IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

THE STATE OF OKLAHOMA, ex rel.,

Plaintiffs,

vs.

R.J. REYNOLDS TOBACCO COMPANY, et al.,

Defendants.

COPY

No. CJ-96-1499-L

* * * * * *

VIDEO DEPOSITION OF THOMAS C. CONIGLIONE, M.D.
VOLUME I
TAKEN ON BEHALF OF THE PLAINTIFFS
ON THE 28TH DAY OF SEPTEMBER, 1998
IN OKLAHOMA CITY, OKLAHOMA

* * * * * *

APPEARANCES:

FOR THE PLAINTIFFS:
Mr. Thomas A. Wallace
NORMAN, EDEM, McNAUGHTON & WALLACE
127 N.W. 10th
Oklahoma City, OK 73103

FOR THE DEFENDANT LORILLARD TOBACCO COMPANY:
Mr. James Cox
THOMPSON COBURN
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VIDEO TECHNICIAN:
Ms. Cheryl Coy

Reported By: Jody McAnally, CSR, RPR, RMR

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INDEX OF PLAINTIFFS' EXHIBITS

S T I P U L A T I O N S

It is stipulated that the deposition of THOMAS C. CONIGLIONE, M.D. may be taken pursuant to agreement on September 28, 1998, before Jody McAnally, CSR, RPR, RMR.

It is stipulated that all objections to questions, except as to the form of the question, may be made at the time of the trial when said deposition is offered into evidence.

* * * * * *

00:01:45 MS. COY: Today is September 28th, 1998. This
00:01:51 begins the deposition of Thomas Coniglione. The time is
00:01:55 00:01:56. The court reporter is Jody McAnally with
00:02:02 Professional Reporters of Oklahoma City. Videographer is
00:02:04 Cheryl Coy with Proof Positive of Oklahoma City. If counsel
00:02:08 will, please, state their appearances for the record.
00:02:10 MR. WALLACE: Tom Wallace for the plaintiffs.
00:02:12 MR. COX: James Cox for Lorillard.

THOMAS C. CONIGLIONE, M.D,

being first duly sworn, was examined and testified as follows, to wit:

DIRECT EXAMINATION

BY MR. WALLACE:

00:02:24 Q Would you state your name for the record, please.
00:02:27 A Thomas Coniglione.
02:29 Q What's your age?

00:02:33 A Fifty-seven.
02:36 Q Where do you live?
00:02:39 A [DELETED]
00:02:40 Q And what's your home residence?
00:02:42 A [DELETED]
00:02:46 Q The Zip on it?
00:02:47 A [DELETED]
00:02:49 Q And your home phone?
00:02:50 A [DELETED]
00:02:53 Q And do you have an office location?
00:02:56 A Yes.
00:02:56 Q Where is that?
00:02:58 A 6205 North Santa Fe.
00:03:01 Q And what's the telephone number there?
00:03:06 A 427-6776.
00:03:09 Q And your Social Security number?
00:03:11 A [DELETED]
00:03:37 MR. COX: I take it this is my copy to write on as
00:03:39 I wish.
00:03:40 MR. WALLACE: Any way you want.
00:03:42 MR. COX: Are you marking that?
00:03:44 MR. WALLACE: Plaintiff's Exhibit 1. Do you want
00:03:46 a --
00:03:47 MR. COX: No. That's fine.
.03:48 Q (BY MR. WALLACE) I hand you what has been marked

00:03:52 Plaintiff's Exhibit Number 1 and ask you to state what that
03:55 is, sir.
00:03:56 A This is a copy of my CV.
00:03:58 Q Were you in the military service?
00:04:03 A I was in the Indian Health Service, not --
00:04:07 Q In the Indian Health Service?
00:04:10 A Correct.
00:04:10 Q And is that mentioned in your CV?
00:04:13 A Lawton Indian Hospital, hospital appointment '71
00:04:17 through '73.
00:04:18 Q Okay. And at that time you were then licensed to
00:04:26 practice your profession of medicine in the State of
00:04:29 Oklahoma?
00:04:29 A Correct. Yes, sir.
00:04:30 Q Would you tell us where you graduated from high
00:04:38 school.
00:04:38 A I graduated from high school in Staten Island, New
00:04:42 York, New York City.
00:04:46 Q When?
00:04:46 A 196 -- '58. 1958.
00:04:56 Q Where did you go to college?
00:04:58 A Columbia University.
00:05:00 Q Which undergraduate school?
00:05:04 A Columbia College and Columbia Pharmacy School.
00:05:08 Q Did you get -- you got a BS from Columbia College?

00:05:14 A Yes.
00:05:15 Q And what did you get from the pharmacology school?
00:05:18 A It was a BS degree, combined BS degree from the
00:05:23 university.
00:05:23 Q I see. In your science courses there, what
00:05:34 courses did you take?
00:05:36 A The courses at Columbia were very heavy into
00:05:41 chemistries, biology, took physics, botany, pharmacology, a
00:05:52 number of humanities courses which were required courses.
00:05:56 Q The pharmacology course, how long did that last?
00:06:01 A Well, there were several pharmacology courses. I
00:06:06 don't recall specifically.
00:06:12 Q Were those given in Columbia College itself or --
00:06:15 A Yes.
00:06:15 Q -- other parts of the university?
00:06:17 A Well, all parts of the university.
00:06:19 Q Which school was that given in, the pharmacology?
00:06:24 A Given in the pharmacy college.
00:06:26 Q Where is that located?
00:06:27 A It was located -- some of it was on the 116th
00:06:33 Street campus and some of it was on West 68th Street.
00:06:36 Q Did you live on campus?
00:06:38 A No, sir.
00:06:39 Q Where did you live?
00:06:41 A At home.

00:06:42 Q Staten Island?
06:43 A Yes, sir.
00:06:44 Q The following -- when did you graduate from
00:06:50 Columbia College?
00:06:51 A 1962.
00:06:53 Q And what did you do then?
00:06:55 A I worked. Worked for a year.
00:06:59 Q Doing what?
00:07:00 A Worked mostly in a pharmacy, did some tutoring.
00:07:08 Q In what subjects?
00:07:10 A Chemistry. It was organic chemistry in which I
00:07:16 tutored. It was mostly designed to pay back some college
00:07:19 loans.
00:07:19 Q Who did you tutor?
00:07:22 A I don't recall the names of the students, but --
00:07:26 Q Well, I'm not --
00:07:27 A College students.
00:07:28 Q Oh, they were college students?
00:07:30 A Yes.
00:07:30 Q That's what I was driving at, what classification
00:07:33 of persons it was.
00:07:34 A Okay.
00:07:35 Q After your one-year working, what did you do?
00:07:41 A Entered medical school.
.07:43 Q Whereabouts?

00:07:43 A Medical College of Virginia.

07:47 Q And you attended there, what, September to June each year for four years?

00:07:54 A School started in September, concluded in May. That's correct.

00:07:55 Q What did you do during the summers?

00:08:04 A Between the first and second years of medical school, I was a research assistant. Between the second and third years of medical school I was a respiratory technician in the hospital. And I had another job, but I can't recall exactly what it was. But it was all hospital-related.

00:08:23 Q When you worked in research, what kind of research was that?

00:08:32 A Immunology.

00:08:44 Q And when you were doing the respiratory, what were -- what was your -- were your duties and the scope of your duties?

00:08:49 A Principally the maintenance of various forms of breathing equipment, establishing breathing equipment treatments for patients and then maintaining the equipment while the patients were using it. I responded to emergency situations in the hospital because I was responsible for the breathing component of the emergency situation at least from a technical perspective.

00:09:00 Q Did you care for anybody with lung cancer?

00:09:06

00:09:11

00:09:15

00:09:21

00:09:24

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09:29

00:09:32 A I don't recall specifically.
09:34 Q With COPD?
00:09:37 A I am certain, but I don't recall a specific
00:09:40 instance.
00:09:40 Q And during your -- between your third and fourth
00:09:44 years, what did you do?
00:09:46 A Classes were -- actually, I took classes between
00:09:50 the third and fourth years of medical school.
00:09:52 Q In what subjects?
00:09:54 A It was an internal medicine assignment.
00:10:02 Ordinarily students were not permitted to take classes in
00:10:05 the summer or take elective courses. And I wanted an
00:10:08 elective course, and to do so I had to complete a compulsory
00:10:12 course. So I did that in the summer while I was also
00:10:15 working just so I could do some extra work during school.
00:10:19 Q What was the compulsory course?
00:10:21 A It was an internal medicine experience.
00:10:26 Q Okay. Let me skip ahead a little bit. What is
00:10:30 the specialty of internal medicine?
00:10:32 A A specialty of internal medicine concerns itself
00:10:36 primarily with the diagnosis, treatment of conditions as
00:10:40 they affect adults.
00:10:49 Q Okay. And upon your graduation from medical
00:10:58 school, you were granted a degree; is that correct?
.11:01 A Correct.

00:11:02 1 Q And an M.D.?
11:03 2 A Yes.
00:11:04 3 Q And what did you do then in pursuit of your
00:11:09 4 profession?
00:11:09 5 A I went to Yale University to continue training.
00:11:15 6 Q At the -- was that at Yale Medical School?
00:11:19 7 A Yes.
00:11:21 8 Q And what was the training that you were taking
00:11:25 9 there?
00:11:25 10 A Internal medicine.
00:11:27 11 Q Okay. Did you -- were you doing what we call an
00:11:31 12 internship?
00:11:32 13 A Yes. The first year was an internship.
00:11:35 14 Q And it was in internal medicine?
00:11:38 15 A Correct.
00:11:39 16 Q And how long was that?
00:11:40 17 A One year.
00:11:41 18 Q Following your internship, what did you do?
00:11:46 19 A Stayed at Yale for a second year to continue
00:11:49 20 training.
00:11:50 21 Q In internal medicine?
00:11:53 22 A Yes.
00:11:54 23 Q How long were you in training in internal medicine
00:12:01 24 in your residency?
:12:02 25 A Total of four years.

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00:12:03 1 Q And what year does that take us to?
12:08 2 A 1971.
00:12:10 3 Q Okay. How did you happen to go into the Indian
00:12:15 4 service?
00:12:15 5 A Choice.
00:12:17 6 Q Okay. How were you recruited?
00:12:21 7 A I wasn't recruited to the Indian Health Service.
00:12:30 8 I -- I applied for a deferment from the military draft in
00:12:34 9 order to complete my training; and when my training was
00:12:37 10 completed, I was then subject to a two-year tour of duty
00:12:46 11 with some military or military-related organization. My
00:12:53 12 application was given to the Indian Health Service. So I
00:12:57 13 then had a two-year obligation to the Indian Health Service.
00:13:01 14 Q I see. And that was performed in Lawton,
00:13:06 15 Oklahoma?
00:13:06 16 A Yes.
00:13:07 17 Q What did you do in this particular service?
00:13:14 18 A Well, Lawton, Oklahoma, that particular hospital
00:13:18 19 was responsible for the health care of Indians in
00:13:23 20 southwestern Oklahoma. The boundaries extended from
00:13:27 21 Oklahoma City to the Texas border, and that would be Wichita
00:13:31 22 Falls. The area we served actually ran south along I-35 to
00:13:37 23 the Texas border, west to Wichita Falls and then north to
00:13:43 24 probably near Clinton, Oklahoma. So we served an enormous
13:47 25 geographic area.

00:13:48 1 Q Did it include Clinton?
13:49 2 A Clinton had a very small hospital, an Indian
00:13:53 3 hospital. If the doctors at Clinton needed help with the
00:13:56 4 care of their patients, I was the referral source for them
00:14:00 5 to bring their -- to send their patients when they needed
00:14:03 6 help. So I was essentially the only internal medicine
00:14:07 7 physician for a population at that time estimated to be
00:14:11 8 close to 100,000 Indians.
00:14:14 9 Q So big caseload.
00:14:17 10 A It was significant, yes.
00:14:19 11 Q Did you do any particular studies of the -- in the
00:14:24 12 nature of any diseases that affected the Indians
00:14:29 13 particularly?
00:14:29 14 A Well, the -- the challenges at this hospital
00:14:36 15 were --
00:14:37 16 MR. COX: Excuse me a minute while I interject an
00:14:40 17 objection to the form of the question as to the vagueness of
00:14:42 18 the term "any studies". I don't think that's well defined,
00:14:47 19 but you may answer.
00:14:48 20 THE WITNESS: Try to give you as short an answer
00:14:52 21 as I can. The Indians here suffered from diseases which
00:14:59 22 those of us physicians were not familiar having seen those
00:15:04 23 before. For example, the pediatricians saw huge numbers of
00:15:09 24 Indian children with diarrhea. And the pediatrician and I
.15:11 25 set about to try to figure out why so many children had

00:15:14 diarrhea. And actually we did figure that out.

00:15:18 I was overwhelmed with the number of patients who
00:15:22 have diabetes and the complexities of the diabetes. So much
00:15:27 so -- and, mind you, now, none of what I was seeing in the
00:15:31 Native American population was in the medical textbooks. I
00:15:34 was so impressed with the magnitude and severity of the
00:15:39 diabetes that I enlisted the aid of a number of diabetes
00:15:45 researchers and diabetes scientists, diabetes
00:15:48 epidemiologists.

00:15:50 And while I was there, I initiated a series of
00:15:53 research studies in diabetes that lasted a decade and a
00:15:57 half. And that was actually the reason I stayed in Oklahoma
00:16:00 instead of going back to the east coast, because it took me
00:16:03 quite a while to start this process of studying Native
00:16:07 American diabetes; and by the time I had completed my tour
00:16:11 of duty, my projects were just about getting started. So I
00:16:15 joined the faculty at the university -- the University
00:16:19 Medical School in Oklahoma City mainly so I could keep close
00:16:22 to my projects and see them completed.

00:16:26 And actually the projects were picked up by a
00:16:29 Dr. Kelly West who at that time was an
00:16:32 internationally-recognized diabetologist, specialist in the
00:16:38 treatment of diabetes. And he then obtained research grants
00:16:46 and organized and conducted all of the studies which I had
00:16:50 started while I was there.

00:16:53 So I've done, I think, a fair amount of work in
16:57 studying Native American diabetes. And while we did that,
00:17:00 we studied Native Americans with diabetes and eye disease
00:17:04 and diabetics with kidney disease and diabetics with heart
00:17:07 disease, and the studies just continued to grow.
00:17:11 Q (BY MR. WALLACE) What -- other than Kelly West, do
00:17:19 you recall the names of any other researchers?
00:17:21 A A gentleman named Keen from London. Jarrett --
00:17:29 one's from Canada, and one's from England. There was
00:17:32 Jarrett, J-A-R-R-E-T-T, Keen, K-E-E-N. A number of the
00:17:46 doctors -- Billy Smith -- William Smith came down and helped
00:17:52 me do a lot of that. A nurse named Maxwell. And those were
00:18:03 the key people for the origins or the beginning years of
00:18:07 these studies.
00:18:09 Subsequently Dr. West died and Dr. Lee at the
00:18:18 College of Public Health in Oklahoma City continued -- I
00:18:22 think most of what he did was continued to publish the
00:18:27 results of several of those studies.
00:18:29 Q Now, were there any publications resulting from
00:18:40 this research?
00:18:41 A There were several publications that resulted from
00:18:44 this research.
00:18:45 Q Now, are those contained in your CV?
00:18:50 A Some are; some are not. For example, bottom of
.19:00 page 3, that West Bailey report, that was 1985. There was

00:19:21 1 another report in 1980 that was published by West, Jarrett
19:26 2 and Keen where they acknowledged the role that I played in
00:19:31 3 -- in that. My name was not one of the authors.
00:19:37 4 There was another publication in 1985. I think
00:19:41 5 Dr. -- I think Dr. Lee was one of the lead authors on that
00:19:56 6 paper, and that's not in there. It was either '85 or later
00:20:02 7 than that. It was a summary article of many of those
00:20:06 8 studies that we had done over the past 12 to 15 years.
00:20:09 9 Q Do you know if any special measures were put in
00:20:16 10 place as a -- for the treatment of Indian diabetes as a
00:20:25 11 result of these studies?
00:20:26 12 A The studies, I think, have had an enormous impact
00:20:34 13 on the -- on the whole issue of diabetes for Native
00:20:37 14 Americans. For example, based on many of those observations
00:20:42 15 -- and those observations pointed out the magnitude and
00:20:46 16 severity of the problem with diabetes.
00:20:48 17 But based on those observations, the Indian Health
00:20:51 18 Service has secured significant funding from the federal
00:20:56 19 government to institute diabetes treatment programs
00:21:02 20 throughout Indian nations. There are 19 Indian Health
00:21:06 21 Service sponsored -- I think they would be called diabetes
00:21:11 22 treatment programs. As a matter of fact, I am currently in
00:21:14 23 the process of developing a comprehensive diabetes program
00:21:18 24 for another group of Indians who prior to this time have not
.21:23 25 had a comprehensive, expansive, inclusive diabetes program.

