF NICOTINE BETWEEN  
28 1964 AND 1988 THAT WOULD HAVE QUALIFIED NICOTINE AS AN

1 ADDICTIVE SUBSTANCE?

2 YOU SAID THE 1964 CRITERIA?

3 A. WELL, THIS GETS TO WHAT I WAS SAYING BEFORE  
4 ABOUT, THERE WERE CONCEPTUAL CHANGES ON HOW TO VIEW  
5 ADDICTION, WHICH DID NOT NECESSARILY FORM ANY GREAT  
6 SCIENTIFIC DISCOVERY. THIS IS ACTUALLY AN EXAMPLE OF THAT.

7 AS FAR AS MEETING THE CRITERIA, THERE WAS  
8 ESSENTIALLY NOTHING REALLY NEW BETWEEN THOSE TWO REPORTS THAT  
9 WOULD HAVE CHANGED THE DEFINITION. IN OTHER WORDS, IF YOU  
10 WENT BACK TO 1964 USED THIS 1988 DEFINITION AS USED BY THE  
11 SURGEON GENERAL, NICOTINE WOULD HAVE BEEN ADDICTIVE BACK IN  
12 1964. IT'S JUST THAT THEY WERE USING THE '57 WORLD HEALTH  
13 ORGANIZATION DEFINITION.

14 IF YOU TOOK THE '64 DEFINITION AND APPLIED IT  
15 TODAY IN 2001, THEN NICOTINE WOULD BE NOT ADDICTIVE.

16 SO AGAIN, THAT'S WHY THE DSM EXISTS, BECAUSE  
17 DEPENDING ON HOW YOU DEFINE THINGS, EVERYTHING CHANGES.

18 Q. SO WOULD IT BE FAIR TO SAY THAT IT WASN'T  
19 MEDICAL DEVELOPMENTS OR MEDICAL OR SCIENTIFIC DEVELOPMENTS  
20 THAT CAUSED THE RECLASSIFICATION OF NICOTINE BY THE SURGEON  
21 GENERAL, BUT A CHANGE IN THE CONCEPT OF WHAT ADDICTION IS?

22 A. THAT'S ESSENTIALLY TRUE. THAT DOESN'T MEAN  
23 THAT THERE WASN'T RESEARCH OVER THE YEARS. AND THERE WAS, I  
24 THINK, VERY INFLUENTIAL RESEARCH LOOKING AT RAT BEHAVIOR AND  
25 THEN LOOKING AT CHEMICALS IN THE RAT BRAIN. AND THAT  
26 RESEARCH IN WHICH NICOTINE WAS LOOKED AT AS WELL AS OTHER  
27 DRUGS OF ABUSE, I THINK, WAS VERY INFLUENTIAL IN THE REPORT,  
28 AND YOU CAN READ ABOUT IT IN THE REPORT.

1                   BUT THAT DOESN'T CHANGE -- THAT DOESN'T CREATE  
2 AN EARTH-SHATTERING CHANGE IN HOW PEOPLE BEHAVE AROUND  
3 CIGARETTES. AND PEOPLE ARE BEHAVING THE SAME WAY  
4 IN '64 AS '88; USE TWO DIFFERENT DEFINITIONS TO GET TWO  
5 DIFFERENT CONCLUSIONS.

6           Q.       VERY BRIEFLY, IF YOU CAN, WHAT'S THE RELEVANCE  
7 OF STUDIES REGARDING RATS AND ADDICTION TO HUMANS?  
8                   HOW DO THOSE TWO THINGS RELATE?

9           A.       WELL, TRADITIONALLY, SINCE YOU COULDN'T CHOP  
10 OFF PEOPLE'S HEADS AND SLICE UP THEIR BRAINS AND LOOK AT THEM  
11 AND ANALYZE THEM BIOCHEMICALLY, TEST TUBES AND ANIMAL MODELS  
12 HAVE BEEN USED IN PLACE OF ACTUAL HUMAN BEINGS.

13                   AND WHEN YOU'RE LOOKING AT A BEHAVIORAL  
14 PROBLEM, YOU TRY TO CREATE OR LOOK FOR A MODEL THAT LOOKS  
15 SOMETHING LIKE WHAT PEOPLE DO AND THEN CHOP OFF THE RATS'  
16 HEADS AND SLICE UP THEIR BRAINS AND DO CHEMICAL ANALYSIS.

17                   AND SO THAT WAS ACTUALLY BEING DONE QUITE A BIT  
18 IN THE '80'S. ROY WEISS AND GEORGE KOOB WERE AT THE  
19 FOREFRONT OF THIS RESEARCH AND DEVELOPED KNOWLEDGE ABOUT THE  
20 PRESENCE OF DOPAMINE IN SELF-ADMINISTERED --  
21 SELF-ADMINISTRATION OF DRUGS.

22                   THEIR MODEL WAS, OKAY, WELL, LET'S SEE IF RATS  
23 WILL GIVE THEMSELVES DRUGS IF WE MAKE IT AVAILABLE. AND THEY  
24 FOUND THAT, PARTICULARLY FOR CERTAIN TYPES OF DRUGS, RATS  
25 WOULD READILY CONSUME IT. FOR EXAMPLE, YOU KNOW, COCAINE.  
26 THERE'S NO RAT THAT WON'T TAKE COCAINE. SOME OF THE OTHER  
27 DRUGS, YOU MIGHT HAVE TO KIND OF EASE THEM INTO IT, BUT MAYBE  
28 ULTIMATELY GET THEM TO USE IT.

1                   SO YOU HAVE ALL THESE RATS THAT ARE, YOU KNOW,  
2 DRINKING WATER OR GETTING INJECTIONS AND THAT SORT OF THING,  
3 THEN YOU KILL THEM, CHOP THEM UP, LOOK AT CHEMICALS IN THEIR  
4 BRAIN. AND THEN THEY CAME UP AND SAID, DOPAMINE IS  
5 IMPORTANT, AND ALL OF THESE DRUGS AFFECT DOPAMINE, DOPAMINE  
6 MUST BE THE REASON FOR DRUG ADDICTION.

7                   MR. CARLTON: I THINK THIS IS PROBABLY A GOOD TIME TO  
8 STOP, YOUR HONOR, AND WE' LL RETURN TO THIS SUBJECT WHEN WE  
9 GET BACK.

10                  THE COURT: VERY WELL.

11                         LADIES AND GENTLEMEN, WE' LL SEE YOU AT  
12 3 O' CLOCK.

13                         DON' T DISCUSS THE CASE WITH ANYONE.

14

15                         (RECESS.)

16

17                  THE COURT: ALL RIGHT.

18                         OUR JURY PANEL IS BACK WITH US; OUR COUNSEL ARE  
19 PRESENT WITH US AS WELL; THE WITNESS IS ON THE WITNESS STAND.

20                         YOU MAY BE SEATED.

21                         YOU UNDERSTAND YOU ARE STILL UNDER OATH.

22                  THE WITNESS: I DO.

23                  THE COURT: MS. KEY, I' LL CHAT WITH YOU AT 4: 00.

24                         ALSO, WE WILL BE LEAVING PROMPTLY AT 4: 00.

25 WE DO HAVE ONE JUROR WHO HAS AN APPOINTMENT.

26                         ALL RIGHT. PROCEED.

27                  Q. BY MR. CARLTON: DOCTOR, YOU WERE TELLING US  
28 ABOUT EXPERIMENTS WITH RATS AND HOW THAT INFLUENCED THE 1988

1 SURGEON GENERAL' S REPORT.

2 BUT LET ME ASK YOU THIS: HAS THE CONCEPT OF  
3 ADDICTION CONTINUED TO DEVELOP AFTER THE 1988 SURGEON  
4 GENERAL' S REPORT?

5 A. SURE. IT' S ACTUALLY DEVELOPED QUITE A BIT.

6 Q. IN WHAT WAY?

7 A. WELL, BACK IN THE '80' S, THERE WAS THIS CONCEPT  
8 OF A PLEASURE CENTER OR A PLEASURE PATHWAY AS BEING THE  
9 REASON WHY PEOPLE GOT ADDICTED. AND SINCE THAT TIME, WE' VE  
10 BEEN ABLE TO START DOING RESEARCH ON HUMAN BEINGS WITHOUT  
11 HAVING TO CHOP THEIR HEADS OFF, BECAUSE WE HAVE SCANNERS, WE  
12 CAN DO CAT SCAN, MRI SCANS, PET SCANS. AND WE CAN START  
13 LOOKING AT PEOPLE.

14 AND THERE' S A BIG DIFFERENCE BETWEEN PEOPLE AND  
15 RATS, AS WE ALL KNOW. AND PEOPLE TEND TO HAVE A MUCH BIGGER  
16 BRAIN, ESPECIALLY, THEY HAVE PART OF THEIR BRAIN -- THE FRONT  
17 PART OF THEIR BRAIN, WHICH IS THE PART WHERE PEOPLE HAVE  
18 SELF-AWARENESS, MAKE DECISIONS.

19 SO THERE' S BEEN A LOT OF RESEARCH DONE THAT, BY  
20 THE '90' S, IT WAS CLEAR THAT THAT WAS NOT A PLEASURE PATHWAY.

21 IN THE YEAR 2000, 2001, THE CURRENT THEORIES  
22 HAVE TO DO WITH WHAT KIND OF FRONTAL LOBE PROBLEMS PEOPLE  
23 HAVE. SURE, YOU KNOW, DRUGS, WATER, STRESS, A LOT OF THINGS  
24 INCREASE DOPAMINE, BUT IT DOESN' T EXPLAIN ADDICTION. NOW,  
25 WE' RE LOOKING AT, IN PEOPLE, WHAT MIGHT BE GOING ON IN THE  
26 FRONT PART OF THEIR BRAIN, WHICH RATS HAVE VERY LITTLE OF  
27 ANYWAY, THAT INTERFERES WITH THEM IN THEIR EFFORTS TO QUIT.

28 Q. NOW, WE' VE HEARD IN THIS TRIAL, NOT JUST ABOUT

1 DOPAMINE, BUT ABOUT RECEPTORS IN THE BRAIN.

2 ARE YOU FAMILIAR WITH THAT CONCEPT AND HOW IT  
3 MIGHT RELATE TO ADDICTION?

4 A. WELL, EVERYTHING THAT TAKES PLACE IN THE BRAIN  
5 INVOLVES AT SOME POINT OR ANOTHER CHEMICALS AND RECEPTORS.  
6 AND SO THERE'S NOTHING SPECIFICALLY UNIQUE ABOUT THAT.

7 IF YOU'RE TALKING ABOUT NICOTINE, SURE, THERE'S  
8 LITERATURE ABOUT NICOTINIC RECEPTORS WHICH ARE ACETYLCHOLINE  
9 RECEPTORS THAT NICOTINE BINDS TO, AND THERE ARE CHANGES THAT  
10 HAVE BEEN DEMONSTRATED, ALTHOUGH I THINK, ULTIMATELY, THE  
11 CONCEPT HAS ALWAYS BEEN NOT SO MUCH WHAT'S IMPORTANT ABOUT  
12 THE NICOTINE RECEPTORS BUT HOW THAT IMPACTS ON THIS DOPAMINE  
13 SYSTEM

14 Q. AND YOU'RE TELLING US THAT EVEN THE DOPAMINE  
15 ISSUE IS NOW, WHAT, FADING AWAY OR BEING REPLACED BY  
16 SOMETHING ELSE?

17 A. STEP BY -- THROUGH TWO DIFFERENT STEPS. IT'S  
18 REALLY KIND OF -- IT'S REMAINED IMPORTANT, BUT CLEARLY,  
19 DOESN'T EXPLAIN ADDICTION.

20 Q. DO PSYCHIATRISTS SUCH AS YOURSELF, MENTAL  
21 HEALTH PROVIDERS, RELY ON THE 1988 SURGEON GENERAL'S  
22 DEFINITION OF ADDICTION?

23 A. NOT TO MY KNOWLEDGE, NO.

24 Q. I THINK YOU'VE TOLD US YOU RELY UPON THE DSM IN  
25 EVALUATING MENTAL DISORDERS?

26 A. THAT'S CORRECT.

27 Q. AND DOES THE DSM USE THE TERM "ADDICTION"?

28 A. IT DOESN'T. AS I SAID BEFORE, THE AMERICAN

1 PSYCHIATRIC ASSOCIATION JETTISONED THE TERM IN FAVOR OF  
2 DEPENDENCE. SO THERE'S DRUG DEPENDENCE, NOT DRUG ADDICTION.

3 Q. IS NICOTINE A DEPENDENCE-PRODUCING SUBSTANCE  
4 UNDER THE DSM CRITERIA?

5 A. IT IS.

6 Q. AND DOES THE FACT THAT SOMEONE MIGHT BE  
7 NICOTINE DEPENDENT UNDER THE DSM MEAN THAT THEY CAN'T QUIT  
8 SMOKING?

9 A. ABSOLUTELY NOT.

10 Q. IN YOUR EXPERIENCE, DOES THE FACT THAT YOU  
11 MIGHT BELIEVE SOMEONE OR THAT SOMEONE MIGHT BE ADDICTED TO  
12 SMOKING MEAN THEY CAN'T QUIT?

13 A. NO, IT DOESN'T.

14 Q. HOW MANY PEOPLE LIVING IN THE UNITED STATES  
15 TODAY ARE EX-SMOKERS?

16 A. I BELIEVE THE RECENT CDC ESTIMATE IS  
17 APPROXIMATELY 50 MILLION AMERICANS ARE EX-SMOKERS, FORMER  
18 SMOKERS WHO HAVE QUIT AND HAVE STAYED QUIT.

19 Q. AND HOW MANY OF THOSE QUIT WITHOUT MEDICAL  
20 ASSISTANCE?

21 A. MORE THAN 90 PERCENT ARE NOT INVOLVED IN ANY  
22 KIND OF MEDICAL ASSISTANCE OR ORGANIZED PROGRAM

23 Q. NOW, IN YOUR EXPERIENCE, DOES THAT MEAN IT'S  
24 EASY TO QUIT?

25 A. IT'S ACTUALLY PRETTY VARIABLE. THERE ARE  
26 PEOPLE FOR WHOM THEIR QUITTING INVOLVES MAKING A DECISION,  
27 THROWING CIGARETTES AWAY, ELIMINATING THEM FROM THEIR LIVES,  
28 AND THAT'S THE END OF IT, AND THEY NEVER GO BACK TO IT.

1 AT THE OTHER END OF THE SPECTRUM, YOU HAVE  
2 PEOPLE WHO REQUIRE NUMEROUS ATTEMPTS. AND ON AVERAGE, ABOUT  
3 FIVE ATTEMPTS ARE WHAT THESE EX-SMOKERS WILL TELL YOU IT  
4 TOOK, THE AVERAGE.

5 Q. NOW, IN THE COURSE OF YOUR PRACTICE, HAVE YOU  
6 HEARD PATIENTS SAY, I'D LIKE TO QUIT, BUT I JUST -- I JUST  
7 CAN'T DO IT?

8 A. I HEAR THAT ALL THE TIME.

9 Q. AND AS A PSYCHIATRIST AND AS A SPECIALIST IN  
10 ADDICTION AND PSYCHIATRY, HOW DO YOU INTERPRET THAT PHRASE?

11 A. IT REALLY DEPENDS ON THE PERSON AND THE  
12 CONTEXT. HOPEFULLY, IT MEANS THAT I HAVEN'T QUIT, AND I HAVE  
13 FAILED IN MY EFFORTS TO DO SO, PLEASE HELP ME, I'M ENJOINING  
14 YOU TO HELP ME IN MY NEXT EFFORT.

15 SOMETIMES, PEOPLE USE IT AS A WAY OF  
16 RATIONALIZING THEIR NOT QUITTING. YOU KNOW, USING IT AS AN  
17 EXCUSE OR SOMETHING LIKE THAT. THAT WOULD BE THE LESS  
18 OPTIMISTIC WAY I WOULD HEAR IT.

19 Q. IN YOUR EXPERIENCE, IT'S NOT A PHRASE THAT YOU  
20 CAN ALWAYS TAKE LITERALLY?

21 A. NO. YOU HAVE TO UNDERSTAND THE PERSON.

22 Q. WHAT FACTORS ARE MOST IMPORTANT IN DETERMINING  
23 WHETHER SOMEONE WILL ACTUALLY QUIT A PARTICULAR ADDICTIVE  
24 BEHAVIOR?

25 A. IT'S REALLY AN ISSUE OF MOTIVATION, HOW  
26 MOTIVATED THE PERSON IS TO QUIT AND WHETHER THEY WILL BE  
27 PERSISTENT IN THEIR EFFORTS.

28 YOU HAVE TO MAKE A DECISION. YOU HAVE TO BE

1 MOTIVATED. YOU HAVE TO ENGAGE IN REALLY CHANGING YOUR  
2 LIFESTYLE AND CONTINUE THAT DAY AFTER DAY. THAT'S WHY  
3 ALCOHOLICS ANONYMOUS SAYS, ONE DAY AT A TIME. AND THERE ARE  
4 STUDIES THAT SUGGEST THAT, YOU KNOW, IF YOU QUIT CIGARETTES  
5 FOR THREE MONTHS, YOUR CHANCE OF GOING BACK TO IT ARE  
6 ACTUALLY FAIRLY LOW.

7 SO YOU HAVE TO REALLY, AT LEAST, GUT OUT THE  
8 FIRST THREE MONTHS, IF QUITTING IS HARD FOR YOU.

9 Q. PERSISTENCY. IS THAT, IN YOUR EXPERIENCE,  
10 PRETTY MUCH THE KEY TO QUITTING?

11 A. WELL, SURE. THE WAY I LOOK AT ADDICTION IS,  
12 WHEN SOMEONE IS QUITTING A DRUG OF ABUSE, THEY HAVE TO MAKE A  
13 CHOICE; I DON'T WANT TO LIVE MY WAY THIS WAY, I WANT TO LIVE  
14 MY WAY, A NEW AND DIFFERENT WAY. THAT'S GOING TO REQUIRE  
15 ELBOW GREASE.

16 THE PERSON'S GOING TO HAVE TO ENGAGE IN SOME  
17 TYPE OF PLAN THAT'S GOING TO REQUIRE MAKING CHANGES, AND NONE  
18 OF US LIKE MAKING CHANGES. IT REQUIRES HAVING TO THINK ABOUT  
19 THINGS AND MAKE EFFORT, AND YOU KNOW, THAT'S WHY SUPPORT,  
20 LIKE SUPPORT OF ONE'S FAMILY, CAN BE VERY IMPORTANT, OR  
21 BELONGING TO SOME SORT OF GROUP MAY BE VERY IMPORTANT.  
22 BECAUSE IT'S HARD FOR SOMEONE WHO HAS DIFFICULTY QUITTING.

23 NOW, IF YOU MAKE THE CHOICE TO QUIT ON DAY ONE,  
24 BUT ON DAY THREE, YOU WAKE UP AND YOU SAY, AWE, YOU CAN'T,  
25 IT'S NOT WORTH IT, YOU'RE EFFECTIVE MAKING THE CHOICE TO GO  
26 BACK TO USING. SO YOU REALLY HAVE TO MAKE THE CHOICE EVERY  
27 DAY THAT I'M NOT GOING TO USE, I'M NOT GOING TO DO THIS;  
28 INSTEAD, I'M GOING TO DO THESE OTHER THINGS THAT ARE GOING TO

1 GIVE ME A DIFFERENT LIFE.

2 SO IF, YOU KNOW -- FOR EXAMPLE, WE ALL KNOW  
3 ABOUT NEW YEAR' S EVE RESOLUTIONS. WE ALL THEM MAKE. THEY' RE  
4 COMMON. THERE' S ALL SORTS OF THINGS THAT WE WOULD LIKE TO DO  
5 IN THE NEW YEAR. AND WHEN WE SAY THEM, WE REALLY MEAN THEM  
6 WE REALLY HOPE IT' S GOING TO COME THROUGH.