00:21:31 The initial programs that were developed were all
21:34 designed to treat diabetes. It's very clear now that
00:21:38 treatment is inadequate, and the -- the issue of prevention
00:21:44 must be addressed. So that comprehensive diabetes program
00:21:48 that I am currently developing is a program designed for
00:21:55 Native American education, disease prevention, early disease
00:22:02 diagnosis and intervention, hopefully to prevent some of the
00:22:07 complications that develop in Native Americans with
00:22:11 diabetes.
00:22:13 Q What -- what group are you doing this work for?
00:22:27 A The Chickasaw Nation.
00:22:30 Q And do you -- do you do this work out of your
00:22:39 office on -- at 6201 North Santa Fe?
00:22:42 A I spend two days a week at that hospital, have
00:22:46 done so for the past -- probably the past two years.
00:22:50 Q Where is that located?
00:22:51 A Ada, Oklahoma. A-D-A, Oklahoma. And I haven't
00:22:55 been there every week, but I have been there most every
00:23:00 week. And my function there has been to analyze their needs
00:23:05 and then to design programs to satisfy those health needs
00:23:10 and then bring in the right people to implement the
00:23:14 programs.
00:23:14 Q Okay.
00:23:16 A And we've just spent about a year, a little more
.23:19 than a year studying the whole question of how this

00:23:22 1 particular group deals with diabetes, my perception of how
23:27 2 they should be dealing with it; and the program has been
00:23:31 3 designed based on my observations and my perception of
00:23:35 4 needs.
00:23:35 5 Q I note that one of the authorities that you cite
00:23:43 6 in your expert witness disclosure statement is a study of
00:23:49 7 Indians in Arizona, southeastern Oklahoma and, I believe,
00:23:52 8 the Dakotas; is that correct?
00:23:53 9 A Correct. That's a Strong Heart study.
00:23:57 10 Q It's a what?
00:23:58 11 A Strong, S-T-R-O-N-G, the Strong Heart study.
00:24:03 12 Q And what -- what tribes of Indians in Oklahoma did
00:24:08 13 that refer to, if you know?
00:24:13 14 A There -- I'll have to look at it to be certain,
00:24:18 15 but I think that the Indians in the southwest and the
00:24:21 16 northeast are heavily represented in that study. So that
00:24:24 17 would be the Cherokees in the northeast and the Lawton
00:24:27 18 Indians in the southwest. There were some other groups, and
00:24:31 19 I don't recall the specific numbers of those Indians that
00:24:35 20 were included in that study.
00:24:38 21 Q Now, the diabetes -- strike that.
00:24:49 22 Is it true that diabetes is one of the big four
00:24:56 23 risk factors for cardiovascular disease?
00:24:59 24 A I'm not sure what you mean by four major risk
.25:07 25 factors. Some authorities talk about four major risk

00:25:10 1 factors; some talk about six
25:13 2 major risk factors when I talk with people, but certainly
00:25:16 3 diabetes is clearly on everyone's list as a major risk
00:25:20 4 factor.
00:25:20 5 Q And does smoking of cigarettes aggravate the
00:25:25 6 situation with a diabetic?
00:25:28 7 MR. COX: Objection. Vague as to what aggravate
00:25:32 8 means in the situation.
00:25:35 9 THE WITNESS: Risk factors combined, we think, are
00:25:43 10 associated with the development of a disease or development
00:25:46 11 of an illness. And those are all generalizations. I can't
00:25:51 12 tell you that something aggravates or compounds or
00:25:57 13 complements, but certainly the more risk factors one has for
00:26:00 14 the development of an illness as far as populations are
00:26:05 15 concerned, we think that it is more likely that the people
00:26:08 16 in that population will develop those diseases.
00:26:12 17 But at the same time, we clinically deal with
00:26:16 18 individual patients. So we would have to look at what we're
00:26:20 19 talking about in terms of compounding or augmenting and in
00:26:25 20 terms of populations or individuals.
00:26:27 21 Q (BY MR. WALLACE) Well, when you're studying those
00:26:30 22 -- the groups of Indians, we're talking about public health,
00:26:34 23 aren't we?
00:26:35 24 A We're talking about public health issues, yes.
.26:37 25 Q And it's appropriate in that context to speak of

00:26:43 causes, is it not?

26:44 A Well, when I think of public health, I think of

00:26:48 populations of people.

00:26:49 Q True.

00:26:50 A When I think of populations of people, I think of

00:26:53 associations that a specific risk factor or specific risk

00:26:58 factors are associated with the development of disease in

00:27:03 that population. As a clinician, when I think of causation,

00:27:10 I have difficulty being specific because to deal with issues

00:27:16 of causation, first thing I would have to know is that

00:27:20 patient as an individual, his medical history, his

00:27:24 environment, his upbringing, his occupation, his physical

00:27:28 examination and then all there is to know about him. And

00:27:32 even at that, frequently if I attempt to come up with

00:27:36 causation of his disease, I'm frequently guessing.

00:27:40 Q Well, now, you're speaking in terms of science

00:27:48 itself; is that right?

00:27:49 A I'm not sure --

00:27:51 Q When you say that you're frequently guessing.

00:27:55 A Well, if I'm looking at a -- a disease, a disease

00:28:00 of -- a multi-factorial disease or a disease, a degenerative

00:28:06 disease, those are the diseases I'm talking about. In

00:28:09 individuals to try to understand causation, I first have to

00:28:15 understand who the patient is, take his history, do a

.28:19 physical exam and look at all the medical information that's

00:28:23 known about him. And then I could attempt to define a
28:28 cause, but frequently that attempt at defining causation in
00:28:32 that group of diseases is quite difficult.
00:28:35 Now, I'm excluding traumatic conditions. Buses
00:28:41 hit people when they're going fast and people are injured,
00:28:44 their causation is rather easy. In some infections I think
00:28:50 causation can be identified. But when I'm looking at an
00:28:54 individual with a degenerative disease, heart disease,
00:28:57 whatever, and that individual has multiple risk factors for
00:29:03 development of that condition, frequently all I could do at
00:29:07 a clinical level is try to associate those risk factors with
00:29:12 that disease. Sometimes if there are very few risk factors,
00:29:16 I can attempt to even use the causation term; but still
00:29:21 that's not very accurate from our perspective as clinicians
00:29:25 dealing with individuals.
00:29:26 Q Well, can't you say in those instances, though,
00:29:31 that there's a reasonable medical probability that such and
00:29:35 such a risk factor is the cause of the disease?
00:29:40 A Probabilities to me are mathematical terms.
00:29:44 Q All right. More likely than not.
00:29:47 A Probabilities to me are mathematical ratios.
00:29:50 There's a probability that a disease will occur. When an
00:29:54 individual has a disease, it's 100 percent probability.
00:29:58 It's either zero or 100 percent. So when I think of
:30:02 probabilities, I'm thinking more in terms of populations.

00:30:06 1 So to me probabilities being mathematical ratios would apply
00:30:13 2 to groups, populations rather than to individuals.
00:30:16 3 Q When you joined the faculty of the University of
00:30:29 4 Oklahoma College of Medicine, what year was that?
00:30:34 5 A 1973.
00:30:35 6 Q What were your duties?
00:30:47 7 A My duties were teaching medical students in the
00:30:52 8 outpatient department, teaching medical students and
00:30:59 9 residents in training on the inpatient services of the
00:31:04 10 hospital. I was also the internist who was responsible for
00:31:09 11 teaching the family practice department. I had a dual
00:31:14 12 appointment within the College of Medicine to both the
00:31:17 13 family practice department and the internal medicine
00:31:21 14 department. The generic description of my job could be
00:31:28 15 summarized in one word, and that would be teaching.
00:31:30 16 Q Did you conduct classes?
00:31:34 17 A Many classes, yes.
00:31:37 18 Q And what subjects did you teach?
00:31:40 19 A Well, most of what I taught was directly related
00:31:46 20 to the patients we were treating at that particular time.
00:31:51 21 The organized classes I delivered had to do with disease
00:31:56 22 conditions, and risk factors were a very popular topic even
00:32:03 23 back then.
00:32:06 24 Q Why was that?
00:32:07 25 A Well, actually, at that time, to me, risk factors

were quite important. There were a number of publications that were available at that time which I think identified risk factors for disease. And we're talking principally cardiovascular disease at this time.

It was my feeling that it was important for the students to know that risk factors applied to populations and that they should take risk factors into consideration. When dealing with patients and when dealing with patient education and patient counsel, risk factors were important.

Now, mind you, this is the mid '70s to late '70s. It was not until the -- I think early to mid '80s that risk factor education of the public was widespread. Actually, in many of the classes I taught back then, we talked about cholesterol and diets as risk factors. And this is before any of those issues were -- were addressed on a large scale.

We talked about inactivity as a risk factor. I thought that there was enough information in the literature at those points in time that those issues needed to be addressed. Even in the mid '80s, 1984, 1985 when I was at St. Anthony Hospital I started a risk assessment, lifestyle modification program, which I was told by my colleagues at that time that that was not a worthwhile endeavor.

Q What wasn't?

A It was not a worthwhile endeavor to deal with risk factors and modifying the lifestyle to minimize risk

00:34:05 1 factors. But it was a program we instituted. I think we
34:08 2 finally got that started in 1985.
00:34:11 3 Q Did that include smoking cessation?
00:34:14 4 A It included whatever we could identify as a risk
00:34:20 5 factor for disease, including smoking cessation.
00:34:22 6 Q Well, I take it, then, that smoking cessation was
00:34:24 7 considered a risk factor for disease --
00:34:27 8 A Yes.
00:34:28 9 Q -- at that time.
00:34:29 10 A Well, smokers, I think, were considered to be at
00:34:35 11 higher risk by virtue of the fact that they smoked.
00:34:39 12 Q Yes.
00:34:39 13 A And that was a risk factor, and we identified as
00:34:43 14 many risk factors as we could, and then we would try to
00:34:46 15 modify all the risk factors we could.
00:34:48 16 Q And how many risk factors -- strike that.
00:34:54 17 Who was this group that was trying to do the
00:34:58 18 identification of the risk factors?
00:35:01 19 A Me and the nurses and technicians who were part of
00:35:07 20 my program.
00:35:08 21 Q How many people were there?
00:35:13 22 A When the program started in 1985, it was myself,
00:35:22 23 half -- half of a dietitian's time, half of an exercise
00:35:28 24 physiologist's time. My -- I was not full-time committed to
.35:32 25 this program. It started off as a very small program.

00:35:36 1 Over the years it became very, very popular. As a
35:41 2 matter of fact, a number of very prominent Oklahomans
00:35:45 3 participated in the program and spoke about the program
00:35:48 4 publicly. And the program then grew to a very large size.
00:35:53 5 At one point, as I recall, I think there were a
00:35:56 6 dozen people employed full-time in the discharge of this
00:36:01 7 program. It was so large that I had to have other
00:36:06 8 physicians come and help me with the medical component of
00:36:12 9 it.
00:36:13 10 Q Who were those other physicians?
00:36:15 11 A Dr. Peter Guzman, G-U-Z-M-A-N, Dr. David Bailey.
00:36:30 12 Currently there's a full-time physician who operates this
00:36:34 13 program. His name is Dr. Randy Morgan.
00:36:41 14 Q Is he associated with the University of Oklahoma?
00:36:44 15 A No. This is a program through St. Anthony
00:36:46 16 Hospital.
00:36:47 17 Q What -- what risk factors did you identify or
00:37:01 18 incorporate into the program?
00:37:02 19 A Well, at -- at that time and at the present time
00:37:08 20 there are a number of established risk factors; and as time
00:37:11 21 goes on, the number of risk factors continues to grow.
00:37:14 22 There are things that we did not know ten years ago that
00:37:19 23 were risk factors that we now identify as being risk
00:37:22 24 factors. So over the years the number of risk factors we've
.37:26 25 identified has increased substantially.

00:37:30 1 What were the risk factors we identified
37:33 2 throughout the program? Gender is a risk factor. Males are
00:37:40 3 at greater risk than females.
00:37:42 4 Q Okay. Now, this was known in the medical
00:37:45 5 community, though, and -- for quite some time before your
00:37:51 6 program started, wasn't it?
00:37:52 7 A Correct. There were several risk factors that
00:37:55 8 were well identified. There were several others that were
00:37:58 9 not related to genetics. But genetics and gender were two
00:38:03 10 issues that I think were quite well established early on,
00:38:08 11 particularly from the Framingham studies that genetics and
00:38:15 12 gender were significant risk factors. The other risk
00:38:19 13 factors that we identified were -- in no particular order,
00:38:23 14 just as they come to me -- hypertension, smoking, diet,
00:38:33 15 obesity, cholesterol, inactivity. And more recently there
00:38:45 16 have been other risk factors identified that we've added --
00:38:51 17 that have been added to the list.
00:38:58 18 Oh, I'm sorry. Nutrition -- when I say diet, let
00:39:02 19 me make certain that we were very interested in the
00:39:06 20 interrelationships between diets and disease. There was
00:39:11 21 considerable data, and there is even more data now,
00:39:14 22 implicating diet and disease.
00:39:21 23 Q I'm not understanding that. Could you explain
00:39:23 24 that a little more.
39:25 25 A Explain more about diet and disease?

00:39:27 1 Q Well, the distinction there that you make in your
39:32 2 explication of nutrition as being more than diet.
00:39:37 3 A Well, by that I mean that the typical high-fat
00:39:46 4 diet of western civilizations has been associated with the
00:39:55 5 development of disease.
00:39:55 6 Q Okay.
00:39:55 7 A But it is not only the high-fat diet, it is the
00:39:57 8 lack of antioxidants, it is the homocystine -- and I --
00:40:04 9 H-O-M-O-C-Y-S-T-I-N-E. It is the homocystine which has
00:40:11 10 become very important as of late. Those are all the other
00:40:15 11 elements of diet. So it's not just the high-fat diet. It's
00:40:19 12 far more than that.
00:40:22 13 Q You're not claiming that your group originated the
00:40:30 14 -- or made the discovery of these risk factors, are you?
00:40:34 15 A I don't think I said anything like that.
00:40:37 16 Q Well, that's what I want to clarify.
00:40:39 17 A What I think my -- what I think our group did very
00:40:43 18 clearly is that we were ahead of the national interest in
00:40:48 19 modification of risk factors. We were doing this at a time
00:40:52 20 when medical care was principally interventional. That is,
00:40:58 21 dealing with the disease after it was established.
00:41:01 22 It was clear to me at this time and even when I
00:41:04 23 was at the university that there were clearly risk factors
00:41:08 24 associated with the development of disease and that we
.41:11 25 should be addressing those risk factors before disease

00:41:14 1 developed, and that was the whole issue. Treating disease
41:18 2 after it developed was fine and that's what we're all
00:41:21 3 trained to do, but we need to be teaching other physicians
00:41:25 4 and professionals and training people to identify and modify
00:41:28 5 risk factors in order for disease to not develop.
00:41:32 6 And I think that we currently feel -- at least, I
00:41:36 7 recently heard an editorial by a physician that the
00:41:39 8 development of a disease nowadays should be considered as a
00:41:43 9 failure of preventive health measures. That's very
00:41:47 10 different than where we were ten years ago.
00:41:49 11 Q What was this group called at St. Anthony's?
00:41:53 12 A It was the SCORE, S-C-O-R-E, SCORE program.
00:41:59 13 Q Does that program continue?
00:42:00 14 A Yes.
00:42:01 15 Q Where -- is it still at St. Anthony's?
00:42:04 16 A Yes.
00:42:05 17 Q Are you still affiliated with it?
00:42:09 18 A No. Affiliated with it to the extent that if
00:42:17 19 Randy Morgan, Dr. Morgan has questions or may require
00:42:25 20 direction for some of the patients, we -- we communicate
00:42:29 21 regularly. And it's not at all atypical for him to ask me
00:42:34 22 my opinion regarding some of the patients or problems he
00:42:37 23 encounters.
00:42:38 24 Q When you joined the faculty at the University of
.42:42 25 Oklahoma School of Medicine, what was your academic rank?