7 IF YOU' RE TALKING ABOUT, WELL, I' M GOING TO  
8 REALLY EXERCISE THIS YEAR, WELL, IF I DID TWO OR THREE DAYS  
9 OF EXERCISING AND STOP, THEN I HAVEN' T PERSISTED, THEREFORE,  
10 AT THE END OF THE YEAR, DID I REALLY EXERCISE?

11 NO. AND THAT CAME DOWN TO THE MOTIVATION AND  
12 PERSISTENCE. AND I THINK THE SUCCESS RATE OF NEW YEAR' S  
13 RESOLUTIONS ARE NOTORIOUSLY POOR.

14 Q. WELL, WITH REGARD TO ADDICTIVE BEHAVIOR AND  
15 SMOKING IN PARTICULAR, DOES THE CHANCE OF SUCCESS INCREASE  
16 THE MORE ONE KEEPS AT IT OR DOES IT GO DOWN WITH EACH  
17 SUCCESSIVE ATTEMPT?

18 A. IT ACTUALLY INCREASES, BECAUSE EVERY ATTEMPT IS  
19 A LEARNING EXPERIENCE. THE IMPORTANT THING IN TREATMENT IS  
20 THAT IF A PERSON ATTEMPTS AND FAILS, THAT THEY COME BACK TO  
21 THE PERSON WHO' S WORKING WITH THEM AND LEARN WITH HELP OR  
22 WITH A FRIEND WHAT THEY COULD DO DIFFERENTLY, WHAT PROVED TO  
23 BE THE DOWNFALL, WHAT WERE THE ISSUES BEHIND THE FAILURE. SO  
24 THAT IN THE NEXT GO AROUND, SOME OF THOSE HOLES ARE PLUGGED  
25 UP AND THE PERSON RENEWS HIS MOTIVATION TO GO BACK.

26 SO THE TYPICAL PROBLEM IS, IF SOMEONE  
27 DISAPPEARS, YOU KNOW, BECAUSE EITHER THEY FIGURE, YOU KNOW,  
28 IT' S NOT WORTH IT OR WHATEVER. AS LONG -- GENERALLY, WHAT WE

1 TELL OUR PATIENTS IS, IF YOU STICK WITH IT, YOU ARE GOING TO  
2 SUCCEED.

3 Q. LET ME ASK YOU THIS: CAN A PERSON DECIDE, I  
4 DON'T WANT TO STOP SMOKING, I WANT TO KEEP SMOKING, I LIKE  
5 IT?

6 IS THAT A DECISION THAT YOU'VE ENCOUNTERED IN  
7 YOUR PRACTICE?

8 A. SURE. I'VE ENCOUNTERED IT IN AND OUTSIDE OF  
9 THE PRACTICE. IN OTHER WORDS, PEOPLE MAKE DECISIONS ALL THE  
10 TIME ABOUT WHAT THEY CHOOSE TO FIND WORTH IT FOR THEM TO DO.  
11 IT'S A VERY INDIVIDUAL THING. IT REALLY DEPENDS ON THE  
12 PERSON'S VALUES, THEIR DESIRES, THEIR EXPERIENCES, THEIR  
13 COMFORT LEVEL. IT CAN BE A CHOICE THAT SOMEONE ELSE  
14 DISAGREES WITH. IT CAN BE A CHOICE THAT SOMEONE MIGHT SAY IS  
15 CRAZY, YOU KNOW.

16 ONE PERSON'S WONDERFUL WEEKEND OF BUNGE JUMPING  
17 IS ANOTHER PERSON'S WEEKEND OF INSANITY TO DO THAT; YOU'VE  
18 GOT TO BE NUTS TO DO THAT, I WOULD NEVER DO THAT. IT'S NOT  
19 THAT THE PERSON JUMPING OFF THE BRIDGE WITH A BUNGE THINKS  
20 THERE'S NO RISKS. BUT FOR THAT PERSON, WHAT THEY GET OUT OF  
21 DOING IT FOR THAT PERSON IS WORTH IT. AND IT DOESN'T MAKE  
22 THE PERSON INSANE, YOU KNOW, FOR SAYING THAT, YES, THAT'S  
23 WHAT I'M DOING THIS WEEKEND. AND THAT APPLIES TO ANY  
24 DECISION THAT A PERSON MAY MAKE.

25 Q. SO THE DECISION TO KEEP SMOKING IS A DECISION  
26 THAT ONE CAN MAKE, EVEN WITH KNOWLEDGE OF THE HEALTH RISK OF  
27 SMOKING?

28 A. SURE. THERE ARE PEOPLE WHO ARE IN THE PROCESS

1 OF QUITTING, AND THERE ARE PEOPLE WHO HAVE NO INTENTION OF  
2 QUITTING.

3 FOR EXAMPLE, THERE'S A '95 STUDY THAT SHOWED  
4 THAT 40 PERCENT OF SMOKERS IN THE STUDY HAD NO INTENTION OF  
5 QUITTING IN THE FORESEEABLE FUTURE. ANOTHER 40 PERCENT WERE  
6 AMBIVALENT; MEANING, THEY HAD MIXED FEELINGS ABOUT WHETHER  
7 THEY WOULD QUIT. AND THEN 20 PERCENT INTENDED TO QUIT IN THE  
8 NEXT THREE MONTHS. SO IT JUST SHOWS YOU THAT IF YOU TAKE ALL  
9 SMOKERS, THERE ARE GOING TO BE PEOPLE IN ALL OF THESE  
10 DIFFERENT POSSIBILITIES.

11 Q. SO JUST TO MAKE IT CLEAR.

12 IS THERE ANYTHING CHEMICALLY ABOUT NICOTINE  
13 ADDICTION THAT PREVENTS SOMEONE FROM STOPPING SMOKING?

14 A. NO, THERE ISN'T.

15 Q. IS THERE ANYTHING ABOUT NICOTINE THAT EFFECTS A  
16 PERSON'S ABILITY TO MAKE DECISIONS?

17 A. NO, THERE ISN'T. IN FACT, NICOTINE RESEARCH IS  
18 ACTUALLY ON THE UPSWING. NICOTINE'S KNOWN TO IMPROVE  
19 CONCENTRATION AND MEMORY. NICOTINE IS THE SUBJECT OF  
20 RESEARCH IN IMPROVING MEMORY IN ALZHEIMER'S DISEASE, IN  
21 IMPROVING PEOPLE'S STATUS IN PARKINSON'S DISEASE. IT'S  
22 ACTUALLY AN EXCITING COMPOUND THAT'S BEEN STUDIED.

23 Q. IS THERE ANYTHING IN NICOTINE THAT WOULD  
24 PREVENT THE ABILITY OF A SMOKER TO RECEIVE AND UNDERSTAND  
25 INFORMATION --

26 A. NO, NOT ALL.

27 Q. -- ABOUT SMOKING AND HEALTH?

28 A. NO.

1 Q. IS THERE ANYTHING ABOUT NICOTINE THAT WOULD  
2 INTERFERE WITH A SMOKER'S ABILITY TO UNDERSTAND WARNINGS OR  
3 RECOMMENDATIONS THEY RECEIVE FROM THEIR PHYSICIAN ABOUT  
4 SMOKING AND HEALTH?

5 A. NO.

6 Q. IS THERE ANYTHING ABOUT NICOTINE THAT WOULD  
7 INTERFERE WITH A SMOKER'S ABILITY TO LISTEN TO ADVICE FROM  
8 FRIENDS OR FAMILY MEMBERS ABOUT SMOKING?

9 A. NOT INHERENTLY THROUGH ITS CHEMICAL ACTION.

10 YOU MIGHT -- IF SOMEONE HAD JUST QUIT AND THEY  
11 WERE FEELING ANTSY FOR CIGARETTE, THEY MAY BE DISTRACTED, YOU  
12 KNOW, IN THAT 48 HOURS AFTER THEY QUIT. BUT INHERENTLY, THE  
13 PROCESS OF SMOKING ON AN ONGOING BASIS DOES NOTHING TO IMPAIR  
14 HOW THE BRAIN FUNCTIONS, ESPECIALLY THE FRONT PART OF THE  
15 BRAIN THAT REALLY RUNS THE SHOW, MAKES THE DECISIONS,  
16 ANALYZES THINGS AND SO FORTH.

17 Q. NICOTINE DOES NOT IMPAIR THAT PART OF THE  
18 BRAIN?

19 A. IT DOES NOT.

20 Q. WOULD NICOTINE IMPAIR A SMOKER'S ABILITY TO  
21 READ AND UNDERSTAND THE WARNINGS ON THE SIDE OF A CIGARETTE  
22 PACK?

23 A. AGAIN, COMPARED TO DRUGS SUCH AS COCAINE WHERE  
24 THERE'S CLEAR BRAIN DAMAGE AND INTERFERENCE WITH ONE'S  
25 ABILITY TO ANALYZE AND MAKE DECISIONS, THAT IS NOT THE CASE  
26 WITH NICOTINE.

27 Q. NOW, WE'VE HEARD TESTIMONY THAT NICOTINE  
28 ADDICTION MAY CAUSE PEOPLE TO GO INTO DENIAL AND DENY

1 INFORMATION ABOUT THE HEALTH RISKS OF CIGARETTES.

2 DO YOU AGREE OR DISAGREE WITH THAT?

3 A. WELL, I KNOW IT GETS BANDIED ABOUT. MY  
4 EXPERIENCE IS NOT THAT THAT IS THE CASE AT ALL.

5 TYPICALLY, ADDICTS KNOW THAT WHAT THEY'RE DOING  
6 IS NOT A GOOD THING. SUBSEQUENTLY, WHAT ADDICTS USE DENIAL  
7 TO -- DENIAL'S USED BY ALL OF US IN ORDER TO ALLOW US TO KEEP  
8 DOING SOMETHING THAT WE WANT TO DO, EVEN THOUGH THERE MAY BE  
9 NEGATIVES ASSOCIATED WITH IT.