00:42:47 A I was initially -- let's see. I was initially an
42:54 assistant professor.
00:42:56 Q Okay. Now, did you do clinical work while you
00:43:06 were in that particular rank?
00:43:10 A I did clinical work for my entire tenure at the
00:43:14 university, which was ten years.
00:43:16 Q You attended at University Hospital?
00:43:21 A Yes.
00:43:22 Q Children's Hospital?
00:43:23 A Somewhat, yes.
00:43:24 Q And you were -- you held that rank, according to
00:43:31 your CV, 1971 to 1973; is that correct?
00:43:35 A Yes.
00:43:36 Q Then you became an assistant professor?
00:43:39 A I think I went from an assistant to an associate.
00:43:44 Q Well, clinic -- you have here clinical instructor.
00:43:48 A That's when I was in Lawton at the Indian
00:43:51 hospital.
00:43:51 Q Okay.
00:43:52 A And then I was an assistant professor and then
00:43:55 promoted to an associate professor. And I was made a full
00:44:01 professor in 1988. This may be slightly out of -- slightly
00:44:10 out of sequence. My recollection is that I was made a
00:44:17 professor before '88, but that's -- that's immaterial, I
.44:21 think.

00:44:21 1 Q How long were you a professor?
44:23 2 A I'm still a professor.
00:44:25 3 Q Well, I mean a full professor.
00:44:27 4 A Since -- at least since 1988.
00:44:30 5 Q Okay. Now, a full professor means you have
00:44:35 6 tenure?
00:44:35 7 A Had tenure. When I left the university in 1982, I
00:44:40 8 was a tenured associate professor.
00:44:43 9 Q Okay. And you resigned that position?
00:44:46 10 A Correct.
00:44:47 11 Q And went to St. Anthony's?
00:44:49 12 A Correct.
00:44:49 13 Q As educational director?
00:44:51 14 A Correct.
00:44:52 15 Q Now, you still have some kind of affiliation with
00:45:03 16 the university; is that --
00:45:05 17 A Yes.
00:45:06 18 Q What is that affiliation?
00:45:07 19 A Well, I'm a -- a clinical professor and have
00:45:12 20 participated in many of the teaching programs of the
00:45:15 21 university, various departments of the university, when I
00:45:19 22 was at St. Anthony much more so than at the present time.
00:45:23 23 At the present time most of what I do has to do
00:45:26 24 with the admissions process to medical school. I'm a member
.45:30 25 of the admissions board of the College of Medicine; and at

00:45:34 certain times of the year when the admissions process is
45:37 underway, I spend a significant amount of time with that
00:45:42 particular board.
00:45:43 I'm also working with a number of the current
00:45:48 faculty at the university to integrate their activities more
00:45:54 closely into the health care of Native Americans. And to
00:45:58 that extent, I'm very closely involved with several
00:46:02 departments of the university.
00:46:04 Q What departments?
00:46:06 A Endocrinology, which is the diabetes group;
00:46:15 nephrology, which is the kidney disease group;
00:46:22 ophthalmology, which is the eye group; and we're about to do
00:46:32 some things with -- I hope -- we're discussing and perhaps
00:46:35 we will be doing some things with the gastroenterology group
00:46:39 at the university.
00:46:40 Q You have no association in this particular
00:46:45 activity then, I take it, with cardiology?
00:46:48 A We've talked with the cardiology department, and
00:46:51 we haven't done anything. There are still some plans on
00:46:55 paper. I didn't mention them because I don't see an end
00:47:01 point to that set of discussions. With these other groups I
00:47:05 see end points and things have actually started to happen
00:47:07 already.
00:47:07 Q What is an end point?
00:47:08 A An end point to me would be some joint

collaborative effort to enhance patient care. For example, with the diabetes group at the university, I have involved them as unofficial consultants to me to help design the comprehensive diabetes program in Ada.

I have introduced them to a diabetes specialist that I have helped to recruit to Ada. If that diabetes specialist comes to Ada, which she will, I want her to have a close relationship with the diabetes department at the university because I think that the Ada Indians could benefit from up-to-the-minute, contemporary knowledge of what's happening in diabetes.

With the diabetes group we have initiated a -- a study. We're specifically looking at the effects of a new diabetes drug. We want to see if that drug is effective in Native Americans. So that's what I would call end points. We have final programs on paper underway. And in cardiology we've talked, and we don't have a final end point as yet.

Q Who have you talked with in the department of cardiology?

A Aaron Kuggelmass, K-U-G-G-E-L-M-A-S-S.

Q M-E-S-S?

A K-U-G-G-E-L-M-A-S-S, I believe it is.

Q First name again?

A Aaron, A-A-R-O-N.

Q Is he a doctor?

00:48:52 A Yes.
48:53 Q Anybody else in that department?
00:48:56 A No.
00:48:57 Q You haven't talked to Dr. Lazzara?
00:49:02 A No.
00:49:03 Q Dr. Whitsett?
00:49:06 A No. Talked with Alex -- Dr. Alex J. Cox who does a lot of work with Dr. Whitsett, and he is much like cardiology. There have been discussions, but nothing has been finalized. I think I just mentioned this to show that I'm -- I'm attempting to interface multiple levels of the medical school with the Chickasaw Nation because I think they could help each other.
00:49:36 Q Aren't diabetes and cardiovascular disease closely related?
00:49:50 A Are diabetes and cardiovascular disease closely related? More specifically, yes, they're closely related. I'm not sure what you mean by closely.
00:50:02 Q Okay. Well, don't diabetics that have the risk factor of diabetes develop cardiovascular disease, say, greater than the general population?
00:50:15 A Cardiovascular and blood vessel diseases are more common in diabetics than in non-diabetics.
00:50:26 Q That's what I mean.
50:27 A Yes. Okay.

00:50:28 Q Do you teach any students now?
50:36 A Yes.
00:50:38 Q Okay. What students do you teach?
00:50:45 A Mostly students from the university who are
00:50:49 working with the family practice residency program at St.
00:50:53 Anthony Hospital.
00:50:53 Q Okay. How do you work with them?
00:50:55 A I am at St. Anthony twice a month teaching classes
00:50:59 to the residents and the students.
00:51:01 Q Okay. Now, who pays for that?
00:51:05 A No one does. I do that on my own time. It's my
00:51:09 contribution to their education.
00:51:10 Q Now, are you a paid professor at the University of
00:51:18 Oklahoma?
00:51:18 A No, sir. My tie with the admissions board is
00:51:25 purely donated time.
00:51:27 Q Do you have students come out to your place of
00:51:36 business on North Santa Fe?
00:51:38 A Students do come out to that office on North Santa
00:51:43 Fe.
00:51:43 Q And what do they do when they come out there?
00:51:46 A They observe some of the physicians and see some
00:51:50 of the patients that some of the physicians see, mostly to
00:51:54 learn a specific skill.
.51:56 Q Okay. When was the last time you had students out

there?

A There's a student out there right now.

Q Okay. And how long does he or she stay?

A A month. One month. And it's intermittently through the month because they have other assignments. And when they are there, I see them, work with them some; and they work with other physicians, as well. They're not exclusively assigned to me.

Q How many hours a day?

A I think we look at half days. They are in the clinic a certain number of half days.

Q Now, are you associated with anyone in the practice of medicine at your location on North Santa Fe?

A I am in a group of ten physicians. My office is in a building, in an office suite occupied by ten physicians.

Q And what -- does this have a name in particular?

A It's -- the name of the group is Oklahoma Sports Science and Orthopedics.

Q You've done a lot of work in sports medicine.

A Your definition of a lot of work. Yes, far more so than most physicians, but probably less so than the other physicians in my group. So I'm not sure I follow you with --

Q Okay. Well, when you were at St. Anthony, didn't

00:53:49 1 you see runners, for example?
53:50 2 A Yes. And still do.
00:53:52 3 Q And you've written articles for the runners' local
00:53:57 4 publication, haven't you?
00:53:58 5 A Many.
00:53:59 6 Q Okay. The -- if a physician has a patient with
00:54:12 7 what he or she might consider running-related disease, do
00:54:18 8 they refer them to you?
00:54:19 9 A I have patients referred to me by other
00:54:22 10 physicians, yes.
00:54:23 11 Q Okay. Now, what do you do specifically in your
00:54:28 12 practice at this time with this group of Oklahoma Sports
00:54:40 13 Science and Orthopedics?
00:54:42 14 A What do I do specifically with that group?
00:54:45 15 Q Yes.
00:54:46 16 A I share office space with those physicians. So
00:54:49 17 that when I do see those patients who come to me for care, I
00:54:54 18 see them in that environment, in that set of offices with
00:54:59 19 those other physicians.
00:55:00 20 Q What kind of patients do you treat?
00:55:04 21 A I basically treat two populations. Personally
00:55:09 22 treat in this office now. Well, actually, I treat several
00:55:12 23 populations. When I go to Ada, I see Native American
00:55:16 24 patients there, quite a few. So that's one population of
00:55:20 25 patients that I see that's not reflected in my current

00:55:24 office environment.

55:25 In my current office environment I see two other

00:55:28 populations of patients. One is a population of runners,

00:55:33 and the second is a population of patients for whom I have

00:55:36 been a primary physician for a considerable period of time.

00:55:48 Q This group that you're officing with, is it a

00:56:03 PLLC?

00:56:04 A Yes, it is.

00:56:06 Q And other than the fact you office together, do

00:56:12 you share any other professional activities?

00:56:18 A Well, yes, to this extent. Working with this

00:56:26 group I have helped the group to look at what I would

00:56:31 consider as important aspects of their practices. For

00:56:35 example, we talk about outcomes analysis. Outcomes analysis

00:56:40 is a very hot button word in the medical community these

00:56:44 days. And knowing a little bit about outcomes analysis, I

00:56:49 have helped this group of physicians to understand the term,

00:56:53 understand what it means and to institute some processes

00:56:58 internally to try to study outcomes.

00:57:00 So I have done that with this group. We have

00:57:05 regular meetings. Their meetings are both scientific and

00:57:10 group oriented, and I participate in those meetings. There

00:57:16 are a number of organizational needs that this group has,

00:57:23 some of which I can help implement and do so if it's within

57:29 my area of expertise or knowledge.

00:57:31 Q What would those be encompassed within the
57:35 organizational?
00:57:37 A Oh, for example, just as an example, one of our
00:57:42 physicians is very knowledgeable regarding cheerleaders and
00:57:46 the injuries of cheerleaders. This is a highly specialized,
00:57:53 focused niche in sports medicine. The question has been
00:57:59 with all of his experience and his knowledge, is there a way
00:58:03 that he can interact with cheerleading coaches to help
00:58:08 prevent cheerleading injuries. So I have determined a
00:58:14 method in which he could accomplish that goal.
00:58:16 Q Do you share fees with other members of your
00:58:25 group?
00:58:25 A Share fees? No.
00:58:26 Q Yeah. Do they share fees with you?
00:58:28 A No.
00:58:29 Q Did you start this SCORE program while you were
00:58:48 still at the University of Oklahoma?
00:58:49 A No.
00:58:50 Q That was put underway when you went to St.
00:58:55 Anthony's?
00:58:55 A It was started in 1985. I arrived at St. Anthony
00:59:00 in 1983.
00:59:02 Q When did that relationship terminate, then?
00:59:08 A With St. Anthony?
59:09 Q No. The SCORE.

00:59:11 A I left St. Anthony in July of 1996, probably.
59:28 1996. So I terminated my -- I didn't officially terminate
00:59:34 my relationship with the program. I think everyone
00:59:36 recognizes -- everyone in the program recognizes that it was
00:59:40 my idea -- everyone calls it my baby. And to this date --
00:59:46 not today, but until very recently, I continued to have
00:59:51 close contact with Dr. Morgan and his entire staff in that
00:59:55 program.
01:00:07 MR. WALLACE: Let's take a break here.
01:00:08 MR. COX: Fine with me.
01:00:09 MS. COY: We're off the record at 01:00:06.
01:00:16 (A recess was taken.)
01:12:09 MS. COY: Okay. We're back on the record at
01:12:15 01:12:15.
01:12:17 Q (BY MR. WALLACE) Doctor, any time you want a break
01:12:21 for any reason at all, would you let us know and we'll take
01:12:23 it?
01:12:23 A Yes, sir. We just talked about that. Thank you.
01:12:26 Q Okay. I noticed from your disclosure statement
01:12:34 that you had testified, that you recalled, in two cases
01:12:40 since 1985, I believe.
01:12:42 A Yes, sir.
01:12:43 Q One of them appears to be a medical malpractice
01:12:49 case that was filed in 1991.
.12:51 A Correct.

01:12:52 Q What was the nature of that case?

12:54 A Am I at liberty to discuss the components of that case?

01:13:00 Q Just what kind of case was it?

01:13:02 MR. COX: I think one of the problems here is that it's an ongoing case.

01:13:07 MR. WALLACE: Oh, I see.

01:13:08 MR. COX: And so there may be some confidentiality issues there that may be involved. So I think, Doctor, for your own, you know, security and potential liability or whatever, I think you can answer general questions about it. After that, you'll have to use your own discretion as to what you feel like you can and cannot discuss about that case.

01:13:28 THE WITNESS: Okay. It is an ongoing case.

01:13:30 Q (BY MR. WALLACE) Are you a defendant in the case?

01:13:32 A No.

01:13:33 Q You're a witness in it?

01:13:34 A No. I believe my role would be as --

01:13:40 Q Consultant?

01:13:41 A -- expert. I was not involved in the care of the patient. It was a patient death. I was asked to review the record to render an opinion as to whether I thought the care was appropriate or not.

01:13:58 Q That's fine. I don't -- I don't need any more.

01:14:02 1 The other one appears to be a divorce case.
14:05 2 A Yes.
01:14:06 3 Q Isaacs versus Isaacs?
01:14:09 4 A Yes.
01:14:10 5 Q And were you an expert in that case?
01:14:13 6 A No.
01:14:14 7 Q You're just a fact witness in it? That's
01:14:21 8 contrasted with an expert witness.
01:14:21 9 A So I have two choice, fact and expert? Those are
01:14:25 10 my only two choices?
01:14:26 11 Q You can characterize it any way you want to,
01:14:29 12 Doctor.
01:14:30 13 A I am a social acquaintance of one of the parties,
01:14:33 14 and my deposition was taken regarding my knowledge of that
01:14:39 15 party.
01:14:39 16 Q You didn't give any expert opinions, did you?
01:14:46 17 A Don't believe so, no, sir.
01:14:48 18 Q You gave your deposition in it?
01:14:50 19 A Yes.
01:14:51 20 Q Have you given any other depositions other than in
01:14:57 21 those two cases you mentioned?
01:14:59 22 A Not in a proceeding such as this, no.
01:15:02 23 Q I notice you're on some kind of firemen's review
01:15:06 24 board.
01:15:06 25 A I have been on a firemen's review board, yes.

01:15:10 Q Have you testified in connection with that
15:15 function?
01:15:16 A No.
01:15:16 Q And those are the only two cases since '85 you've
01:15:21 testified in, either in court or by deposition?
01:15:26 A Yes. I appeared in court in Chickasha probably in
01:15:34 the '70s, and then there was another case involving the City
01:15:38 of Oklahoma City which I hadn't thought about and I was in
01:15:42 court, and that was probably in the early '80s, late '70s,
01:15:47 early '80s.
01:15:49 Q What did that involve?
01:15:52 A A gentleman who wanted to be a police officer,
01:16:03 fire fighter or wanted to have some role with the city who
01:16:08 had a preexisting medical condition that could have rendered
01:16:13 that job hazardous to him or those around him.
01:16:18 Q Okay. I hope that's not ongoing.
01:16:21 A That's '80, '82, perhaps '83 at the latest. But
01:16:28 that's very, very old.
01:16:29 Q Are you acquainted with the nature of this case
01:16:37 that you're appearing as a witness for the defendants in
01:16:42 today?
01:16:42 A I think I'm somewhat familiar with the case.
01:16:46 Q You read The New York Times?
01:16:50 A On occasion.
16:52 Q Sundays?

01:16:53 A Sundays.

16:55 Q And you are aware that a series of cases have been filed by attorney generals across the United States against the cigarette, tobacco companies are you not?

01:17:09 A I am aware of that.

01:17:11 Q Okay. And you're aware that Mississippi filed and Florida filed, Texas filed, Oklahoma filed, are you not?

01:17:18 A The only one I can specifically mention is Minnesota because that one was being tried, I think is the right term, during the time that I became involved in this case. Prior to that, it was just distant news to me.

01:17:36 Q Okay. The Oklahoma case, when did you first become aware that that case had been filed?

01:17:49 A March or April, perhaps April of this year. Either March or April of this year.

01:17:57 Q Now, you hadn't heard about it when it was originally filed?

01:18:02 A I'm certain I had heard about it. It did not make an impression on me.

01:18:08 Q So you first really became fully aware of it in April of this year; is that correct?

01:18:18 A I believe it was April. March or April.

01:18:21 Q March or April. Do you know any of the attorneys representing the defendants in this case?

.18:30 A Know any of the attorneys --

01:18:34 Q Well, what I mean is in the local community, not,
18:38 for example, counsel that sits here at the table.
01:18:42 A Well, first of all, I only know of two or three
01:18:45 attorneys involved in the case. There is one local attorney
01:18:49 who I knew socially many years ago and have remet him one
01:18:55 time since this case was filed, and I think he's involved
01:18:59 with the case.
01:19:00 Q Who is that?
01:19:01 A George Dahnke.
01:19:03 Q And do you know how they happened to retain your
01:19:12 services in the case?
01:19:16 A I had a phone call from a physician, Dr. Darrell
01:19:20 Fisher. Dr. Darrell Fisher is a physician, cardiovascular
01:19:27 surgeon, attorney and author who called me one day -- it was
01:19:34 on a Friday afternoon, I recall -- and mentioned -- and said
01:19:38 that he had given my name to someone. And I don't recall
01:19:42 who it was, and wanted to know that he had given my name.
01:19:45 And the context of that conversation was that the
01:19:49 person to whom he gave my name was an attorney, and that
01:19:53 attorney was asking Dr. Fisher about someone who knew about
01:19:56 risk factors in this community. Well, Dr. Fisher was at St.
01:20:01 Anthony Hospital when I developed the SCORE program, and he
01:20:11 was a -- a very strong supporter of the program. As a
01:20:12 matter of fact, the acronym SCORE was his. So that he was
20:14 very familiar with my work in risk factors going back into

01:20:18 1 the mid '80s, and, therefore, he gave my name to whoever it
20:23 2 was who was asking him about this.
01:20:25 3 Q Okay. And that was George Dahnke?
01:20:29 4 A It may have been George Dahnke. I don't recall,
01:20:32 5 but some -- he was talking with someone who had asked him
01:20:35 6 for a recommendation.
01:20:36 7 Q And this was in March or April of '98?
01:20:40 8 A Yes.
01:20:42 9 Q What was the next thing that you heard about the
01:20:51 10 case from along this line?
01:20:52 11 A The next I heard about the case was that I was
01:20:59 12 asked if I would go to breakfast with three attorneys who
01:21:06 13 were involved in the case to obtain more detail about the
01:21:15 14 process and if I would be interested in participating in
01:21:18 15 this process.
01:21:20 16 Q When you say process, what do you mean?
01:21:24 17 A The need for a local expert who could address risk
01:21:32 18 factors, local physician who had had experience in dealing
01:21:36 19 with risk factors, someone who could review medical records.
01:21:45 20 Q Okay. Who were the three attorneys you -- or did
01:21:50 21 you accept the invitation for breakfast?
01:21:52 22 A Oh, I did go to breakfast.
01:21:55 23 Q And where did you go?
01:21:56 24 A We were at the Waterford.
01:21:58 25 Q When?

A March or April. Same time frame. Who were the attorneys? Cornfield, Cassetta -- there were four attorneys. Cornfield, Cassetta, Dahnke and Callcott. I think that's the correct pronunciation.

Q And what did they tell you?

A Essentially, most everything that Dr. Fisher had told me. And that was the process of -- by which the 35 patients' records were selected. And I think a fair amount of it was exploring my interest in reviewing those medical records and exploring my interest in discussing risk factors further.

Q Did they tell you how these 35 patients were selected?

A I -- yes, they did.

Q And what did they tell you?

A If I remember correctly, they said that the judge in the case selected the letter H at random and that any individual whose last name began with H who was a Medicaid recipient was eligible to participate in this process and that they then went through the Hs and selected a group of 35 Medicaid recipients whose last name began with H who were smokers.

Q And they -- they had to be patients; is that correct?

A They had to be patients?

01:24:09 Q Patients, yes.
01:24:10 A They were Medicaid recipients.
01:24:19 Q Okay. How long did this conference last, the breakfast conference?
01:24:26 A Hour, hour and 15 minutes, roughly.
01:24:31 Q Were you told that you would have to testify in this case?
01:24:42 A I don't specifically recall that statement being made.
01:24:49 Q Were you -- was compensation discussed?
01:24:52 A No.
01:24:53 Q So at this meeting all they told you, then, was that they wanted you -- that you were knowledgeable about risk factors and they wanted you to review the 35 records of the Medicaid recipients?
01:25:31 MR. COX: Let me object to the form of the question. Mischaracterizes the witness's prior testimony. You may answer.
01:25:37 THE WITNESS: They asked if I would review a portion of those 35 records.
01:25:42 Q (BY MR. WALLACE) A portion of them. How many of them did you review?
01:25:45 A Eighteen.
01:25:47 Q Why did you stop at 18?
01:25:49 A I was given 18 records to review.

01:25:53 Q Did they tell you what the case of the State of
26:05 Oklahoma versus RJR and Phillip Morris and Brown &
01:26:13 Williamson and so forth, Lowes, Lorillard was about?
01:26:19 MR. COX: Objection. Vague as to time.
01:26:21 Q (BY MR. WALLACE) At the meeting. At the breakfast
01:26:26 meeting at the Waterford with the four attorneys or five
01:26:29 attorneys.
01:26:29 A At that time my recollection of that meeting is
01:26:33 that we did not go into great detail about the specifics of
01:26:36 the suit itself. More so about the 35 medical records and
01:26:45 my knowledge and experience in counseling patients and
01:26:49 addressing risk factors.
01:26:51 Q Have you since learned anything more about the
01:26:58 litigation?
01:26:58 A I've read the -- read -- I've reviewed the
01:27:03 complaint. I believe that's the appropriate term.
01:27:10 Q The whole hundred pages?
01:27:15 A I've reviewed it. I have not read it.
01:27:17 Q Okay. When you say reviewed, what does that --
01:27:21 what is a review in your terminology?
01:27:24 A I have the document and scanned pages, pretty much
01:27:33 looked at titles of sections, but did not read it in -- in
01:27:39 great detail.
01:27:40 Q At this breakfast meeting, did you agree to
28:00 undertake the review of the records of the Medicaid

01:28:06 1 patients, of the 18?
28:07 2 A I'm not certain if at that meeting I agreed
01:28:16 3 entirely. I think the meeting was more get acquainted and
01:28:22 4 to determine my level of interest. And I don't recall
01:28:25 5 specifically if I said at that time that I was anxious to do
01:28:31 6 this.
01:28:31 7 Q Well, what was your level of interest?
01:28:33 8 A What was my level of interest?
01:28:35 9 Q Yes.
01:28:36 10 A Well, initially I was struck by the fact that I
01:28:41 11 had an opportunity to participate in history, history of the
01:28:47 12 State of Oklahoma. And I thought this was an intriguing
01:28:52 13 challenge.
01:29:13 14 Q And you felt, then, that -- is it fair to say that
01:29:21 15 you felt this was a historical case?
01:29:23 16 A Yes.
01:29:24 17 Q And that you wanted to participate in a historical
01:29:29 18 case?
01:29:29 19 A I'm not certain at that point that I wanted to
01:29:32 20 participate in it. It was intriguing to think about
01:29:37 21 participating in something that had historical significance.
01:29:40 22 Q Did you read any of the answers of the defendants
01:29:51 23 in this case?
01:29:52 24 A No.
.29:53 25 Q See what their position was?

01:29:56 A No. The aspect of this case that I was asked to
30:01 address had to do with patient records and risk factors.
01:30:05 Q And when did you agree to undertake the work that
01:30:12 was proposed to you at this breakfast meeting with the
01:30:18 various attorneys at the Waterford?
01:30:19 A Either at that time or at some later date.
01:30:22 Q When you say at that time, do you mean at the
01:30:29 breakfast meeting?
01:30:30 A Yes. I don't recall specifically agreeing to do
01:30:35 this or declining the opportunity. It was either at that
01:30:39 meeting or at some subsequent meeting where I indicated I
01:30:44 would be interested in pursuing this further.
01:30:46 Q All right. What was the next meeting you had?
01:30:48 A I don't recall the specific meeting -- the next
01:30:58 specific meeting.
01:31:01 Q Okay. What was the next time that you had a
01:31:07 meeting that you had agreed to serve on behalf of the
01:31:13 defendants in this case?
01:31:14 A I don't recall the specific point in time that I
01:31:18 made that statement of agreement.
01:31:21 Q Okay. Did they -- at any point in time did they
01:31:25 talk to you in terms of compensation for undertaking this
01:31:28 work?
01:31:28 A Not specifically.
31:35 Q Are you being paid for your testimony in this

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01:31:37 case?

31:37 MR. COX: Objection to the form of the question in

01:31:39 that it assumes that he's -- his testimony is being paid

01:31:43 for.

01:31:43 THE WITNESS: I'm being paid for -- I think I'm

01:31:46 being compensated -- the agreement was that I be compensated

01:31:49 for my time spent in reviewing records and documents.

01:31:53 Q (BY MR. WALLACE) Okay. And what was the amount of

01:31:56 your compensation?

01:31:56 A We've never agreed to that. We've discussed it,

01:32:00 and we've never reached any agreement, and I have not been

01:32:04 compensated for the time that I have applied to this

01:32:08 process.

01:32:09 Q And they've never paid you a quarter in this case?

01:32:12 A I haven't asked for anything, no.

01:32:15 Q And you haven't billed them for any of your time?

01:32:18 A No, sir.

01:32:19 Q Are you keeping time records?

01:32:20 A Yes.

01:32:21 Q How much time have you put into your work?

01:32:26 A I can only give you a guess as to the number of

01:32:33 hours I've put in on this process.

01:32:35 Q What's your best estimate of the time that you've

01:32:39 put in on the process?

32:39 A One hundred twenty hours, perhaps.

01:32:44 1 Q Do you have a figure in mind that you're going to
33:03 2 charge them for this service?
01:33:05 3 A No.
01:33:09 4 Q At what point in time do you expect to bill them
01:33:12 5 for your services?
01:33:13 6 A I had not thought about that in any great depth.
01:33:19 7 Q Okay. When was the next time that you recall that
01:33:31 8 you had a conference with the attorneys to discuss your
01:33:43 9 testimony?
01:33:44 10 A Perhaps we need to make a distinction between
01:33:47 11 testimony and my knowledge of the clinical records and risk
01:33:54 12 factors of the individuals because I'm not certain that
01:34:00 13 we've ever had a meeting to discuss my testimony, what I
01:34:04 14 would say.
01:34:06 15 Q Okay. When had you discussed your knowledge of
01:34:13 16 the risk factors of the individuals whose medical records
01:34:17 17 you reviewed?
01:34:18 18 A Probably -- I don't recall specifically when I
01:34:32 19 received the records, but after I received the records I
01:34:35 20 reviewed them and then summarized my thoughts on several of
01:34:42 21 the patients at subsequent meetings. And I'm going to say
01:34:47 22 that the majority of them took place in August -- July and
01:34:53 23 August.
01:34:53 24 Q How many meetings did you have with them?
34:58 25 A Again, I don't know specifically. And I can only

01:35:04 1 be conjectural, if that's acceptable.
35:08 2 Q Yes. Just your best estimate.
01:35:10 3 A Ten.
01:35:11 4 Q How long do these meetings last?
01:35:15 5 A Anywhere from hour and a half to two and a half
01:35:23 6 hours.
01:35:24 7 Q Are all these meetings attended by the same
01:35:29 8 lawyers each time?
01:35:30 9 A No.
01:35:31 10 Q What lawyers have you conferred with at these ten
01:35:36 11 meetings?
01:35:36 12 A I've con -- I've conferred with Mr. Cox, Adam --
01:35:45 13 Adam -- I'm just blanking on Adam's last name. Met with
01:35:59 14 Mr. Cornfield once and Carl Rowley.
01:36:08 15 Q How long did you meet with -- how many times have
01:36:10 16 you met with Mr. Rowley?
01:36:12 17 A Twice.
01:36:13 18 Q And Mr. Cornfield?
01:36:19 19 A Once.
01:36:20 20 Q And Adam?
01:36:23 21 A Adam Smith, Adam -- I'm sorry. I'm embarrassed
01:36:31 22 that I forgot his last name already. Adam. Three times,
01:36:35 23 perhaps.
01:36:36 24 Q And Mr. Cox?
.36:38 25 A Half a dozen times, and at times there were more

01:36:43 1 -- it was more than one attorney there. So some of the
36:46 2 numbers would overlap, and the total would come to more than
01:36:50 3 the ten or dozen times we met.
01:37:01 4 MR. COX: If you need to answer that, Doctor, you
01:37:03 5 may.
01:37:04 6 THE WITNESS: No. That's fine. We'll get it at
01:37:08 7 the next break.
01:37:09 8 Q (BY MR. WALLACE) Now, Doctor, I've handed you
01:37:48 9 marked Plaintiff's Exhibit 2 a document that says at the
01:37:55 10 top, "Expert Disclosure." Is this a part of the document on
01:38:05 11 expert disclosure which was produced to the plaintiffs in
01:38:09 12 this case?
01:38:11 13 A Yes.
01:38:12 14 MR. COX: Let me object to lack of foundation as
01:38:14 15 to whether he would know that it had been produced to you,
01:38:17 16 but you may answer.
01:38:20 17 THE WITNESS: My understanding is that this
01:38:22 18 statement as a part of the discovery process, I think, was
01:38:33 19 to be turned over to the plaintiffs a week or so before
01:38:39 20 today.
01:38:40 21 Q (BY MR. WALLACE) So there's no great confusion,
01:38:48 22 there is another seven-day disclosure, Doctor. I'll tell
01:38:57 23 you that. This is the -- this is not the seven-day
01:39:06 24 disclosure.
39:06 25 A Okay. Then I have been confused. I'm sorry.

01:39:09 1 This is not my area of knowledge.
39:11 2 Q Okay. Are you familiar with this document?
01:39:15 3 A Yes.
01:39:16 4 Q Have you seen it before?
01:39:20 5 A Not this specific document, no.
01:39:22 6 Q Do you know who prepared it?
01:39:24 7 A I believe Mr. Cox prepared this. No, I don't know
01:39:34 8 who prepared this. The seven-day document I think Mr. Cox
01:39:37 9 prepared. I do not know the author of this document.
01:39:41 10 Q In the second paragraph, first sentence says,
01:40:21 11 "Dr. Coniglione will testify regarding the multitude of risk
01:40:22 12 factors that tend to occur in individuals that are
01:40:26 13 economically disadvantaged." Do you know what the meaning
01:40:30 14 of that term "economically disadvantaged" is?
01:40:33 15 A Well, I think we can each have our own definition
01:40:37 16 of the term "economically disadvantaged". I have looked at
01:40:42 17 that term to mean patients whose income is below the federal
01:40:47 18 poverty level or in some cases in Oklahoma income less than
01:40:53 19 185 percent of the federal poverty level.
01:40:56 20 Q Do you know when this was prepared?
01:41:07 21 A No, sir.
01:41:09 22 Q Doctor, I show you Plaintiff's Exhibit 3 and ask
01:42:11 23 you to state for the record what that is.
01:42:14 24 A This is entitled Dr. Thomas C. Coniglione's
42:18 25 seven-day disclosure.

01:42:21 Q Do you know who wrote this?

42:25 A I believe Mr. Cox wrote this.

01:42:27 Q Okay. Over on page 2 in the second paragraph on the page, the first unnumbered paragraph on the page, states, "Dr. Coniglione's opinions will be based on," skipping down to number 3, "his review of information, medical records, questionnaires, documents and deposition testimony concerning his case" -- that should be this case, should it not?

01:43:20 A I would agree that the word "this" would be more appropriate than "his".

01:43:27 Q Up at the first paragraph labeled "7" on page 2 of the seven-day disclosure, you state that, "Dr. Coniglione may also comment on the opinions offered by the plaintiffs' experts as well as on the evidence on which they may rely, to the extent that their opinions relate to his area of expertise." Have you gained any knowledge of any of the opinions offered by the plaintiffs' experts in this case?

01:44:28 A That's a broad-ranging question, and my answer would be yes.

01:44:36 Q Okay. What experts' opinions have you reviewed -- plaintiffs' experts' opinions have you reviewed in this case?

01:44:49 A I have reviewed Dr. Nida's deposition.

44:53 Q Okay.