10 WE ALL ARE USING -- EVERY ONE HERE TODAY HAS  
11 BEEN USING DENIAL AT VARIOUS JUNCTURES. IT'S REALLY THE  
12 ABILITY TO NOT THINK ABOUT SOMETHING SO THAT YOU CAN GO ABOUT  
13 YOUR BUSINESS. YOU DON'T WANT TO THINK ABOUT THE BILL  
14 COLLECTORS CALLING YOUR HOUSE WHEN YOU'RE GOING ON A JOB  
15 INTERVIEW, FOR EXAMPLE. SO YOU MIGHT SAY THAT PERSON'S AT  
16 THAT MOMENT IN DENIAL THAT THE BILL COLLECTOR'S AFTER THEM

17 WHAT ADDICTS TYPICALLY ARE IN DENIAL ABOUT IS  
18 THAT THEY ARE ADDICTED. THAT IS THE MOST COMMON USE OF  
19 DENIAL ADDICTS. THE PERSON SAYS, I'M NOT ADDICTED. I CAN  
20 PUT IT DOWN ANY TIME I WANT. THAT'S MOST COMMONLY WHAT  
21 YOU'LL SEE. AND THEN YOU ALSO WILL SEE SOMEONE WHOSE LIFE IS  
22 GOING TO HELL IN A HAND BASKET, BECOMING UNMANAGEABLE AND  
23 THEY DON'T WANT TO LOOK AT ANY OF THAT, AND SAY, AH, NO, YOU  
24 KNOW, IT'S ALL UNDER CONTROL.

25 THE MAIN ISSUE WITH DENIAL AND ADDICTS IS  
26 THEY'RE TRYING TO REMAIN BELIEVING THAT THEY ARE IN CONTROL.  
27 AND THEY DON'T WANT TO COME TO GRIPS WITH THE FACT THAT  
28 THEY'RE NOT IN CONTROL. THEIR LIVES AREN'T IN CONTROL. IT'S

1 UNMANAGEABLE, AND IT HAS TO DO WITH THE DRUG TAKING. THAT'S  
2 WHERE THAT'S -- WHERE DENIAL LIVES AND BREATHS IN ADDICTS.

3 Q. SO IS DENIAL A CHEMICAL REACTION TO ADDICTION?  
4 IS IT AN ARTIFACT OF ADDICTION, OR WHAT IS IT?

5 A. NO. DENIAL IS A NORMAL PSYCHOLOGICAL MECHANISM  
6 THAT'S USED TO COVER YOUR ACTIONS.

7 IN OTHER WORDS, YOU MAY BE HOOKED INTO USING A  
8 PARTICULAR DRUG, AND THE DENIAL ALLOWS YOU TO NOT BE  
9 MISERABLE. I MEAN, IF YOU'RE GOING TO SNORT THE COCAINE, YOU  
10 WANT TO HAVE A GOOD TIME. YOU DON'T WANT TO BE THINKING  
11 ABOUT THE FACT THAT YOU'RE GOING TO GET FIRED THE NEXT  
12 MORNING. THAT'S WHAT DENIAL ALLOWS YOU TO DO. IT'S NOT  
13 CREATED BY A DRUG. WE'RE ALL BORN WITH THE PSYCHOLOGICAL  
14 ABILITY TO USE THAT, AND WE HAVE TO USE IT.

15 Q. NOW, THERE'S BEEN TESTIMONY IN THIS CASE THAT  
16 NICOTINE IS SIMILAR TO HARD DRUGS, SUCH AS HEROIN AND  
17 COCAINE.

18 IN YOUR EXPERIENCE, DOES NICOTINE HAVE THE SAME  
19 EFFECT ON A PERSON'S BEHAVIOR AS THOSE KINDS OF HARD DRUGS  
20 DO?

21 A. WELL, I THINK IT'S PRETTY CLEAR THAT THEY  
22 DON'T. THERE ARE SOME INTERESTING SIMILARITIES THAT HAVE  
23 BEEN DEMONSTRATED IN RESEARCH, BUT, NUMBER ONE, NICOTINE'S  
24 NOT INTOXICATING. THAT'S WHAT THE '64 SURGEON GENERAL WAS  
25 TALKING ABOUT. IT MAY BE PSYCHOACTIVE, LIKE THE '88 SURGEON  
26 GENERAL SAYING -- MEANING IT CAN EFFECT HOW YOU FEEL. I  
27 MEAN, PEOPLE LIKE -- THEY CAN HANDLE STRESS BETTER, OR IT  
28 WILL MAKE THEM MORE ATTENTIVE OR CONCENTRATE.

1                   SO, YES, PSYCHOACTIVE, BUT IT DOES NOT GET YOU  
2 HIGH. IT DOESN'T CHANGE YOUR PERCEPTION OF THE WORLD. IT  
3 DOESN'T LAY YOU FLAT UNTIL YOU RECOVER FROM ITS EFFECTS.  
4 THAT'S, YOU KNOW, THAT'S REALLY FOR STARTERS.

5                   COMING OFF OF IT, YOU KNOW, THE WITHDRAWAL  
6 SYNDROME THAT A THIRD TO A HALF OF PEOPLE WHO COME OFF  
7 CIGARETTES EXPERIENCE IS GENERALLY CONSISTENT WITH GOING TO  
8 WORK. I MEAN, YOU CAN BE QUITTING CIGARETTES AND GOING TO  
9 WORK. YOU CAN'T BE QUITTING A LOT OF DRUGS AND BE GOING TO  
10 WORK. YOU MAY BE IN A HOSPITAL. SO THOSE ARE SOME BASIC  
11 DIFFERENCES.

12                   ALSO, THE KEY THING ABOUT THESE HARD DRUGS OF  
13 ABUSE ARE THAT THE PERSON PERSIST IN THE USING THE DRUGS  
14 UNTIL THEIR LIFE BECOMES WHAT'S REFERRED TO AS UNMANAGEABLE.  
15 THE WHEELS ARE COMING OFF. THEIR WIFE LEFT THEM THEY'VE  
16 LOST THEIR JOB. THE BANK'S FORECLOSING ON THE HOUSE. THE  
17 CAR'S BEEN REPOSSESSED. THE PERSON'S GOT A WARRANT OUT ON  
18 THEM

19                   THAT'S -- YOUR LIFE IS UNMANAGEABLE WITH ALL OF  
20 THAT HAPPENING AT THE SAME TIME. AND IF THAT'S BECAUSE  
21 YOU'RE SO HOOKED INTO USING CRACK, FOR EXAMPLE, YOU KNOW,  
22 THAT'S A WHOLE DIFFERENT STORY THAN IF YOU'RE TRYING TO QUIT  
23 SMOKING.

24                   Q.       SO JUST TO SUMMARIZE, THEN, NICOTINE, UNLIKE  
25 HARD DRUGS, IS NOT INTOXICATING, UNLIKE HARD DRUGS, THE  
26 WITHDRAWAL SYMPTOMS OF NICOTINE ARE RELATIVELY MILD.

27                               WOULD THAT BE FAIR TO SAY?

28                   A.       THAT WOULD BE FAIR TO SAY.

1 Q. AND UNLIKE HARD DRUGS, NICOTINE DOES NOT MAKE  
2 YOUR LIFE UNMANAGEABLE?

3 A. THAT'S TRUE.

4 Q. LET'S LOOK AT INTOXICATION FOR JUST A MINUTE  
5 HERE.

6 INTOXICATION AFFECTS A PERSON'S ABILITY TO  
7 RECEIVE AND UNDERSTAND INFORMATION, DOESN'T IT?

8 A. WELL, THE WHOLE ISSUE WITH INTOXICATION IS THAT  
9 THE DRUG'S NOT JUST AFFECTING YOUR DOPAMINE RECEPTORS. THE  
10 DRUG IS HAVING DIRECT EFFECTS ON YOUR WHOLE FRONTAL LOBE.  
11 YOUR ABILITY TO THINK, TO MAKE JUDGMENTS, TO PLAN AND CARRY  
12 OUT YOUR PLANS IS DIRECTLY AFFECTED BY THE INTOXICATION. HOW  
13 YOU PERCEIVE REALITY IS DIRECTLY AFFECTED BY THE  
14 INTOXICATION.

15 Q. AND NICOTINE DOESN'T INTOXICATE A PERSON?

16 A. NO, IT DOESN'T.

17 Q. WELL, IS THERE A DIFFERENCE IN THE WAY THAT YOU  
18 TREAT PEOPLE WHO ARE ADDICTED TO HARD DRUGS AS OPPOSED TO  
19 YOUR TREATMENT OF PEOPLE WHO ARE ADDICTED TO NICOTINE?

20 A. WELL, SURE.

21 FIRST OF ALL, EVEN THOUGH HARD DRUG USERS QUIT  
22 ALL THE TIME, ABOUT 40 PERCENT OF HARD DRUG USERS WILL  
23 REQUIRE MEDICAL ASSISTANCE IN A PROGRAM AS COMPARED TO LESS  
24 THAN 10 PERCENT OF SMOKERS. SO WHEN SOMEONE PRESENTS --  
25 WHETHER IT'S FOR ONE OR THE OTHER. I MEAN, ISSUES HAVE TO BE  
26 CONSIDERED LIKE, DOES A PERSON NEED TO GO INTO THE HOSPITAL  
27 AND BE DETOXED MEDICALLY. YOU WOULDN'T DO THAT WITH A PERSON  
28 WHO'S TRYING TO QUIT CIGARETTES.

1                   DOES THE PERSON HAVE SOME SEVERE DRUG-INDUCED  
2 MENTAL PROBLEM LIKE THEY'RE NUTS, THEY'RE PARANOID, THEY'RE  
3 SEEING OR HEARING THINGS. IT'S NOT A CONSIDERATION IF YOU'RE  
4 EVALUATING A SMOKER.

5                   GENERALLY, YOU'LL HAVE TO CONSIDER WHETHER TO  
6 SEQUESTER SOMEONE WHO'S COMING DOWN OFF OF SOMETHING LIKE  
7 CRACK, JUST TO LIMIT THE CRACK, THAT THEY'RE GOING TO RUN OUT  
8 THERE AND USE. SO TRY TO GET THEM IN A DRUG-FREE  
9 ENVIRONMENT.