01:44:54 A I've reviewed Dr. Crutcher's deposition.
44:58 Q And any others?
01:44:59 A Those are the only depositions I've reviewed.
01:45:02 Q Okay. What comments do you have on the deposition
01:45:19 of Dr. Nida that you reviewed?
01:45:21 A Well, Dr. Nida's deposition was long. There were
01:45:30 several points that he made in his deposition that I think
01:45:33 were very pertinent points. He addressed issues of, in
01:46:09 general, health care in Oklahoma pertinent to its
01:46:10 population, specifically teenage pregnancy, prenatal care,
01:46:14 immunization rates. I think those are the major -- although
01:46:16 his -- his comments were broad and far reaching, those are
01:46:17 the issues that I specifically recall reading.
01:46:19 Q What -- did he say anything about teenage
01:46:21 pregnancy in Oklahoma that you happen to disagree with?
01:46:23 A No.
01:46:25 Q How about health care in Oklahoma?
01:46:27 MR. COX: Let me object to the overbreadth of that
01:46:33 question and the vagueness of that question.
01:46:36 THE WITNESS: The general terms of his discussion
01:46:44 of the health care in Oklahoma are similar issues that have
01:46:46 been addressed in the newspaper, in the press conferences,
01:46:51 in the state medical journal. So the general principles
01:46:59 that he addressed, the general issues and topics have been
47:03 publicized elsewhere. None of that was new information.

01:47:07 Q (BY MR. WALLACE) Did you agree with -- disagree
47:14 with any of the opinions which Dr. Nida expressed in
01:47:19 connection with health care -- the topics of health care in
01:47:23 Oklahoma?
01:47:24 MR. COX: Let me object to the form of the
01:47:25 question in that it assumes that he has read all of the
01:47:29 opinions and the entire deposition.
01:47:32 THE WITNESS: The three aspects of the deposition
01:47:35 with which I concur, as I recall, had to deal with childhood
01:47:41 immunization rates, teenage pregnancies and the low level of
01:47:46 prenatal care in Oklahoma.
01:47:47 Q (BY MR. WALLACE) Okay.
01:47:53 A These are the three issues with which I agree.
01:47:55 Q Okay. And what are the three -- strike that.
01:47:58 What are the issues that you disagree with that he
01:48:01 expressed his opinions about?
01:48:03 A I did not read his deposition in that detail. The
01:48:07 three issues that I recall reading are the three we just
01:48:11 discussed, and those are the three with which I agree.
01:48:14 Q What are the issues that you reviewed that you
01:48:27 recall concerning Dr. Crutcher's deposition?
01:48:29 A The issues of Dr. Crutcher's deposition that I
01:48:33 recall reviewing had to do with populations and risks of
01:48:41 disease in populations.
48:43 Q What knowledge did you hope to gain by reviewing

01:48:55 Dr. Crutcher's deposition?

48:57 A Just a -- I didn't hope to gain any knowledge in particular from reading either of these depositions. I just hoped to gain a general flavor, a general sense of what was being asked and what some of the issues were.

01:49:13 Q Do you currently treat Medicaid patients?

01:49:38 A Yes.

01:49:39 Q And in what context do you treat them?

01:49:43 A I treat Medicaid patients when I see patients at the Indian hospital in Ada.

01:49:49 Q And how often are you there, did you say?

01:49:56 A I'm there two days a week.

01:49:58 Q Now, who pays for that -- for your services on those instances?

01:50:09 A The Chickasaw Nation health system is responsible for the health care of Chickasaw Indians. Let me correct that. The Chickasaw health system is responsible for the medical care of Indians who reside within their geographic territory in Oklahoma. I am a consultant to the Chickashaw Nation. I am paid by the Chickashaw Nation.

01:50:38 Q Okay. Back to your employment as an expert in this case. Do you know which one of the tobacco companies will be paying you or who will be paying you?

01:50:58 A Well, the use of the term "employment" is

51:05 different to me. I don't believe that I am employed by

01:51:09 anyone.

51:10 Q Okay. Well, your services are engaged. Are you

01:51:15 more comfortable with that terminology?

01:51:17 A I think that would be better. Even more

01:51:22 acceptable, I think, would be compensated for time spent on

01:51:28 reviewing records.

01:51:29 Q Have you ever viewed any videotape presentations

01:51:43 on giving a deposition?

01:51:44 A No.

01:51:45 Q Have you done any mock presentations on a

01:51:54 deposition?

01:51:54 A What do you mean by mock presentations?

01:52:01 Q Well, for example, Mr. Cox might have asked you a

01:52:10 question and you responded as if you were in a deposition

01:52:16 setting.

01:52:18 A I would call that play-acting.

01:52:20 Q Yes.

01:52:20 A We did some, how would I respond to this question

01:52:24 or that question and I would give my responses. We did some

01:52:28 of that.

01:52:29 Q Were you asked to give any opinions that you

01:52:36 didn't feel that you could give in this case or in any case?

01:52:42 A Early on we explored my areas of expertise, and I

01:52:50 was asked if I could address certain areas of expertise, and

52:55 I declined. And what specific areas of expertise did I

01:53:03 decline? I felt that I was not knowledgeable enough in some
53:08 epidemiology and statistical questions to address those.
01:53:13 There were other areas where I volunteered to address.
01:53:24 Q What -- what areas of epidemiology and statistics
01:53:33 did you decline?
01:53:35 A Just general -- that was early on. I was asked
01:53:40 what I knew about epidemiology or statistics or in the
01:53:44 course of conversation it was clear that that would be an
01:53:48 area better addressed by someone else.
01:53:55 Q And what did you volunteer to address?
01:54:01 A Well, the question came up about how Oklahoma is
01:54:08 different from the rest of the country in terms of its
01:54:12 Medicaid population and in terms of the specific health
01:54:16 challenges in Oklahoma. And I have been working and reading
01:54:21 and participating in that area now for quite a few years and
01:54:26 felt comfortable that I could address some of those
01:54:29 questions.
01:54:29 Q When you were putting together, founding SCORE and
01:54:53 working out the risk factors, did you include in such a
01:55:08 program or in that program smoking cessation?
01:55:17 A As a risk factor, we addressed as many risk
01:55:21 factors as were possible.
01:55:23 Q Did you then go on to decide how to eliminate risk
01:55:31 factors?
01:55:32 A Well, I think it's probably important to clarify

here what we did in the SCORE program. In the SCORE program we identified individuals' risk factors. Then in working with the individual and looking at the individual as a person, his environment, his genetics, his family, looking at him, looking at those things in which he had an interest, we attempted to modify risk factors.

Certainly we attempted to educate about as many risk factors as possible, so the educational process was broad. The specific interventions were really designed to address those issues which that individual was prepared to address.

Q Well, would you wait until an individual was prepared to address the issue of cigarette smoking before you would present a specific intervention?

A In the consultation portion of the program, we would outline for the individual the risk factors that we thought needed to be addressed; and then, depending on the individual's interests and responses, we would attempt to address a single risk factor.

It was very clear that we could not address more than one risk factor at a time. We and everyone else who had ever tried to do this knows that you cannot change one's lifestyle dramatically. That is, to change all the risk factors means a dramatic change in one's lifestyle. Even one's very being, one's character would have to change

dramatically. When people reach middle age, that's rather -- it's impossible to accomplish.

Our goal was to then find an opportunity to address a single risk factor, usually one where we felt we would have a success, and then building on the success of dealing with that risk factor we would then attempt to deal with another risk factor. And certain ones were more appropriate to address in certain individuals.

Q All right. You have an individual presenting with a sedentary lifestyle, poor nutritional habits and smoking. You identified those as the outstanding three risk factors for that individual. Then what do you do at that point?

A In working with that individual, I would come to a conclusion that one of those three was the appropriate risk factor to address. The individual would help me to understand which risk factor he was ready to address and to address first. So working with the person we would identify the risk factor to be addressed.

Q Okay. Suppose that smoking cessation -- strike that.

Suppose that smoking was a risk factor that the patient was readiest to address. What would you do then?

A What we did would depend on the point in time that we addressed this question. Recall, now, we're going back 10 to 15 years of history in this program. And during that

01:59:18 period of time there have been different efforts or
59:24 different techniques useful to stop smoking.
01:59:29 Q In 1985, what would you do?
01:59:33 A In 1985, we probably worked on several. We looked
01:59:40 at hypnosis, we looked at cold turkey and we looked at
01:59:45 weaning, cutting back on smoking. However, it was -- you
01:59:50 couldn't address smoking by itself. You had to do something
01:59:55 else for the behavior.
01:59:57 We tried to understand why people smoked and to
02:00:02 see what need was being satisfied by smoking because to just
02:00:07 take the smoking away doesn't really change the person. And
02:00:11 I needed to get an understanding of what satisfaction that
02:00:15 person derived from smoking so that I could hopefully offer
02:00:19 that form of satisfaction in some other manner.
02:00:34 Q Well, a part of the -- do you believe that smoking
02:00:40 cigarettes with nicotine is addicting?
02:00:43 A The term "addiction", I think we would have to
02:00:50 define what we meant by the term "addiction".
02:00:53 Q Okay. How would you define it?
02:00:54 A Well, I could define it the way it was defined
02:00:58 when I was in medical school many years ago, and there have
02:01:01 been multiple definitions that have been developed in the
02:01:06 intervening 30 years now.
02:01:08 Q All right. How would you define it?
.01:11 A Addiction?

02:01:13 Q Yes.

01:13 A There are probably two definitions of the term. One is a behavior which is -- in which one participates within 90 minutes of awakening. That's one definition of addiction. I think there are strengths and weaknesses of that definition. Another definition of addicting -- addiction would be that the agent induces tolerance, interferes with judgment. As a third component of that definition, judgment, tolerance and -- and is intoxicating. I think that's the third component of that definition.

Q Well, there are many people that define it differently and that would leave out intoxication, aren't there?

A There are many definitions of the term "addiction," and I don't know which one is most appropriate.

Q Well, do you believe that ingestion of nicotine by means of a cigarette is addicting?

A I can tell you that I have reviewed 18 medical records and 18 depositions and based on the comments made from those 18 people, I cannot say that I see addiction as the reason for cigarette use in that population of patients.

Having never been a smoker I cannot address that personally. Having worked with patients, I can be reasonably confident to say that cigarette smoking is a habituating behavior. By the same token, I have seen large

numbers of patients who have discontinued smoking and have no adverse effects from discontinuation of smoking and on that basis cannot say it's an addicting substance.

Q Well, have you run across many patients who have great difficulty in stopping smoking?

A Well, the patients frequently say they have difficulty in stopping smoking, and I naturally want to get into that with them. What do you mean, you have difficulty stopping? What have you done?

And I frequently hear stories like this: "Well, I quit smoking for six months, but then I started again." Well, if you quit smoking for six months, obviously, you weren't addicted to it. And when I get into that and discuss that with the patient, it's actually a form of behavior that the patient enjoyed. So he returned to the smoking after a long absence from it. And I hear that from quite a few patients.

Then I ask them what happened to you when you quit? "Well, I was in the hospital," or, "My mother was sick," or they have some reason. And, "Well, I don't recall anything in particular happening to me," but then they returned to it because it was a pleasant experience. Well, that's not -- to me, that can't -- I can't interpret that as addictive behavior.

In reading those depositions and reviewing those

02:04:55 medical records, I clearly get the sense that it's a habit
05:00 that is enjoyed by people.
02:05:07 Q On your expert witness, seven-day disclosure, did
02:05:28 you make any changes in the disclosure, in the text of it?
02:05:34 A I -- I personally did not write this and did not
02:05:39 write on it. I discussed it with Mr. Cox who took notes on
02:05:43 what I said and then came back with this document.
02:05:49 Q Okay. And do you agree with the -- with the
02:05:54 document itself?
02:05:55 A I agree with the general points made in the
02:06:01 document.
02:06:04 MR. WALLACE: Let's take a break.
02:06:06 MS. COY: We're off the record at 02:06:07. This
02:06:10 is the end of tape one.
02:11:38 (A recess was taken.)
02:12:50 MS. COY: Back on the record. This begins tape
02:13:07 number two at 02:13:08.
02:13:10 Q (BY MR. WALLACE) You listed one of the authorities
02:13:28 you rely on the Surgeon General's report of 1998. Is that
02:13:36 correct?
02:13:37 A Yes.
02:13:38 Q In what way are you relying on that, Doctor?
02:13:43 A That is a document that I reviewed as a part of
02:13:49 the material I reviewed for this particular case.
.13:53 Q And to what extent did you review it? I mean, you

had previously described your reviewing plaintiff's complaint in this case by skimming portions of it, looking at it --

A Right. And I skimmed this. This is a report that is, in all likelihood, 2 to 300 pages. It deals with the smoking habits of minority groups and African Americans, Hispanics, Alaska natives, American Indians, I believe also Asian and Pacific Islanders. And I specifically looked at those portions that were related to the tobacco use among American Indians.

Q Okay. And what did you find when you reviewed it? What conclusions did you come to?

A Well, most of what the Surgeon General used for that report regarding Native Americans was derived from the Strong Heart study; and even with reference to the Strong Heart study, most of the questions that were being addressed were answered with there being not enough information in the Native American population to address that specific question. It actually -- to me it asked more questions than it answered.

Q So you -- well, let me put it this way. What -- what did you read in the Surgeon General's report, 1998, that either contributed to your opinions in your seven-day disclosure or detracted from them?

A I thought that this disclosure was to indicate

those reference materials which I have in my possession which I have reviewed which I have utilized to form opinions. To that extent, it is a document that I have reviewed specifically related to questions of tobacco use among Native Americans.

Q And it states here, "Dr. Coniglione has relied in part upon the following documents in forming the opinions he expects to give at trial." Now, what was in that document, the Surgeon General's report of 1998 that you relied on in forming your opinions that you expect to give at trial?

A In that report I relied upon the comments that were made regarding the tobacco use pattern by Native Americans and the fact that there is not enough data available for specific conclusions to be reached regarding tobacco use by Native Americans.

Q Well, did it tell you anything about the patterns of usage of tobacco among Native Americans?

A That report indicates -- as I recall that report, it indicated that Native Americans smoke fewer cigarettes per smoker, but that there appears to be more total smokers in the Native American population.

Q Did you find out anything relating to the American Indian population in Oklahoma from the report?

A Some, but in that report it is -- it is impossible to tell the derivation of the Native Americans they're

02:17:54 1 describing because they never tell you in that report which
17:58 2 Native Americans they're referring to.
02:18:00 3 To get that detail, I think one must go to the
02:18:03 4 Strong Heart study which was the reference for that material
02:18:07 5 in the Surgeon General's report. And the Strong Heart study
02:18:11 6 is a little more specific about the tobacco use patterns
02:18:16 7 among three diverse groups of Native Americans. But that
02:18:20 8 specificity does not come from the Surgeon General's report.
02:18:23 9 Q Okay. What specificity, then, is in the Heart
02:18:28 10 report that would apply to Oklahoma Indians?
02:18:33 11 A The Strong Heart study utilized Native Americans
02:18:38 12 in the northeast and southwestern parts of the state
02:18:41 13 primarily, and the Strong Heart study indicated that --
02:18:52 14 let's see, Strong Heart study said that diabetes,
02:18:56 15 hypertension and obesity are more prevalent in Native
02:18:59 16 Americans. And I'm quite certain that one of the Strong
02:19:01 17 Heart study publications refers to the fact that the number
02:19:07 18 of smokers among the Native American population is greater
02:19:11 19 than the numbers in the non-Native American population.
02:19:16 20 Q Have you referred -- or have you found anything in
02:19:22 21 any data anyplace concerning the rate of smoking and the
02:19:31 22 amount of smoking among Oklahoma Native Americans?
02:19:35 23 A There is some information that addresses the
02:19:41 24 smoking in Oklahoma Native Americans.
02:19:44 25 Q What is that information?

02:19:45 A Probably the best source of that information would
19:50 be a report from the Oklahoma State Department of Health.
02:19:54 The State Department of Health report was authored by Gordon
02:20:01 Deckert, D-E-C-K-E-R-T. It was published in the Oklahoma
02:20:06 state medical association journal. Some of it has been in
02:20:10 the media.
02:20:15 And that's probably the report -- oh, Dr. -- there
02:20:20 was another report in the state medical journal authored by
02:20:24 either Dr. Ed Brandt, B-R-A-N-D-T, or authored by or
02:20:31 co-authored by Dr. Everett Rhodes, and I can't recall which.
02:20:45 But that's another publication that addresses tobacco use
02:20:46 among native persons in Oklahoma.
02:20:47 Q What did Dr. Deckert's article say about the
02:20:48 smoking among Native Americans in Oklahoma?
02:20:49 A Either Dr. Deckert's or those other articles
02:20:56 addressed numbers or the percentages of Native Americans who
02:21:04 smoke and/or the number of cigarettes smoked per day.
02:21:10 Q Okay. Dr. Deckert is a psychiatrist, isn't he?
02:21:16 A Correct.
02:21:17 Q What in the world would he be doing writing an
02:21:21 article on smoking among Native Americans?
02:21:23 A He is chairman of the Oklahoma board of health,
02:21:31 state agency, state committee composed of, oh, probably half
02:21:36 a dozen physicians. And they recently issued a report on
21:39 the health of the State of Oklahoma.

And the issues they addressed are the teen pregnancy rates, the level of prenatal care given to Oklahoma women, the difficulty in access in Oklahoma. They emphasized a lot of issues pertinent to Oklahoma which helps us to understand how different Oklahoma is from the rest of the country.

Q How different they are?

A How different they are in terms of the challenges to provide health care.

Q On some of these issues Oklahoma, say, would be -- would ranked sixth in the nation.

A It depends on the -- the topic being addressed.

MR. WALLACE: Okay. Ten second break here.

MR. COX: Sure.

MS. COY: Off the record at 02:22:49.

(A recess was taken.)

MS. COY: We're back on the record at 02:23:31.

Q (BY MR. WALLACE) You told us about what would be done in connection with a risk factor of an individual presenting himself or herself in -- to SCORE in 1985 regarding -- well, period. Can you tell us what would be done on such an individual presenting himself or herself in 1990 to SCORE where that person has three risk factors, one of which is smoking cigarettes, and that individual is ready -- or you feel is ready to do something about the risk

02:24:28 1 factor of smoking.
02:24:30 2 A The -- the question, as I understand it, is the
02:24:36 3 differences in approach by the SCORE program 1985 versus
02:24:42 4 1998 --
02:24:42 5 Q No. 1990.
02:24:44 6 A 1985 and 1990, the differences in how we would
02:24:49 7 approach that person who was ready to stop smoking?
02:24:52 8 Q Yes.
02:24:53 9 A I think it's important that we recognize that all
02:25:01 10 of this is transitional. This is constantly in change. And
02:25:05 11 to go back and pick a specific point in time and what we
02:25:08 12 would have done at that point in time requires using my
02:25:13 13 memory that I'm not certain I'm capable of -- of doing.
02:25:19 14 My recollection would be that in 1990 we were
02:25:24 15 about on the verge of using drugs to augment the
02:25:29 16 stop-smoking process if people wanted drugs. I think we
02:25:33 17 were beyond the nicotine gum and I think we were at the
02:25:37 18 nicotine patch. But, remember now, this is all
02:25:40 19 transitional, constantly changing. I think we were either
02:25:44 20 at gum or patches at that time, perhaps not yet to the
02:25:48 21 drugs.
02:25:49 22 Q All right. And in 1998 what sort of cessation
02:25:59 23 program would you have such an individual undertake?
02:26:03 24 A Well, 1998 I would say that based on my experience
.26:08 25 over the years, that I still think one of the most effective

cessation programs is sudden discontinuation of cigarettes.

Q With any kind of assistance?

A Of all the techniques that I have seen used in my experience, I think that is about the best. I think it goes to do -- the success of any program has to deal with motivation and substitute behavior. I think when you have motivation and substitute behavior, there's potential for all of these things to work.

In talking with a lot of patients, those who suddenly stop are extremely motivated; and I think that -- my opinion is that they're more successful.

Q You're talking now just cold turkey?

A Yes.

Q How successful is that technique with the Medicaid patients in the Chickashaw Nation?

A I don't think there's any technique with the Medicaid patients in the Chickasaw population that is universally successful. Of those I have discussed this topic with, that is as successful, if not more successful, than other programs.

Q Well, you have -- in the article you cite, there's an incidence of diabetes in the Native American population of 33 and a third percent, don't you?

A Which article are we discussing now?

Q The first article in your seven-day disclosure.

02:28:12 No. I'm sorry. It's the "Howard B.V., Diabetes and
02:28:24 Coronary Heart Disease in American Indians, the Strong Heart
02:28:28 Study."
02:28:28 A What that article says is that the prevalence of
02:28:32 diabetes in the Pima Indians is 70 percent greater. The
02:28:38 prevalence of diabetes in Oklahoma Indians is in the range
02:28:42 of 40 to 60 percent, and the prevalence of diabetes in the
02:28:47 South Dakota Indians is slightly less. So the prevalence of
02:28:50 diabetes in populations that I have studied in Oklahoma
02:28:54 ranges from 40 to 60 percent, second only to the Pima
02:28:58 Indians in terms of frequency.
02:29:00 Q Wouldn't you agree, Doctor, then, that these
02:29:16 diabetic patients among the Chickasaw Nation, of all people,
02:29:22 should not be smoking cigarettes?
02:29:23 A Wouldn't I agree that these diabetic patients --
02:29:31 if I had my way, these diabetic patients would be doing many
02:29:35 things differently than they currently do them. I would
02:29:38 first address the issue of obesity in the Native American
02:29:42 population. There is ample reason to think that the obesity
02:29:47 plays a role in the development of diabetes in this
02:29:50 population. If I had a wish, it would be that I could
02:29:53 address obesity and then the content of the Native
02:29:57 American's diet.
02:30:02 Q Okay. Now, the -- we're beyond this now with a
.30:19 patient. They have diabetes, the -- you still going to just

02:30:29 1 treat their diet and their obesity?
30:31 2 A No. That's not the question I answered. Perhaps
02:30:35 3 I misunderstood your question. I thought we were addressing
02:30:39 4 the principal risk factor to address or that risk factor
02:30:44 5 which if addressed would have the greatest impact on the
02:30:49 6 population. And my answer was that diet and the obesity. I
02:30:54 7 think that's the most significant risk factor for this
02:30:58 8 population.
02:30:58 9 Q Where would you rank cigarette smoking?
02:31:01 10 A In the middle. And, again, I don't know which
02:31:12 11 risk factors we're addressing. And I think we're going to
02:31:16 12 have to be more specific and --
02:31:18 13 Q Let's take the risk factors for cardiovascular
02:31:22 14 disease.
02:31:23 15 A Okay.
02:31:23 16 Q You listed, what, about six of those?
02:31:26 17 A Let's just make a list. Diabetes, inactivity,
02:31:36 18 diet.
02:31:39 19 MR. COX: Wait a minute. I think that is an
02:31:41 20 exhibit.
02:31:42 21 THE WITNESS: I'm sorry.
02:31:44 22 MR. COX: I'm sure that counsel doesn't want you
02:31:47 23 to write on his exhibit.
02:31:53 24 THE WITNESS: Well, my list, smoking, high
32:10 25 cholesterol, diabetes, obesity, hypertension, high-fat diet,

a diet high in fat and low in antioxidants and then inactivity.

Q (BY MR. WALLACE) Okay. Now, you said you would rank smoking in the middle of these?

A Well, now that we have a new group from which to choose, the question is about the relative rank, order of importance.

Q In your -- in your opinion.

A Diabetes, obesity and diet would have to be in the first tier. Inactivity, smoking and cholesterol in the second tier. Hypertension in the third tier.

Q Excuse me. Inactivity, smoking and what in the second tier?

A High cholesterol. I'm having great difficulty selecting one as more significant or more important than any of the others. I think that given the context of an individual patient, I might have a different answer; and this is an abstract answer now.

Q Okay. We're talking about populations, though, or rather I was trying to talk about populations. What would come in the third tier of your population?

A Hypertension.

MR. COX: I assume we're talking about American Indian population still?

MR. WALLACE: Yes.

02:34:23 Q (BY MR. WALLACE) Would family history play a part
34:37 in this?
02:34:37 A Family history or genetics, I can't change. It's
02:34:42 a risk factor, I think we all recognize it's a risk factor,
02:34:46 but it's not a modifiable risk factor. I made my comments
02:34:53 pertinent to those risk factors which if -- if modifiable,
02:34:57 can or should be modified.
02:34:59 Q Now, in -- in the SCORE program, the population
02:35:21 you're dealing with there is quite different from the
02:35:26 Medicaid population, is it not?
02:35:28 A Yes.
02:35:29 Q Those people are very often highly motivated.
02:35:38 A Highly motivated is, again, a -- a subjective
02:35:43 term. They're more motivated, I think, than the Medicaid
02:35:46 population with some differences in degree of motivation.
02:35:49 Q I'm talking about towards health practices or
02:35:55 elimination of risk factors.
02:35:57 A The individuals who participated in the SCORE
02:36:00 program were more highly motivated.
02:36:05 Q And how else would they differ from your Medicaid
02:36:11 population among the Chickasaw Nation?
02:36:15 A Oh, how else were they different? Well,
02:36:23 motivation is probably the first, as you mentioned. Second
02:36:27 is occupation. The vast majority of the SCORE participants
36:31 are employed. The vast majority of the Chickasaw Nation

02:36:36 1 citizens, Medicaid or not, have difficulty obtaining
36:43 2 employment. The -- now, we're talking about Medicaid
02:36:49 3 Chickasaw population? Was that your question?
02:36:51 4 Q Yes, sir.
02:36:51 5 A The Medicaid Chickasaw population is probably no
02:36:55 6 -- not much different from the remainder of the Medicaid
02:36:59 7 population in terms of other behaviors that we would
02:37:04 8 identify as high-risk behaviors. High-risk behaviors would
02:37:10 9 be exemplified by teen pregnancy rate, sexually-transmitted
02:37:19 10 disease, prevalence rates, risky behavior rates. I think
02:37:29 11 that this is a population that engages in risky behaviors.
02:37:34 12 That is, not wearing seat belts, substance abuse. I think
02:37:38 13 that all those factors are far more prevalent in the
02:37:43 14 Medicaid population.
02:37:44 15 Q The -- in your original -- or in the original
02:37:58 16 expert disclosure that we received, the second full
02:38:12 17 paragraph, Doctor, says -- refers to a multitude of risk
02:38:16 18 factors. Would you read that, please, for the record, that
02:38:25 19 sentence.
02:38:25 20 A Number two?
02:38:26 21 Q Second paragraph.
02:38:28 22 A The sentence that addresses multitude of risk
02:38:32 23 factors?
02:38:32 24 Q Yes, sir.
38:33 25 A "Where an individual has multiple risk factors,

02:38:36 1 the risk factors tend to interact and may synergistically
38:42 2 impact the individual's health."
02:38:47 3 Q Okay. Now, would you agree that the risk factors
02:38:58 4 of obesity and the risk factor of poor nutrition and the
02:39:09 5 risk factor of smoking are synergistic?
02:39:14 6 A I don't -- I don't know that factually. I don't
02:39:19 7 know if they're simply additive or if they're actually
02:39:24 8 synergistic.
02:39:25 9 Q Now, when you say you don't know that, you mean
02:40:10 10 you don't know it of your own knowledge or you don't know
02:40:15 11 any people who maintain that it's synergistic?
02:40:17 12 A Well, couple things. That particular sentence is
02:40:20 13 not in the seven-day disclosure.
02:40:24 14 Q Okay.
02:40:24 15 A My seven-day disclosure statement has a different
02:40:28 16 sentence that does not address the question of synergism.
02:40:31 17 Synergism, as I understand it, is the presence of
02:40:38 18 two independent concurrent risk factors which when present
02:40:43 19 together act greater than their potential additive effects,
02:40:59 20 that being synergism. Risk factors are synergistic. The
02:41:00 21 degree of synergism is difficult to predict especially in an
02:41:07 22 individual.
02:41:10 23 Q Well, would you agree that in accordance with your
02:41:16 24 definition of synergistic that diabetes and cigarette
.41:23 25 smoking are synergistic risk factors?

02:41:26 MR. COX: Let me object to the form of the
02:41:28 question in that it's vague as to whether or not the
02:41:31 question addresses populations or individuals.
02:41:35 Q (BY MR. WALLACE) Okay. Addressing -- I'll accept
02:41:40 his -- one of his suggestions. We're addressing
02:41:49 populations.
02:41:50 A In -- and, again, I have to think of examples.
02:41:57 The Framingham heart study showed that -- if I'm not
02:42:04 seriously mistaken, showed that all risk factors were
02:42:07 synergistic. And they added up many risk factors, some of
02:42:12 which we have not put on our list. But the tables from the
02:42:16 Framingham heart study would indicate that risk factors were
02:42:21 all potentially synergistic.
02:42:25 Q Would you agree with that, then?
02:42:27 A I have no reason to disagree that that's a
02:42:33 statistical association that is pertinent when addressing
02:42:38 populations.
02:42:38 Q And is it important to know these characteristics
02:42:46 of populations such as we have been discussing here in the
02:42:51 Framingham study?
02:42:52 A Is it important --
02:42:54 MR. COX: Let me object to the form of the
02:42:55 question in that importance is not defined in this context,
02:43:00 to who, to what, whatever. But you may answer if you can.
02:43:03 THE WITNESS: Well, I have -- the question is --

02:43:10 the question was: Is it not important to know -- was the
43:17 importance of the factors synergism important to know? What
02:43:21 was the question again?
02:43:23 Q (BY MR. WALLACE) Let's back up, then. You say
02:43:27 that the Framingham study talks about risk factors being --
02:43:34 in a population being synergistic.
02:43:36 A Yes. It's a combination.
02:43:44 Q How is that information useful to you as a medical
02:43:49 doctor?
02:43:49 A That information is useful to me when I'm
02:43:54 consulting with, dealing with an individual patient.
02:43:56 Q Okay.
02:43:57 A If I know that information, I know that -- that
02:44:01 those are the risk factors that I should attempt to address
02:44:05 with that individual. The fact that there is synergism or
02:44:10 the fact that there is a relative level of importance
02:44:14 doesn't translate into the individual patient quite so
02:44:18 readily. I think that's all important epidemiologic
02:44:23 information which I as a clinician should attempt to apply
02:44:26 from those Framingham studies to the individual patient.
02:44:30 But now I'm limited by the individual patient's
02:44:33 receptivity or the patient's ability to deal with any of
02:44:39 those risk factors. Now, I have to use my knowledge of that
02:44:43 individual in an attempt to modify risk factors. So it's
44:47 important for me to know what they are, but then more

02:44:50 1 importantly I have to know how to apply that to the
44:53 2 individual.
02:44:53 3 Q Okay. You have this information, then, that --
02:44:57 4 would you agree that diabetes and cigarette smoking are both
02:45:05 5 risk factors for cardiovascular disease, for example?
02:45:09 6 A Yes.
02:45:10 7 Q Would you agree that --
02:45:12 8 A I would agree.
02:45:14 9 Q Okay. You have a patient who presents with the
02:45:18 10 diabetes and smoking cigarettes. Would you agree that that
02:45:23 11 is synergistic, that combination is?
02:45:26 12 A I would agree that the statistics as applied to
02:45:31 13 populations would indicate that that is synergistic in
02:45:34 14 considering populations. To that one individual, I don't
02:45:39 15 know if that's synergism. I don't even know if that risk
02:45:44 16 factor is operative in that person.
02:45:46 17 I know that from looking at the population
02:45:48 18 studies; but when it comes down to a single individual, I do
02:45:53 19 not know -- no one knows which risk factor is more
02:45:56 20 important, which ones are additive. As a matter of
02:46:02 21 principal, we address those risk factors that have been
02:46:05 22 identified for populations when we deal with individuals.
02:46:07 23 Q I'm sorry. You do what now?
02:46:09 24 A We address the risk factors identified for
.46:12 25 populations when we're dealing with individuals.