10                  GENERALLY, YOU'RE GOING TO HELP A SMOKER QUIT  
11 IN THE CONTEXT OF THEIR JOB, THEIR LIFE, THEIR FAMILY, THAT  
12 SORT OF THING. AND GENERALLY, YOU KNOW, WHILE THERE ARE  
13 CERTAINLY HEALTH RAMIFICATIONS ASSOCIATED WITH SMOKING, YOU  
14 GENERALLY DON'T NEED SOCIAL, WORK INTERVENTIONS TO DEAL WITH  
15 WARRANTS AND EMPLOYMENT AND THAT SORT OF THING. SO IT'S A  
16 DIFFERENT PICTURE.

17                  Q.       IS THERE A WITHDRAWAL SYNDROME FOR NICOTINE?

18                  A.       THERE IS. IT'S ACTUALLY DEFINED WITH CRITERIA  
19 IN THE DSM

20                  Q.       I'M LOOKING AT PAGE 244, DSM-IV.

21                            IS THIS THE MOST CURRENT VERSION OF THE DSM?

22                  A.       IT IS.

23                  Q.       AND IT SAYS, "DIAGNOSTIC CRITERIA FOR" -- AND  
24 THEN THERE'S A NUMBER -- "NICOTINE WITHDRAWAL."

25                            IS THAT NUMBER THE REFERENCE THAT PSYCHIATRISTS  
26 USE IN --

27                  A.       IT'S A DIAGNOSTIC CODE NUMBER.

28                  Q.       ALL RIGHT. AND THEN IT LISTS SEVERAL CRITERIA

5644

1 FOR NICOTINE WITHDRAWAL. LET'S SEE IF I CAN GET THIS A  
2 LITTLE LARGER HERE.

3 THE FIRST ONE (READING):

4

5 "DAILY USE OF NICOTINE FOR AT  
6 LEAST SEVERAL WEEKS. "

7 AND THEN B, "ABRUPT CESSATION  
8 OF NICOTINE USE, OR REDUCTION IN THE AMOUNT  
9 OF NICOTINE USED, FOLLOWED WITHIN 24 HOURS BY  
10 4 (OR MORE) OF THE FOLLOWING SIGNS:

11 "DYSPHORIC OR DEPRESSED MOOD.

12 "INSOMNIA, IRRITABILITY,  
13 FRUSTRATION OR ANGER.

14 "ANXIETY.

15 "DIFFICULTY CONCENTRATING. "

16

17 THEN IT'S CONTINUED UP HERE, THREE OTHERS  
18 (READING):

19

20 "RESTLESSNESS.

21 "DECREASED HEART RATE. "

22 AND "INCREASED APPETITE OR  
23 WEIGHT GAIN. "

24

25 NOW, IS IT CORRECT THAT UNDER THE CRITERIA THAT  
26 YOU AS A PSYCHIATRIST AND OTHER MENTAL HEALTH PROVIDERS USE,  
27 A PERSON WILL, IF THEY'RE TO BE DIAGNOSED AS HAVING NICOTINE  
28 WITHDRAWAL, HAVE TO EXPERIENCE FOUR OR MORE OF THESE THINGS?

1           A.       IF YOU'RE GOING TO STICK WITH THAT  
2 CLASSIFICATION. IF YOU WANT TO SAY, THIS PERSON HAS DSM-IV  
3 NICOTINE WITHDRAWAL AND KNOW THAT THE OTHER PERSON HAS AN  
4 IDEA OF WHAT YOU'RE TALKING ABOUT.

5           Q.       ALL RIGHT. NOW, IN YOUR EXPERIENCE -- OR JUST  
6 TELL US, HOW LONG DO THESE SYMPTOMS OF WITHDRAWAL NORMALLY  
7 LAST?

8           A.       WELL, FIRST OF ALL, THEY MAY NOT OCCUR AT ALL.  
9 THAT'S SORT OF A PREFACE. DEPENDING ON THE STUDY, ONE-THIRD  
10 OR ONE HALF OF PEOPLE WHO QUIT WILL EXPERIENCE SIGNIFICANT  
11 WITHDRAWAL.

12                   NOW, IF THEY DO EXPERIENCE WITHDRAWAL AS  
13 DEFINED, THAT GENERALLY IS GOING TO PEAK AT ABOUT A WEEK,  
14 MAYBE TWO. AND GENERALLY, BY A MONTH'S TIME, THE PERSON HAS  
15 RETURNED TO NORMAL.

16           Q.       DO YOU KNOW WHAT IS THE HALF LIFE OF NICOTINE  
17 IN THE BODY?

18           A.       IN TWO HOURS, HALF OF ALL THE NICOTINE THAT'S  
19 IN YOUR BODY WILL LEAVE YOUR BODY, WHICH LEAVES YOU WITH  
20 HALF. AND IF YOU KEEP TAKING IT, HALF OF THAT, AND HALF OF  
21 THAT. GENERALLY, OVER FIVE OF THOSE TWO-HOUR HALF LIVES, OR  
22 TEN HOURS, NICOTINE'S ESSENTIALLY GONE FROM THE BODY.

23           Q.       OKAY. NOW, ONE OF THE CRITERIA THAT WE SAW IN  
24 THE DSM WAS A DYSPHORIC OR DEPRESSED MOOD.

25                   WHAT IS THAT?

26           A.       FOR SOME PEOPLE WHO ARE QUITTING WHO HAVE  
27 WITHDRAWAL SYMPTOMS, THEY'RE NOT HAPPY. YOU KNOW, DYSPHORIA  
28 MEANS YOU'RE NOT HAPPY. YOU'RE NOT HAVING A GOOD DAY. YOU

1 KNOW, FEELING DEPRESSED MEANS A LITTLE BIT MORE LIKE MAYBE  
2 YOU'RE FEELING DOWN.

3 Q. WELL, GENERALLY, DOES THAT DISAPPEAR WITH THE  
4 OTHER SYMPTOMS WITHIN A FEW WEEKS?

5 A. NO.

6 Q. AT LEAST INSOFAR AS IT'S RELATED TO NICOTINE?

7 A. THEY TEND TO ALL RUN THAT COURSE PERHAPS WITH  
8 THE EXCEPTION OF THE WEIGHT GAIN ISSUE. PEOPLE -- PEOPLE WHO  
9 QUIT SMOKING OFTEN PUT ON SOME WEIGHT OVER THE FIRST YEAR  
10 THAT THEY QUIT AND THEN STABILIZE. AND STATISTICALLY,  
11 SMOKERS ARE ABOUT FIVE POUNDS OR SEVEN POUNDS, SOMETHING LIKE  
12 THAT, THINNER AS A GROUP THAN NONSMOKERS.

13 Q. NOW, YOU'VE SAID THAT BETWEEN 30 AND 50 PERCENT  
14 OF SMOKERS WILL EXHIBIT THESE WITHDRAWAL SYMPTOMS.

15 CAN YOU PREDICT WHICH SMOKERS WILL HAVE THESE  
16 SYMPTOMS?

17 A. NO. THERE'S ACTUALLY BEEN QUITE A LOT OF  
18 RESEARCH, BECAUSE IT'S ALWAYS BEEN OF INTEREST GOING BACK TO  
19 THE LATE '70'S AND '80'S TO BE ABLE TO PREDICT WHO IS GOING  
20 TO HAVE WITHDRAWAL, WHO IS GOING TO HAVE THE MOST DIFFICULTY  
21 QUITTING WITH NICOTINE REPLACEMENT THERAPY, WHO SHOULD BE  
22 GIVEN NICOTINE REPLACEMENT THERAPY.

23 AND THE RESEARCH HAS DEMONSTRATED VERY CLEARLY  
24 THAT YOU CAN'T PREDICT WHO IS OR WHO ISN'T GOING TO HAVE  
25 WITHDRAWAL. THAT IT HAS REALLY NOTHING TO DO WITH THE  
26 HEAVINESS OF THE SMOKING OR HOW MANY CIGARETTES SOMEONE  
27 SMOKES. IT TENDS TO BE A VERY INDIVIDUAL THING THAT CAN'T BE  
28 PREDICTED.

1                   AND IT SEEMS TO -- WITHDRAWAL IN AND OF ITSELF  
2 SEEMS TO HAVE NO PREDICTIVE VALUE IN WHO'S GOING TO SUCCEED  
3 IN QUITTING. SO ALL BETS ARE OFF. YOU DON'T KNOW WHO'S  
4 GOING TO HAVE WITHDRAWAL. THE GUY WHO'S SMOKING THREE PACKS  
5 MAY NOT HAVE WITHDRAWAL, AND THE GUY WHO'S SMOKING ONE PACK  
6 MAY HAVE SEVERE WITHDRAWAL IN TERMS OF THOSE SYMPTOMS.

7                   ON THE OTHER HAND, THE GUY WITH THE SEVERE  
8 WITHDRAWAL, HE MAY BE THE ONE WHO SUCCEEDS. SO, REALLY, ALL  
9 BETS ARE OFF.

10                  Q.        SO ARE YOU SAYING THAT THE SEVERITY OF  
11 WITHDRAWAL DOESN'T CORRELATE WITH SUCCESS RATES?

12                  A.        NO. IN FACT, I WAS LOOKING AT DR. KOOB'S S  
13 WEBSITE, AND HE SAID 2 TO 9 PERCENT OF PEOPLE WHO RELAPSE  
14 RELAPSED BECAUSE OF WITHDRAWAL. SO THAT'S ACTUALLY A VERY  
15 SMALL NUMBER, IF YOU THINK ABOUT IT. YOU HAVE 100 PEOPLE WHO  
16 RELAPSE AND LESS THAN 10 OF THEM RELAPSE BECAUSE OF THE  
17 WITHDRAWAL SYMPTOMS.

18                  HE FOCUSES MORE ON PEOPLE, YOU KNOW, AT ANY  
19 POINT IN THEIR LIFE GETTING STRESSED OR HAVING EMOITIONAL  
20 DISTRESS AND THEN FALLING BACK ON OLD HABITS.