02:46:15 1 Q Wouldn't you tell a -- strike that.
46:20 2 In reaching your prognosis, wouldn't you regard in
02:46:27 3 an individual, an individual who has diabetes and has smoked
02:46:32 4 cigarettes, that those are likely -- that that combination
02:46:36 5 is likely to be synergistic?
02:46:40 6 A Again, I think here we have an issue with -- with
02:46:48 7 words. That combination is likely to be synergistic. I
02:46:53 8 would use the term that combination could be. I don't know
02:46:57 9 that it will. I don't know that it won't. But it can be.
02:47:02 10 I don't know if it's likely or not. It's the same
02:47:05 11 as the probability question we addressed earlier. The
02:47:08 12 probability is a ratio that applies to a population. When
02:47:12 13 I'm dealing with a patient, the disease is either there or
02:47:14 14 it's not there.
02:47:19 15 Q Well, you get down, then, to then the patient
02:47:23 16 would be a statistic of one, would you not?
02:47:25 17 A Well, in terms of probability of disease, it's
02:47:28 18 either zero or 100 percent.
02:47:31 19 Q Well, you're -- now say that you're engaged in
02:47:36 20 predicting what's going to happen to this individual. The
02:47:45 21 individual has diabetes, the individual has smoked
02:47:49 22 cigarettes; okay. What do you do as far as the risk factor
02:47:56 23 of diabetes is concerned?
02:47:58 24 MR. COX: Let me object to the preface of that
.48:00 25 question, that it misstates the witness's testimony and it

02:48:03 1 is a gratuitous comment, not part of the question and ask
48:07 2 that it be stricken; but you may answer the question as best
02:48:10 3 you can.
02:48:10 4 THE WITNESS: Well, I have a problem with the word
02:48:13 5 "prediction". We in medicine can't predict anything. I
02:48:16 6 think predictions are hazardous for clinicians or
02:48:20 7 physicians. Perfect example, we see people we think are
02:48:25 8 perfectly healthy and well who suddenly die a week later.
02:48:29 9 We had no way of predicting that person would die.
02:48:32 10 We see people who have complex degenerative
02:48:35 11 diseases where logically we might -- we might predict that
02:48:42 12 that individual's anticipated life expectancy would be very
02:48:46 13 short. We're wrong more often than we're right. I -- I
02:48:49 14 don't predict anything.
02:48:51 15 And when I teach my residents and my students, I
02:48:56 16 stay away from predictions. Predictions are of statistical
02:48:59 17 importance. We know that an individual who has a diagnosis
02:49:03 18 of whatever condition, a population of those patients would
02:49:07 19 have a predictable chance of survival or death of a given
02:49:12 20 percentage. But in an individual patient, prediction of
02:49:17 21 prognosis, I think, is -- is not clinically appropriate.
02:49:24 22 Q You don't ever put down anything in your prognosis
02:49:29 23 to that effect?
02:49:29 24 A In terms of percentages and probabilities?
49:32 25 Q No. In terms of likelihoods.

02:49:35 A I use the terms "risk," you have a low risk of
49:41 developing heart disease or based on my assessment, I think
02:49:44 your risk of developing heart disease is high. What does
02:49:47 that mean? I don't know if he's going to develop it today,
02:49:51 tomorrow or if he will ever develop it.
02:49:53 I can say that based on population statistics, I
02:49:57 think your risk is high, but I think your risk is high. If
02:50:01 I take your history and do a physical exam and study your
02:50:05 body the best I can, all I can do is say, "I think your risk
02:50:10 is high." But I don't know that. No one knows that. This
02:50:16 is --
02:50:16 Q Okay. You have a patient then presenting with
02:50:18 diabetes and cigarette smoking. Would you say to that
02:50:22 patient, "I think your risk is high that you will get
02:50:25 coronary artery disease"?
02:50:27 A I can say that.
02:50:28 Q Would you say that his risk of -- or her risk of
02:50:41 developing coronary artery disease is greater if that
02:50:49 individual smokes and has diabetes than in an individual who
02:50:55 only has the diabetes?
02:50:57 A I can say that the statistics would show that you
02:51:03 are at greater risk by virtue of the smoking or by virtue of
02:51:12 any other of the risk factors being present.
02:51:15 Q Doctor, second full paragraph here starting out,
51:38 "Dr. Coniglione will testify," would you read that, please.

02:51:42 A This is now in the expert disclosure and not the
51:46 seven-day disclosure?
02:51:47 Q Yes, sir.
02:51:48 A Okay. Paragraph two, "Smoking is only one of many
02:51:52 risk factors and lifestyle choices that can impact an
02:51:55 individual's health status."
02:51:57 Q No. The one that starts Dr. Co --
02:52:02 A Oh, I'm sorry. That one, the non-numbered
02:52:05 paragraph. "Dr. Coniglione will testify regarding the
02:52:09 multitude of risk factors that tend to occur in individuals
02:52:12 who are economically disadvantaged and will review the
02:52:17 medical records, questionnaires and deposition testimony of
02:52:22 Oklahoma Medicaid recipients chosen for disclosure as a part
02:52:25 of this case. Dr. Coniglione will comment on the presence
02:52:29 and role of various risk factors for the diseases occurring
02:52:33 in those individuals."
02:52:34 Q Okay. The question I have is regarding the term
02:52:41 "multitude of risk factors". What does that term mean to
02:52:46 you, Doctor?
02:52:47 A There are risk factors, and I think that there are
02:52:54 large numbers of risk factors that have been identified.
02:52:58 And the longer we go in the history of medicine, the more
02:53:02 risk factors are identified. That statement to me would
02:53:06 indicate that I am prepared to make comments regarding many,
53:14 most of the risk factors that have been identified that

occur in this particular population in question.

Q The -- which population?

A The individuals who are, quote, economically disadvantaged.

Q Okay. Okay. What are the multitude of risk factors, then, for coronary heart disease that occurs in this particular population?

A Well, we have identified so far seven -- ten. To review those?

Q No. Let's go from the ten. From ten on, what -- what are the multitude of risk factors that you're prepared to testify to in this Medicaid population?

A Whether or not they pertain to the 18 records I've reviewed or pertinent to the 18 records?

Q Not limited to the 18 records. To the multitude of risk factors that tend to occur in individuals who are economically disadvantaged.

A Can I refer to one of the other documents on my disclosure statement?

Q You can refer to anything you wish, Doctor.

A Reference 8. Do you have those references? I don't. The Hopkins article.

Q Paul N. Hopkins, "A Survey of 246 Suggested Coronary Risk Factors." Have you read all those risk factors that are in that?

02:55:30 A I've reviewed that article.
55:32 Q You've reviewed it?
02:55:34 A Yes.
02:55:34 Q Have you considered the risk factors that he
02:55:37 suggests in them, all 264 (sic) of them?
02:55:41 A Have I thought about or reviewed those risk
02:55:46 factors?
02:55:46 Q Yeah. Thought about them would be more what
02:55:49 I'm --
02:55:50 A I've reviewed his list of 264 (sic).
02:55:53 Q Okay.
02:55:54 MR. COX: If it would assist, I do have a copy of
02:55:57 it here, that particular article.
02:56:00 Q (BY MR. WALLACE) Would that assist you, Doctor?
02:56:02 A To give you a comprehensive list. I think that he
02:56:06 has in his article a reasonably comprehensive list. He
02:56:10 leaves off a couple of others that I think are pertinent.
02:56:13 Q What does he leave off?
02:56:14 A I think he leaves off homocystine. When I look
02:56:18 through this, I'm -- I don't recall his mentioning
02:56:21 homocystine which is a definite risk factor.
02:56:25 Q What is homocystine?
02:56:26 A Homocystine is an amino acid which occurs in the
02:56:35 body. It is not naturally-occurring in the body, but it's
56:41 produced from other substances within the body. Homocystine

02:56:46 1 has the potential to accelerate the blood vessel
56:56 2 degenerative process known as arteriosclerosis. Therefore,
02:57:04 3 in individuals who have high levels of homocystine, they
02:57:08 4 have more cardiovascular disease than individuals with
02:57:12 5 normal levels of homocystine.
02:57:14 6 And there are things we know that can reduce the
02:57:17 7 level of homocystine, thereby theoretically reducing the
02:57:22 8 risk. So homocystine, I don't think, was addressed in this
02:57:28 9 particular article.
02:57:30 10 Other issues are carbon monoxide exposure or
02:57:35 11 carbon monoxide intoxication.
02:57:38 12 Q In addition to the article?
02:57:42 13 A I'm looking to see if he addressed carbon monoxide
02:57:48 14 intoxication. I thought he did, but now I have to remember.
02:57:52 15 Certainly I don't recall seeing the homocystine. I think he
02:57:56 16 addressed -- he doesn't address carbon monoxide exposure or
02:58:03 17 poisoning. He addresses the blood test for that. So
02:58:08 18 indirectly I think he addresses it.
02:58:12 19 Other issues that we have not addressed that
02:58:16 20 affect cardiovascular disease development are personality,
02:58:26 21 stress. There is a -- a psychologist in Minnesota who uses
02:58:41 22 the term "life change", and he actually has a scoring system
02:58:48 23 for life change units. And he says that if one attains
02:58:52 24 enough life change units, he is at risk for developing
58:59 25 cardiovascular disease. And he addresses life change units

as things such as divorce, death of a close member of the family, children being ill, jailed and otherwise. So that's an attempt to address stress as one of the risk factors.

Q Did you review his article?

A Not for this today, no; but I recall reading it at some point in time and referring to it in some of the classes I've taught.

Q This is a psychologist?

A Psychologist. I believe he's from Minnesota and the term "life change units" was a term he coined.

Q You're not a psychologist, are you, Doctor?

A I am not a psychologist, but there are some basic principles of human behavior which are applied to clinical medicine. And I think I'm reasonably knowledgeable in aspects -- psychological aspects of behavior as they apply to medicine.

Q What courses in psychology have you taken?

A Collegiate courses in psychology. In medical school we had a two-year course in understanding people and their environment. Subsequently I have read many reports of principles of psychology and how they are applied to medicine.

Q Have you written any articles in psychology?

A No.

Q Have you reviewed any, done any peer review of

03:01:16 articles on psychology?

01:16 A Well, I -- let's go back just one -- one question.

03:01:18 Have I written any articles in psychology? Some of the

03:01:19 articles I have written imply to psychological aspects of

03:01:23 disease and in illness. Those are mostly the articles that

03:01:28 are not on my CV that have to do with human dynamics as they

03:01:37 relate to injuries.

03:01:50 Q Cigarette smoking is one of the risk factors that

03:01:58 can be addressed and can be done away with, isn't it, as

03:02:06 contrasted, say, to AIDS or sex or family history?

03:02:10 A The act of cigarette smoking, I think, is one of

03:02:14 what I would call the modifiable risk factors.

03:02:17 Q Modifiable risk factors.

03:02:18 A Those risk factors that are choice rather than

03:02:22 genetics.

03:02:24 Q And that's one of the most important risk factors

03:02:35 in the -- the disease process, is it not?

03:02:40 MR. COX: Objection. Vague.

03:02:41 THE WITNESS: I'm not sure I know what you mean by

03:02:44 the term "one of the most important."

03:02:45 Q (BY MR. WALLACE) Okay. Well, are you familiar

03:02:48 with what the Surgeon General has to say about smoking as a

03:02:53 risk factor?

03:02:53 A There have been several Surgeon General reports.

02:57 If you want to be specific or refer to a specific one or

show me something from the Surgeon General's report.

Q Well, on page 6, chapter 1 of the Surgeon General's report of 1998, he states, "Cigarette smoking is a major cause of disease and death in each of the poor population groups studied in this report." You saw that statement when you were reading the Surgeon General's report of 1998, didn't you, Doctor?

A I -- I assume I did as I -- as I reviewed components of that report.

Q Okay. Well, do you agree or disagree with his statement when he says that -- when the Surgeon General says in his report of 1998 that cigarette smoking is a major cause of disease and death in each of the poor population groups studied in this report?

A Cigarette smoking is a major cause of disease and death in those four populations studied.

Q Yes, sir.

A Well, there are -- there are several things we need to talk about here. A major cause, that assumes that there are major and minor causes. I don't know what he's talking about in terms of major and minor or other categories of causes first.

Second, the whole word of "causation" is a difficult word. I think he's using the term "causation" as it applies to populations.

03:04:48 We've already discussed the fact that causation is
04:51 an issue that we attempt to address when we deal with
03:04:54 individuals. And my earlier comment or the earlier, I
03:05:00 guess, testimony I gave was that even if I know all of the
03:05:04 medical details of an individual, I still have difficulty
03:05:07 determining cause of disease.
03:05:10 I think it would be more correct to state -- and
03:05:12 I'm just going to paraphrase and I may change this -- that
03:05:16 cigarette smoking is associated with disease and death in
03:05:23 the four populations studied and, therefore, I would put it
03:05:27 in the category of other risk factors for disease.
03:05:30 Q Well, how do you handle the word "major"?
03:05:34 A Well, that's my problem. I don't understand -- I
03:05:37 don't have a definition, I don't have the context in which
03:05:40 he's using that word. If you can give me the context of the
03:05:45 word "major" as opposed to other categories of words, I
03:05:50 think I would have some other thoughts on the question.
03:05:54 Q Well, I only have the context of the statement of
03:05:58 the Surgeon General's report, 1998. Is it fair to say,
03:06:04 then, Doctor, that you do not understand what the Surgeon
03:06:08 General's report of 1998, this quotation is talking about?
03:06:13 A I think the Surgeon General's use of the word is
03:06:19 vague and, if not defined, I think it would be difficult for
03:06:22 anyone to gather a relative appreciation of the intent of
06:26 that statement.

Q Wouldn't you say that he regards cigarette smoking as an important health risk in each of the four population groups studied?

A Important --

MR. COX: Let me object to the scope of the question or the form of the question in that it asks the -- the witness to speculate as to what is in the Surgeon General's mind.

THE WITNESS: I think that that's stated better than I could state it. I'm not sure I know what he's talking about when he uses relative terms. A major cause, an important cause. Well, I think there are many important causes of disease.

And as I've already stated, I think a poor diet and inactivity, high cholesterol are -- I think are very important causes of disease. I think cigarette smoking is an important cause of disease. When asked to put these things in relative proportion, I think we know -- need to know what he's thinking when he makes that statement or how you want to interpret that in the context in which you prefer I answer it.

Q In the seven-day disclosure, Doctor, on numerical paragraph 4, would you read that first sentence, please.

MR. WALLACE: I'm sorry. Let's take a break for lunch.

03:08:27 THE WITNESS: You want to break for lunch.
03:08:29 MS. COY: We're off the record at 03:08:29.
03:08:32 (A lunch recess was taken.)
04:22:37 MS. COY: We're back on the record at 04:24:25.
04:24:27 THE WITNESS: Before we start, can I make an
04:24:31 amendment or a modification of a statement or some
04:24:35 statements made just before the break?
04:24:37 Q (BY MR. WALLACE) Surely.
04:24:38 A We were discussing the Surgeon General's statement
04:24:45 of major causes of death in four populations; and then when
04:24:50 I spoke about risk factors, I spoke about risk factors
04:24:54 causing disease. I misspoke. I should have said risk
04:25:01 factors associated with disease. I think that was the
04:25:05 intent of the Surgeon General's statement and that's
04:25:10 consistent with all the other comments I had made this
04:25:12 morning regarding risk factors.
04:25:14 Q Well, do you think that, Doctor, in connection
04:25:19 with your amendment, that cigarette smoking has a -- is a
04:25:30 major causal connection with -- has a major causal
04:25:33 connection with disease and death in each of the four
04:25:39 population groups studied in the report?
04:25:41 A I think cigarette smoking is one of the risk
04:25:44 factors that is associated with those things in that report
04:25:51 and that the association is pertinent to population
04:25:54 discussions. The term "causation" -- I think before the

break we alluded to the Surgeon General's use of the word "cause", and I know that in other -- in all the Surgeon General reports they use the word "cause" and then they elsewhere in the report say that statistics can't prove cause. So my position is that these risk factors are associated with the development of various diseases.

Q So if the association is large enough, can't you infer causation?

A Not to an individual.

Q To a population, can you infer it?

A I think you can infer association with a population, but I can only talk in terms of causation relative to individuals. And I can only do that after I understand that patient's entire medical history, his examination, his testing; and then it -- even after all that is done, my ability to determine cause for an individual is limited and speculative.

Q You're here not only to offer opinions on individuals, but also on populations, aren't you, Doctor?

A I'm here to offer opinions regarding those individual Medicaid recipients whose files I reviewed.

Q Well, can you generalize for me your findings on reviewing those files -- Medicaid recipient files to the Medicaid population in Oklahoma?

A No, no. I've reviewed 18 files. The Medicaid

04:27:56 population in Oklahoma is -- it's, what, 3, 400,000
28:04 recipients, I believe.
04:28:05 Q So you can't generalize from your review to the
04:28:11 Medicaid population in Oklahoma; correct?
04:28:13 A I think you can generalize to the Medicaid
04:28:17 population after you have studied in detail a significant
04:28:21 number of that population; and that significant number would
04:28:28 be what I mean, a statistically significant number. And the
04:28:33 number of patients studied would represent an entire
04:28:36 cross-section of that whole population of several hundred
04:28:40 thousand.
04:28:41 Q Yeah. But my question of you, Doctor, is that
04:28:45 based upon your examination of the records, depositions --
04:28:50 and depositions of the 18 Medicaid patients, you're not able
04:28:57 to generalize as to the population of -- the Medicaid
04:29:03 population in Oklahoma; correct?
04:29:06 A Can you get more specific and ask -- or help me
04:29:09 understand what specific characteristics of the Medicaid
04:29:13 population I should be thinking about.
04:29:15 Q Well, really, I'm trying to get your -- your view
04:29:23 of the -- this. What would be a statistically-significant
04:29:27 number of Medicaid recipients that one would have to study
04:29:34 in the sense of reviewing their medical records,
04:29:39 interviewing them, doing a medical examination before you
29:42 could generalize to the Medicaid population as a whole in

Oklahoma?