21                  Q.        A FALLING BACK ON OLD HABITS AS OPPOSED TO  
22 RESPONDING TO SOME CHEMICAL?

23                  A.        YEAH. AS OPPOSED TO THE IDEA THAT THEY'RE  
24 CONTROLLED BY A CHEMICAL.

25                  Q.        WELL, JUST TO SUM UP, HOW DO WITHDRAWAL  
26 SYMPTOMS OF NICOTINE COMPARE TO WITHDRAWAL SYMPTOMS OF HARD  
27 DRUGS?

28                  A.        WELL, IF SOMEONE'S HAVING WITHDRAWAL FROM

1 NICOTINE, THEY' RE NOT GOING TO BE HAPPY, BUT THEY' RE PROBABLY  
2 GOING TO BE GOING WORK. THEY MAY BE A PAIN TO THEIR FAMILY,  
3 BUT THEY' RE GENERALLY NOT GOING TO BE MOVED TO VIOLENCE.

4 AND YOU KNOW, WHEN YOU HAVE SOMEONE COMING OFF  
5 OF HARD DRUGS, THEY MAY BECOME SO ILL THEY NEED TO GO TO THE  
6 EMERGENCY ROOM AND THEY MAY ACTUALLY LOSE TRACK OF REALITY  
7 BECAUSE OF THE WITHDRAWAL AND START TO BECOME PARANOID OR SEE  
8 THINGS. SO I' M JUST SORT OF GIVING YOU SOME OF THE THINGS  
9 THAT YOU HAVE TO BE CAUTIOUS ABOUT WHEN SOMEONE' S IN  
10 WITHDRAWAL.

11 Q. DO YOU KNOW WHETHER MR. BOEKEN EXPERIENCED ANY  
12 WITHDRAWAL SYMPTOMS AS A RESULT OF QUITTING SMOKING?

13 A. HE HAD A NUMBER OF THE ONES THAT WERE ON THAT  
14 LIST. AS I RECALL, HE TALKED ABOUT BEING HUNGRY, SWITCHING  
15 TO EATING CHIPS INSTEAD OF SMOKING. HE WAS ANXIOUS,  
16 RESTLESS. THOSE SORT OF COMPLAINTS. SO HE DID EXPERIENCE  
17 WITHDRAWAL.

18 Q. AND FOR WHAT PERIOD OF TIME, DO YOU KNOW THAT?

19 A. WELL, YOU KNOW, TYPICALLY, IT' S DAYS TO A  
20 COUPLE WEEKS. I BELIEVE MR. BOEKEN IMPLIED THAT HE DIDN' T  
21 FEEL RIGHT AT THE END OF A MONTH OR FIVE WEEKS, ALTHOUGH I  
22 WASN' T ABLE TO GET EXACTLY WHAT SYMPTOMS HE WAS FEELING AT  
23 WHAT POINT, AND THAT JUST TURNED OUT TO BE TOO DETAILED. BUT  
24 HE CLAIMS HE WASN' T FEELING RIGHT AT THE END OF A MONTH,  
25 WHICH WOULD BE PRETTY UNUSUAL.

26 Q. I WANT TO RETURN JUST FOR A MINUTE TO THE ISSUE  
27 OF HOW NICOTINE EFFECTS THE BRAIN.

28 YOU MENTIONED YOU TALKED A BIT ABOUT DOPAMINE

1       RELEASE.  YOU TALKED A BIT, AND WE'VE HEARD A LITTLE BIT  
2       ABOUT RECEPTORS.

3                       DOES ANY OF THIS MEAN THAT PEOPLE WHO ARE  
4       ADDICTED TO NICOTINE CAN'T QUIT?

5               A.       NO.  IT JUST MEANS THAT WE HAVE KNOWLEDGE ABOUT  
6       CERTAIN CHEMICAL FINDINGS IN SMOKERS.  FOR EXAMPLE, WE KNOW  
7       THEIR NICOTINE RECEPTORS ARE UP REGULATED.  BUT THE  
8       50 MILLION PEOPLE WHO QUIT SMOKING HAD ALL UP-REGULATED  
9       NICOTINE RECEPTORS.  YOU'RE NOT GOING TO SAY BECAUSE YOUR  
10      NICOTINE RECEPTORS ARE UP REGULATED, YOU CAN'T QUIT.  THAT  
11      DOESN'T FOLLOW

12                    SO I THINK IT'S OF INTEREST.  IT HELPS US TO  
13      UNDERSTAND HOW TO DEVELOP NEW TREATMENTS.  FOR EXAMPLE,  
14      NICOTINE REPLACEMENT THERAPY CAME OUT OF RESEARCH.  WE'RE  
15      ALWAYS LOOKING FOR UNDERSTANDINGS TO HELP US WITH TREATMENT.  
16      THAT'S REALLY WHAT IT'S ABOUT.

17                    AND YOU KNOW, WE KNOW HOW SMOKERS BEHAVE.  I  
18      MEAN, THAT'S NOTHING NEW.  PEOPLE HAVE BEEN SMOKING FOR QUITE  
19      A WHILE.  WE KNOW THAT.  THAT, YOU CAN SEE WITH A NAKED EYE.  
20      THAT'S REALLY THE GOLD STANDARD IN TERMS OF UNDERSTANDING  
21      SMOKING.

22               Q.       DOES ANY OF THAT EFFECT YOUR OPINION THAT IT IS  
23      MOTIVATION AND PERSISTENCE THAT ARE THE KEYS TO QUITTING  
24      ADDICTIVE BEHAVIOR, INCLUDING SMOKING?

25               A.       WELL, KNOWING SMOKERS, KNOWING ADDICTS, THAT  
26      INFORMS ME THAT MOTIVATION AND PERSISTENCE IS THE KEY.  
27      KNOWING ABOUT RECEPTORS ONE WAY OR THE OTHER, THAT DOESN'T  
28      CHANGE THAT.

- 1 Q. LET' S TURN NOW TO MR. BOEKEN, IF WE COULD.  
2 YOU MENTIONED THAT YOU MET WITH HIM, YOU  
3 EVALUATED HIM, YOU REVIEWED VARIOUS MATERIALS RELATED TO HIM  
4 A. THAT' S CORRECT.  
5 Q. AND AMONG THE THINGS THAT YOU SAID YOU REVIEWED  
6 WERE A REPORT BY A DR. BINDER, CORRECT?  
7 A. DR. MARTIN BINDER, A PSYCHIATRIST.  
8 Q. AND WHO IS DR. BINDER?  
9 A. HE' S A FORENSIC PSYCHIATRIST WHO I BELIEVE WAS  
10 RETAINED BY THE PLAINTIFF TO DO A SIMILAR EXAMINATION AS THE  
11 ONE THAT I DID.  
12 Q. ALL RIGHT. AND DID YOU YOURSELF USE THE  
13 CRITERIA THAT WE JUST SAW IN THE DSM TO MAKE A DIAGNOSIS AS  
14 TO WHETHER MR. BOEKEN IS NICOTINE DEPENDENT?  
15 A. YES.  
16 Q. WHAT IS YOUR OPINION?  
17 A. MY OPINION IS THAT MR. BOEKEN IS NICOTINE  
18 DEPENDENT.  
19 Q. AND IN YOUR OPINION, DOES THAT EQUATE WITH  
20 ADDICTION?  
21 A. IT DOES.  
22 Q. ALL RIGHT. ARE YOU FAMILIAR, BASED ON YOUR  
23 MEETINGS WITH MR. BOEKEN AND YOUR REVIEW OF THESE MATERIALS,  
24 WITH THE VARIOUS EFFORTS HE SAYS THAT HE MADE TO QUIT  
25 SMOKING?  
26 A. I AM  
27 Q. AND I' D LIKE TO PUT UP A DEMONSTRATIVE AT THIS  
28 POINT, PLEASE.

1 IS THIS A DEMONSTRATIVE THAT YOU'VE HAD MADE?

2 A. YES. IT'S A DEMONSTRATIVE THAT I REQUESTED  
3 THAT YOU HAVE SET UP FOR ME.

4 Q. AND WHAT DOES IT ILLUSTRATE?

5 A. IT ILLUSTRATES THE VARIOUS EFFORTS OVER THE  
6 YEARS THAT MR. BOEKEN MADE TOWARD NOT SMOKING -- QUITTING  
7 SMOKING.

8 MR. CARLTON: MR. CLERK, WHAT IS THE NEXT IN ORDER?

9 THE CLERK: IT'S 08. 11108.

10 MR. CARLTON: 11108. THANK YOU.

11

12 (I. D. 11108 - DEMONSTRATIVE)

13

14 Q. BY MR. CARLTON: SO LOOKING AT THIS, IS IT  
15 CORRECT THAT MR. BOEKEN MADE A QUIT ATTEMPT IN 1967?

16 A. YES. HE REPORTS THAT HE STOPPED SMOKING FOR A  
17 PERIOD OF THREE OR FOUR WEEKS IN ORDER TO BE WITH A GIRL THAT  
18 HE TOOK FANCY TO WHO WAS ANTISMOKING AND REQUIRED THAT HE NOT  
19 SMOKE IF HE WANTED TO BE WITH HER. AND WHATEVER HAPPENED  
20 OVER THE COURSE OF THE THREE OR FOUR WEEKS, HE WENT BACK TO  
21 THE SMOKING, AND THE GIRL WENT SOMEWHERE ELSE.

22 Q. AND DO YOU KNOW HOW HE WAS ABLE TO DO IT?

23 A. HE DID IT COLD TURKEY, LIKE VIRTUALLY ALL  
24 PEOPLE WHO QUIT.

25 Q. OKAY. IS THERE A CRITERION THAT YOU APPLY THAT  
26 MENTAL HEALTH PROVIDERS APPLY IN EVALUATING WHETHER A QUIT  
27 ATTEMPT IS A SERIOUS QUIT ATTEMPT OR NOT?

28 A. WELL, THERE IS A DEFINITION IN THE NICOTINE

1 RESEARCH LITERATURE THAT SUGGESTS THAT A SERIOUS QUIT ATTEMPT  
2 INVOLVES BEING OFF CIGARETTES FOR AT LEAST 24 HOURS. THAT  
3 REALLY IS QUITE DIFFERENT FROM WHAT IS USED FOR OTHER DRUGS  
4 OF ABUSE.

5 IN ORDER TO RELAPSE TO OTHER DRUGS OF ABUSE, A  
6 PERSON'S GOING TO HAVE TO BE OFF THE DRUGS FOR A SIGNIFICANT  
7 PERIOD OF TIME, OFTEN ONE, TWO, THREE, FOUR MONTHS. SO  
8 IT'S -- IT DOESN'T TAKE MUCH TO MAKE A SERIOUS QUIT ATTEMPT  
9 AS A SMOKER, BUT IT REQUIRES AT LEAST 24 HOURS OFF  
10 CIGARETTES.

11 Q. OKAY.

12 A. THAT'S THE DEFINITION.

13 Q. ARE THERE OTHER FACTORS THAT YOU LOOK AT IN  
14 EVALUATING WHETHER A QUIT ATTEMPT IS A SERIOUS MOTIVATED QUIT  
15 ATTEMPT?

16 A. WELL, YOU TAKE A LOOK AT WHAT HAPPENS AFTER  
17 THEY STOP SMOKING, AFTER THEY PUT THE CIGARETTE DOWN.

18 FOR EXAMPLE, HAVE THEY SET UP THE SUPPORT OF  
19 THE PEOPLE AROUND THEM, THE PEOPLE THEY LIVE WITH. HAVE  
20 CIGARETTES BEEN REMOVED FROM THE HOME?

21 IS THE PERSON WORKING WITH A PROFESSIONAL?

22 DO THEY KEEP UP WITH A PROFESSIONAL WITH  
23 FOLLOW-UP APPOINTMENT OR PHONE CALLS?

24 YOU REALLY WANT TO SEE WHAT THE PERSON'S  
25 ACTUALLY DOING. YOU KNOW, THERE'S A SAYING IN ADDICTION  
26 TREATMENT THAT TALK IS CHEAP. THAT IT DOESN'T MATTER WHAT  
27 THE PERSON SAYS; IT MATTERS WHAT THE PERSON DOES.

28 AND SO YOU LOOK AT WHAT THE PERSON DOES IN

1 TERMS OF PREPARING AND EXECUTING THEIR PLAN, AND IF THEY'RE  
2 PERSISTENT, THEN YOU HAVE TO FIGURE THAT AS MUCH MOTIVATION  
3 THAT THEY MAY HAVE HAD ON DAY ONE, MAYBE THAT MOTIVATION  
4 WANED AND THEY JUST GAVE IT UP.

5 Q. OKAY. AND WOULD YOU CHARACTERIZE THIS AS A  
6 SERIOUS QUIT ATTEMPT, 1967?

7 A. WELL, IT WOULD, BY DEFINITION, BECAUSE IT WAS  
8 MORE THAN 24 HOURS OFF CIGARETTES.

9 Q. OKAY. WHAT DO WE KNOW ABOUT HIS EFFORTS IN  
10 1974 AND 1976?

11 A. ACTUALLY, QUITE LITTLE. MR. BOEKEN REPORTS  
12 THAT HE DID QUIT, BUT HE WAS UNABLE TO RECALL, FOR EXAMPLE,  
13 HOW LONG, SO I PROBABLY WOULDN'T VENTURE A GUESS.

14 I KNOW THAT THOSE ATTEMPTS OCCURRED DURING A  
15 TIME IN WHICH HE WAS HAVING SERIOUS PROBLEMS WITH ALCOHOL AND  
16 DRUGS. THAT'S ONE OF THE BIGGEST BARRIERS TO QUITTING THAT  
17 WE KNOW OF. THE PEOPLE WHO CONTINUE TO DRINK DO NOT STOP  
18 SMOKING, AND THAT'S BEEN IN THE LITERATURE. THAT'S CLINICAL  
19 EXPERIENCE. SO WHATEVER WAS GOING ON IN '74 AND '76, I  
20 SUSPECT IT WAS DOOMED BECAUSE OF THE SUBSTANCE ABUSE.

21 Q. OKAY. JUST -- AND STOPPING AT THAT POINT FOR  
22 JUST A MINUTE.

23 YOU SAY PEOPLE WHO CONTINUED TO DRINK DO NOT  
24 STOP SMOKING. WHAT ABOUT PEOPLE WHO STOP DRINKING?

25 ARE YOU FAMILIAR WITH?

26 A. PEOPLE WHO STOP DRINKING ARE ABLE TO STOP  
27 SMOKING. AND THE MOST RECENT LITERATURE SUGGESTED THAT YOU  
28 CAN STOP IT ALL AT THE SAME TIME. IT USED TO BE BELIEVED

1 THAT, WELL, YOU COULD ONLY DO ONE THING AT A TIME. AND SINCE  
2 THE ALCOHOL IS A MORE SERIOUS ADDICTION, PUT ALL YOUR EFFORTS  
3 INTO THE ALCOHOL, SMOKE TO YOUR HEART'S CONTENT, MAYBE YOU'LL  
4 DO THAT LATER, OR MAYBE YOU WOULDN'T.

5 NOWADAYS, WHAT'S COMMON IN TREATMENT PROGRAMS  
6 IS THEY GET THE SMOKING CESSATION WHEN THEY GO IN FOR THE  
7 ALCOHOL TREATMENT. AND THE SUCCESS RATES FOR THE ALCOHOL IS  
8 THE CIGARETTES ARE JUST AS GOOD AS, YOU KNOW, OTHER WAYS OF  
9 DOING IT.

10 SO THAT'S ONE ASPECT OF IT.

11 ANOTHER ASPECT IS THAT IF SOMEONE HAS DONE  
12 WHATEVER IT TOOK TO GET CLEAN FROM DRUGS AND ALCOHOL, THEY'VE  
13 DEMONSTRATED THAT THEY CAN QUIT A HIGHLY ADDICTIVE SUBSTANCE  
14 AND THAT THEY'VE ALREADY GONE THROUGH THE EXPERIENCE OF BEING  
15 MOTIVATED AND PERSISTENT AND DONE WHATEVER IT TOOK TO CHANGE  
16 THEIR LIFESTYLE TO A CLEAN LIFESTYLE.

17 Q. WOULD IT BE FAIR TO SAY THAT THE PEOPLE WHO  
18 HAVE SUCCEEDED IN KICKING A DRUG OR ALCOHOL HABIT HAVE SORT  
19 OF SELFSELECT THEMSELVES AS BEING MORE LIKELY TO SUCCEED IN  
20 QUITTING SMOKING?

21 A. WELL, IT CERTAINLY TELLS YOU THAT THEY HAVE THE  
22 CAPACITY. YOU KNOW, WHAT THAT PERSON'S DECISION IS ABOUT  
23 WHETHER THEY WANT TO QUIT OR NOT, YOU'D HAVE TO ASK THE  
24 PERSON.

25 AS I SAID, THERE ARE LOTS OF PEOPLE WHO DON'T  
26 HAVE AN INTENTION OF QUITTING ANY TIME SOON. SO IT REALLY  
27 DEPENDS ON THE INDIVIDUAL.

28 Q. OKAY. 1980. WHAT DID MR. BOEKEN DO THERE?

1           A.       WELL, MY UNDERSTANDING IS THAT IN 1980,  
2 MR. BOEKEN'S SISTER HAD A DISCUSSION WITH HIM AFTER HAVING  
3 BEEN TALKED TO HER BY HER DOCTOR ABOUT LUNG CANCER AND OTHER  
4 HEALTH RISKS OF SMOKING, AND SHE WAS QUITE CONCERNED ABOUT  
5 IT, DISCUSSED IT WITH HER BROTHER RICHARD, SUGGESTED THAT HE  
6 QUIT, SAID THAT THEY WANTED TO QUIT. AND ACTUALLY, THEY BOTH  
7 WENT TOGETHER TO QUIT BY GOING TO A HYNOSIS. THEY WERE  
8 HYPNOTIZED, AND MR. BOEKEN SAYS HE WAS OFF CIGARETTES FOR  
9 ABOUT FIVE WEEKS AFTER THAT.

10           Q.       SERIOUS QUIT ATTEMPT?

11           A.       BY DEFINITION.

12           Q.       DO WE HAVE ANY INFORMATION AS TO WHY HE  
13 RELAPSED?

14           A.       I BELIEVE THAT MR. BOEKEN CARRIED FORWARD FROM  
15 HIS DISCUSSION OF '67 THAT HE WASN'T FEELING RIGHT AND THAT'S  
16 WHY HE WENT BACK TO SMOKING. BUT IT'S NOT VERY SPECIFIC.

17           Q.       OKAY. AND THEN YOU'RE FAMILIAR WITH HIS  
18 ATTENDING A SMOKENDERS PROGRAM FOR A PERIOD OF TIME?

19           A.       YES. HE REPORTS THAT HE WENT TO THE COURSE.  
20 IT LASTED MAYBE TWO OR THREE WEEKS. HE COMPLETED THE COURSE.  
21 DIDN'T CUT DOWN ON HIS SMOKING. DIDN'T STOP FOR ANY PERIOD  
22 OF TIME. TECHNICALLY, WOULD NOT BE A SERIOUS QUIT ATTEMPT.  
23 OBVIOUSLY, HE HAD AN INTEREST IN QUITTING, OTHERWISE, HE  
24 WOULDN'T HAVE GONE. BUT HE CLEARLY HAD MIXED FEELINGS ABOUT  
25 THE ACTUAL QUITTING.

26           Q.       SMOKERS ANONYMOUS.

27           A.       SIMILAR, IN THAT MR. BOEKEN SAYS THAT HE WENT,  
28 WENT MAYBE ONCE A WEEK FOR MAYBE EVEN A FEW YEARS. NEVER CUT

1 DOWN. NEVER STOPPED FOR ANY PERIOD OF TIME. AGAIN, CLEARLY  
2 SOME DESIRE, BUT MIXED FEELINGS ABOUT ACTUALLY DOING IT. NOT  
3 A SERIOUS QUIT ATTEMPT.

4 Q. AND THESE ARE ALSO IN THE MID 1980'S,  
5 SMOKERS AND SMOKERS ANONYMOUS?

6 A. THEY'RE IN THE MID 80'S.

7 Q. OKAY. AND THEN MR. BOEKEN AT SOME POINT GOT A  
8 PRESCRIPTION FOR NICOTINE GUM FROM DR. TRABULUS?

9 A. THAT IS CORRECT.

10 Q. TELL US ABOUT THAT EFFORT.

11 A. WELL, AGAIN, THE MOST RELEVANT PART IS THAT IT  
12 WAS VERY SHORT-LIVED. IT'S NOT CLEAR THAT HE EVER STOPPED  
13 SMOKING AT ALL. SMOKED WHILE HE CHEWED THE GUM, AND  
14 BASICALLY THREW THE GUM AWAY, SAID IT DIDN'T WORK. DIDN'T GO  
15 BACK TO DR. TRABULUS OR CALL HIM UP, WHICH MIGHT HAVE HELPED  
16 HIM IN HIS LONG-TERM EFFORTS. HE JUST SORT OF WALKED AWAY  
17 FROM IT. NOT A SERIOUS QUIT ATTEMPT.

18 Q. HOW ABOUT THE NICOTINE PATCH?

19 A. SIMILAR. PRESCRIBED THE NICOTINE PATCH BY  
20 DR. TRABULUS, STOPPED FOR 10 HOURS, TORE OFF OF THE PATCH,  
21 THREW IT AWAY. DIDN'T CALL DR. TRABULUS. DIDN'T GO BACK TO  
22 SEE HIM NOT A STOP. NOT A SERIOUS QUIT ATTEMPT.

23 Q. AND THAT WAS IN THE VERY LATE 1980'S?

24 A. THAT'S PROBABLY IN THE EARLY '90'S.

25 Q. EARLY '90'S. OKAY.

26 AND THEN HE TOOK A TRIP TO HAWAII IN THE EARLY  
27 '90'S SOMETIME?

28 A. I BELIEVE HE USED NICOTINE REPLACEMENT TO TAKE

1 THE PLANE RIDE. THERE WAS NO INTENTION ON HIS PART TO QUIT  
2 SMOKING. HE JUST WAS TRYING TO MINIMIZE ANY DISCOMFORT ON  
3 THE PLANE.

4 Q. ALL RIGHT. AND THEN MR. BOEKEN QUIT SMOKING  
5 FOR A PERIOD OF TIME AFTER HIS LUNG CANCER SURGERY?

6 A. YES. ACTUALLY, HE QUIT FOR A LONG PERIOD OF  
7 TIME. HE WAS HIGHLY MOTIVATED, OF COURSE, BECAUSE HE HAD HAD  
8 THE DIAGNOSIS OF CANCER, WAS TERRIFIED.

9 AT THAT POINT, THERE WAS A HOPE THAT HIS CANCER  
10 WOULD BE CURED, AND HE USED THE PATCHES. HE STAYED OFF  
11 CIGARETTES FOR ABOUT TEN MONTHS. AND UNFORTUNATELY, WOUND UP  
12 HAVING REOCCURRENCE OF HIS DISEASE, HAD TO BE PUT ON  
13 STEROIDS, WHICH HAD A TERRIBLE EFFECT ON HIS ABILITY TO SLEEP  
14 AND MAKING HIM EDGY. AND AT THAT POINT, I BELIEVE HE FELT  
15 THAT THERE WAS REALLY NO REASON TO BE MAKING ANY KIND OF  
16 SERIOUS EFFORT. HE MIGHT AS WELL JUST DO WHATEVER IT TOOK TO  
17 FEEL BETTER, AND HE THEN WENT BACK TO SMOKING AT THAT POINT.

18 Q. OKAY. NOW, PUTTING ASIDE THIS LAST EFFORT,  
19 DOESN'T THIS PATTERN HERE, DOESN'T THE MERE FACT THAT HE  
20 ENGAGED IN THIS BEHAVIOR ILLUSTRATE AND DEMONSTRATE THAT HE  
21 WANTED TO QUIT SMOKING?

22 A. WELL, AGAIN, IF YOU LOOK AT BEHAVIOR AS THE  
23 ULTIMATE INDEX, HE CLEARLY HAD MADE EFFORTS IN THAT  
24 DIRECTION. THEY'VE BEEN VARIABLE, BUT THEY DO SPEAK TO HIS  
25 INTEREST IN ACCOMPLISHING THAT GOAL, ALTHOUGH, AS I SAID, I  
26 BELIEVE HE HAD MIXED FEELINGS.

27 I BELIEVE THAT HE WAS CONCERNED ABOUT SOME OF  
28 THE HEALTH EFFECTS THAT HE HIMSELF WAS EXPERIENCING AND THAT

1 HE WAS TAKING ON AS RISKS. BUT HE WAS NEVER OF ONE MIND  
2 CLEARLY OUT TO QUIT AND DO WHATEVER IT TAKES, UNTIL HE HAD  
3 THE CANCER SURGERY. THEN HIS BEHAVIOR WAS QUITE DIFFERENT.  
4 NOTHING WAS GOING TO STOP HIM AT THAT POINT. IT WAS A MATTER  
5 OF LIFE AND DEATH FROM HIS POINT OF VIEW, AND HE WAS HIGHLY  
6 MOTIVATED. HE WAS OF ONE MIND. NO MIXED FEELINGS THEN.

7 Q. AND PRIOR TO THAT TIME, IN YOUR OPINION, HE WAS  
8 OF MIXED MIND?

9 A. YEAH. YOU KNOW, THE TERM "AMBIVALENT" CAPTURES  
10 IT. MIXED FEELINGS. THERE'S EVIDENCE THAT HE KNEW HE SHOULD  
11 QUIT. HE VERBALIZED TO FRIENDS, I KNOW I SHOULD QUIT. HE  
12 GAVE IT LIP SERVICE, AND HE EVEN PUT SOME EFFORT INTO IT.  
13 BUT A LOT OF THEM REALLY WENT THE WAY OF A NEW YEARS'  
14 RESOLUTION, YOU KNOW I SHOULD EXERCISE, YOU KNOW I'M  
15 GOING TO. TWO WEEKS LATER, WHATEVER HAPPENED TO IT, IT'S  
16 ALREADY HISTORY.

17 SO I THINK THAT IT SPEAKS TO MIXED FEELINGS.  
18 KNOWING THAT ONE SHOULD, HAVING SOME DESIRE TO DO IT, BUT ON  
19 THE OTHER HAND, REALLY LIKING WHAT YOU'RE DOING AND NOT  
20 REALLY WANTING TO GIVE IT UP AND MAYBE NOT WANTING TO GIVE IT  
21 UP NEARLY ENOUGH TO DO WHAT IT REQUIRED TO GIVE IT UP.

22 MR. CARLTON: YOUR HONOR, I COULD GO ON TO ANOTHER  
23 SUBJECT.

24 THE COURT: NO. THIS ACTUALLY WOULD BE A WONDERFUL  
25 TIME TO GO AHEAD AND BREAK.

26 MS. KEY, WOULD YOU STAY WITH US JUST ONE  
27 SECOND.

28 ALL RIGHT. EVERYONE ELSE, WE'LL SEE YOU

1 TOMORROW MORNING AT 8:45.

2 THE WITNESS: THANK YOU.

3 THE COURT: DON'T DISCUSS THE CASE WITH ANYONE.

4

5 (THE FOLLOWING PROCEEDINGS WERE HELD

6 IN OPEN COURT OUT OF THE PRESENCE

7 OF THE JURY:)

8

9 THE COURT: ALL RIGHT. WE'RE STILL ON THE RECORD  
10 OUTSIDE THE PRESENCE WITH JURY PERSON MS. KEY WHO HAS GIVEN  
11 ME A NOTE AND, UNFORTUNATELY, BROKE ONE OF HER FRONT TEETH  
12 DURING LUNCHTIME.

13 ALL RIGHT. YOU HAVEN'T CALLED YOUR DENTIST  
14 YET?

15 JUROR KEY: IT JUST HAPPENED TODAY DURING LUNCH. WHAT  
16 I'M GOING TO DO IS GO HOME RIGHT AWAY, CALL HIM -- CALL THEM  
17 RIGHT AWAY BEFORE THEY CLOSE, BECAUSE I THINK THEY CLOSE AT  
18 6:00. SO IF I CAN SCHEDULE AN APPOINTMENT -- HE'LL TAKE ME  
19 TOMORROW OR THE DAY AFTER. I'M GOING TO GET AN APPOINTMENT  
20 ONE DAY THIS WEEK, BECAUSE IT'S IRRITATING, BECAUSE IT'S  
21 LOOSE. AND I'LL SEE IF I CAN GET HIM TO FIX IT OR REMOVE IT.  
22 BUT IT WILL BE AN AFTERNOON, LATE AFTERNOON APPOINTMENT.

23 THE COURT: OKAY.

24 JUROR KEY: I'LL TRY TO GET IT WHERE IT DOESN'T  
25 CONFLICT WITH WHAT'S GOING ON.

26 THE COURT: YOU'VE GOT IT.

27 JUROR KEY: IF ANYTHING, I MAY NEED TO LEAVE 30  
28 MINUTES EARLY OR SOMETHING LIKE THAT.

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1 THE COURT: WE' LL WORK AROUND IT.

2 JUROR KEY: OKAY.

3 THE COURT: OKAY. THANK YOU, MS. KEY.

4 JUROR KEY: OKAY. THANK YOU.

5 THE COURT: YES, MA' AM

6

7 (JUROR KEY EXITS THE COURTROOM )

8

9 MR. PIUZE: WE' RE OFF THE RECORD

10 THE COURT: WE' RE OFF THE RECORD.

11

12 (AT 3:57 P. M , AN ADJOURNMENT WAS TAKEN

13 UNTIL TUESDAY, MAY 15, 2001 AT 9:00 A. M )

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