A I would speculate that that number would be in the range of 20 to 25 percent of all of that population.

Q So we're talking about 100,000 at least?

A If that's 20 or 25 percent of the entire population. To get the accurate answers to the question I think you're asking, it would be a significant or a substantial number of those recipients.

Q Okay. Now, also in the Surgeon General's report, 1998, on page 6, chapter 1, first sentence, first column he says, "The report of the Surgeon General also responds to the need to thoroughly analyze the smoking-related health status of racial/ethnic groups and to determine if there's a differential risk for tobacco addiction."

And then he puts in there in parentheses (CHEN, 19) -- 1993.

A Where are we? Oh, I see. On the back, page 6, top paragraph.

Q Yeah. Okay. My question of you now, Doctor, after you've read that. What do you think the Surgeon General is referring to when he uses the term "tobacco addiction"?

MR. COX: Let me object as it calls for speculation. You may answer if you can.

THE WITNESS: Well, that -- that's my problem. I

04:32:17 1 don't think that I've reviewed -- oh, I've run among --
32:21 2 okay. I know which one this is. My speculation would be
04:32:27 3 that this report attempted to address minority groups in an
04:32:37 4 effort to answer the question if there was risk of the
04:32:41 5 minority group to tobacco use.
04:32:44 6 Q (BY MR. WALLACE) Okay. You've read out
04:32:48 7 completely, then, the word "addiction" in answering the
04:32:51 8 question?
04:32:51 9 A That's the Surgeon General's choice of words.
04:32:54 10 Q Do you know what the Surgeon General means --
04:32:57 11 A No, sir.
04:32:58 12 Q -- when he uses that term?
04:33:00 13 A That is -- that is nowhere in the document which I
04:33:03 14 have.
04:33:03 15 Q Okay. So my question to you is: Do you know what
04:33:06 16 he means when he's talking about -- or when he uses the term
04:33:11 17 "tobacco addiction"?
04:33:12 18 A From reading this document, I do not know that
04:33:16 19 information.
04:33:16 20 Q Okay. Well, other than the document, do you know
04:33:20 21 what he means by tobacco addiction?
04:33:22 22 A I could only speculate on the Surgeon General's
04:33:28 23 intent for the use of that word.
04:33:30 24 Q Other than speculation, though, you have no
33:34 25 knowledge of what he means by tobacco addiction?

04:33:37 A Not in this report. I think earlier in the day we
33:42 stated that the term "addiction" has been defined
04:33:45 differently in different years. In the last 25 or 30 years
04:33:52 there have been several definitions for the term
04:33:54 "addiction," and I don't know what definition he's using
04:33:57 here.
04:33:57 Q Okay. Before you recommended this report, then,
04:34:03 you didn't look for an answer to that question?
04:34:08 MR. COX: Let me object to the question to the
04:34:11 extent it misstates the witness's prior testimony about
04:34:16 having recommended anything. But you may answer it.
04:34:25 THE WITNESS: I think my disclosure statement says
04:34:28 that I referred to this document to obtain information or
04:34:32 insight into the questions being addressed. I do not verify
04:34:37 or substantiate any statements made in these reports.
04:34:41 Q (BY MR. WALLACE) Well, your disclosure statement
04:34:46 says "Dr. Coniglione has relied in part upon the following
04:34:50 documents in forming the opinions he expects to give at
04:34:53 trial."
04:34:54 A That doesn't say that I concur with the content of
04:34:57 the document. I used the document to look up factual
04:35:02 information, if there was factual information on a given
04:35:05 point.
04:35:07 Q When a patient comes into your office who smokes
35:17 at your office on North Santa Fe and indicates that she

04:35:24 wants to quit smoking, do you prescribe -- ever prescribe
35:29 medicine for her, any kind of drugs?
04:35:32 A If requested, I can prescribe drugs. Have not
04:35:38 prescribed any in recent memory. But when I get a question
04:35:45 like that or a statement like that, I usually need to get a
04:35:50 better understanding of what the patient's goal is and
04:35:54 motivation for reaching that goal and how I can help the
04:35:58 patient adapt to being a non-smoker.
04:36:02 Q Are you familiar with the drug Zyban?
04:36:09 A Yes.
04:36:10 Q Have you ever prescribed it for a patient?
04:36:11 A Yes.
04:36:11 Q You have prescribed it?
04:36:12 A Not recently, but I have, yes.
04:36:14 Q Okay. Now, that drug is not available to the
04:36:20 Medicaid population under their Medicaid guidelines, is it?
04:36:25 A I am -- I do not know that.
04:36:27 Q Okay. Doctor, do you think that in the -- strike
04:36:58 that.
04:36:58 I believe you stated that you had never smoked
04:37:03 cigarettes.
04:37:04 A I didn't make that statement.
04:37:05 Q You did make it?
04:37:06 A Did not make such a statement.
.37:08 Q Oh, have you ever smoked cigarettes?

04:37:10 A No, sir.

04:37:11 Q Okay. Have any immediate members of your family, wife, parents, siblings ever smoked?

04:37:18 A One brother smoked for a number of years, and a former wife smoked.

04:37:21 Q Okay. Do you know how she -- to what extent she smoked? How many packs a day?

04:37:27 A Approximately a pack a day.

04:37:28 Q Okay. Did you try to intervene to convince her not to smoke?

04:37:38 A No.

04:37:42 Q You just went along with it?

04:37:49 A I did not -- I did not approve. I'm not sure what you mean by didn't go along with it, no. I did not approve. But, then again, that was her choice.

04:37:55 Q Would you like to see the time when no one is smoking in America?

04:38:02 A If no one smoked in America, I would like to know how we convert the smokers to be non-smokers. Because there are other things about the smokers that I think we have to consider.

04:38:08 Q Okay. So based on your present knowledge, would you -- would that be a wish of yours, to have smoking stopped in the United States? I mean, nobody smoke, regardless of how it was accomplished.

04:38:15

04:38:21

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04:38:45

04:38:48 A I -- I think that there are lots of things I would
38:53 wish for. I think that that's highly speculative. It would
04:38:57 -- it's creating an environment that's artificial; and I
04:39:01 think we can create artificial environments all we wish
04:39:05 here, but that's a highly artificial environment because I
04:39:08 think there are issues of choice over which I believe I
04:39:14 should have no control when it comes to other people.
04:39:16 Q Oh, I'm not asking you, Doctor, how you would
04:39:21 control it. I'm just saying would you like to see a
04:39:24 smoke-free America?
04:39:26 A In the context of a hypothetical question, I would
04:39:35 -- I would be in favor of seeing a smoke-free society.
04:39:41 Q Are you a member of the coalition in Oklahoma?
04:39:45 A No.
04:39:46 Q And you a member of the American Heart
04:39:48 Association, or rather are you on a board or subscribe or
04:39:54 contribute to the American Heart Association?
04:39:56 A No.
04:39:56 Q Do you have any relationship to the American Heart
04:39:59 Association?
04:40:00 A No.
04:40:00 Q Any relationship to the American Lung Association?
04:40:03 A No. Only as a donor.
04:40:08 Q Have you read the July, 1995, issue of the Journal
40:30 of the American Medical Association?

04:40:32 A Can you help me with the content of that issue of
10:38 the journal.
04:40:39 Q It had -- it was an issue which had an article on
04:40:46 the Brown & Williamson tobacco papers that were reputedly
04:40:53 taken from Brown & Williamson dealing with certain
04:40:57 disclosures.
04:41:00 A I don't recall specifically that issue of the AMA
04:41:04 journal.
04:41:05 Q Are you a member of the American Medical
04:41:08 Association?
04:41:08 A Yes.
04:41:09 Q And do you receive its publications?
04:41:11 A Yes.
04:41:12 Q But do you have any recollection of reading about
04:41:18 the Brown & Williamson papers?
04:41:19 A No.
04:41:21 Q Doctor, concerning this particular lawsuit, do you
04:42:06 have any view on -- or opinion on what the outcome should
04:42:07 be?
04:42:08 A I believe the outcome should be one which is
04:42:16 moral, appropriate, based on data and evidence.
04:42:27 Q Okay. And based on what you know about the data
04:42:33 and evidence, do you have -- do you want to see the
04:42:36 plaintiffs win or the defendants win?
04:42:41 A I don't think either should win, in my opinion.

04:42:44 Q Okay. The -- do you understand that the State of
42:53 Oklahoma's position is that cigarette smoking causes
04:42:59 disease, disease costs money and the State of Oklahoma has
04:43:03 had to pay for the treatment of these diseases and they're
04:43:07 seeking restitution or recovery from the cigarette, tobacco
04:43:11 companies for a portion of the cost of the treatment of
04:43:15 these diseases?
04:43:16 A I understand that that's the general theme of the
04:43:22 allegation or the complaint. I think that's the term you
04:43:27 use.
04:43:27 Q Well, technically in Oklahoma it's called a
04:43:29 petition.
04:43:30 A I'm sorry.
04:43:31 Q In the federal court, other states it's called a
04:43:35 complaints. But we understand.
04:43:49 Well, looking at that, as far as populations are
04:43:53 concerned, do you believe that cigarette smoking causes
04:43:57 disease?
04:43:57 A As far as populations are concerned?
04:44:01 Q Yes.
04:44:02 A I believe that cigarette smoking or smokers are at
04:44:08 risk for developing disease and that smoking is a risk
04:44:15 factor in smokers for disease.
04:44:17 Q But you wouldn't go so far as to say that in
04:44:24 populations, that cigarette smoking causes disease in that

population?

A From my perspective, the determination of causation is one which was made after an analysis of the patient's entire clinical history and his examination, his occupation and his various exposures and after a detailed consideration of the individual patient on -- in some cases I can hope to be close or I can hope to be -- to render an educated guess regarding causation, but causation in populations -- I don't think anyone would go so far as to make a statement that a specific agent causes disease in a population. I recognize the Surgeon General's statements, but also in the Surgeon General reports there -- they're also quite clear that statistics cannot prove causation.

Q Well, in the sense that the Surgeon General uses the term "causation", can you agree with that?

A No. I think the Surgeon General should be using the term "association" and not causation when he refers to populations.

Q So you disagree, then, with the Surgeon General's use of the term "causation"?

A I think it's grammatically incorrect.

Q Do you agree with the American Heart Association that people should not smoke?

A Yes.

Q Do you agree with the American Lung Association

that people should not smoke?

A I think all professional societies have made that statement as the professional societies have made statements regarding exercise, diet and all the other recognized risk factors. So in context I agree with all those position statements by all those organizations, any position statement that addresses the reduction of a risk factor.

Q And if people -- if a -- if a population stopped smoking, that would reduce the risk factor, according to your testimony.

A Well, I need to know what you're going to do with those current smokers when you say you reduce smoking to reduce the risk factor. What do we do with those smokers? Do we just erase them from the equation and -- and pretend they disappear? What are we going to do with the smokers? To answer your question I need to know how you would address the smokers and what you would do with them.

Q I'm merely talking about a reduction of the risk factor would lead to a reduction in disease, wouldn't it, Doctor?

A I don't -- well --

Q In a population.

A I think that that's difficult to say for this reason. Smokers are different than non-smokers. They engage in different behaviors, and those other behaviors are

high-risk behaviors. So just to take a smoker and magically make him a non-smoker does not remove from him those other behaviors that are high-risk behaviors. Specifically diet and inactivity, just two for example.

So to say if we reduced the number of smokers, we would reduce the amount of disease to me means we must understand what we are doing with that person who was a smoker. And if we just erase that person from the equation magically -- and that would be an artificial manipulation of numbers. And that would be fine, but I think if we converted the smokers to be non-smokers, we're not at all addressing their other high-risk behaviors.

So I think that that's artificial, and I don't think you can do that. You can take the smoke out of the smoker, but you can't change that personality.

Q Well, you've had patients who quit cold turkey --

A Yes.

Q -- have you not?

A Yes.

Q And by removing that risk factor, statistically they are less at risk for, say, lung disease or heart disease, are they not?

A Ordinarily in those patients in whom there has been a cessation of smoking, there has been effort directed at the other risk factors to attempt to change the other

risk factors because just changing the smoking and eliminating one risk factor to me indicates that I still have work to do because there are still other unaddressed risk factors.

Q Yeah. But to the extent -- isn't it reduced by the extent that the smoking is a risk factor?

A It's not easy to keep all other factors equal. That smoker by virtue of his smoking, ordinarily is going to have other risk factors, specifically inactivity, high-fat diet, high-fat/low-nutrient diet. And to just stop the smoking means I still have other risk factors. So to just stop the smoking is not really addressing the needs of that person.

Q So that stopping smoking doesn't help reduce the risk factor of smoking in that person's lifestyle.

A Reducing the smoking is one of many risk factors that need to be addressed and reduced.

Q Okay. But what happens, though, when a person stops smoking? Isn't that risk factor eliminated from the person's risk for disease?

A Person's risk for disease would -- would decline some period of time removed from the stopping of the smoking. My concern is that just addressing the smoking and reducing the number of smokers does not adequately deal with the problem because we -- we have some inherent basic

04:50:52 differences between smokers and non-smokers and that smokers
50:58 in general have higher risk behaviors. And to really change
04:51:03 long term the health effects, I think we have to address all
04:51:07 of the other behaviors.

04:51:09 Besides, if you had said if we just reduce
04:51:13 smokers, reduce the number of smokers, we would reduce
04:51:18 disease. I think that was the original question you asked
04:51:21 me. Any smaller number of human beings leads to decrease in
04:51:26 disease if we're looking at just numbers.

04:51:29 So whether we take them out of the equation or we
04:51:34 erase them by some artificial means, we will have reduced
04:51:39 disease, irrespective of whether we're reducing the smokers
04:51:43 or the people with the bad diet or people who are inactive.
04:51:47 So I think that reducing any number of people in the
04:51:53 population reduces the amount of disease.

04:51:56 Q Does cigarette smoking cause Burger's disease?

04:52:02 A Again, Burger's disease is a generic disease
04:52:09 applied to a population of individuals. When I see a
04:52:14 patient who has a diagnosis of Burger's disease, I -- I
04:52:20 associate smoking with a -- as a risk factor for that
04:52:24 disease.

04:52:25 Now, Burger's disease is an interesting one you
04:52:28 should mention. There's a number of people we've diagnosed
04:52:31 as having Burger's disease over the years, and that is only
04:52:35 because we did not identify other risk factors for disease.

04:52:38 Now that we understand homocystine, the compound I addressed
52:43 this morning, we recognize that there are people who we
04:52:47 thought had Burger's disease but really had homocystine
04:52:50 disease, but at the time we made the diagnosis of Burger's,
04:52:53 we didn't know homocystine was a problem. Therein lies the
04:52:58 problem of the nomenclature of some of the diseases we
04:53:04 address.

04:53:04 Q Okay. Well, somebody who is diagnosed correctly
04:53:09 as having Burger's disease, you would look for cigarette
04:53:15 smoking as the causative agent there, would you not?

04:53:17 A I would look at cigarette smoking as a risk factor
04:53:21 for the development of Burger's disease in that person.

04:53:25 Q And you would recommend that person not smoke
04:53:31 cigarettes, would you not?

04:53:32 A I would recommend that person discontinue any
04:53:34 behaviors that I thought could be contributing to the
04:53:38 development of that disease including smoking, including
04:53:42 homocystine, including his dietary habits.

04:53:45 Q Isn't it true that a person would -- that's
04:53:53 correctly diagnosed as having Burger's disease, that that
04:53:57 person always has cigarette smoking as a risk factor?

04:54:03 A I'm troubled by your terms. Always has smoking as
04:54:15 a risk factor, I don't know that. I don't know that that's
04:54:19 accurate.

.54:20 Q You don't know that?

04:54:21 A I don't know whether that's --

54:23 Q You don't know whether that's true or not?

04:54:24 A No, sir. I have seen patients who were thought to have Burger's disease who years later did not have Burger's disease and it was clear at the time that that really was Burger's disease. I think Burger's disease may be more of a mixture of diseases rather than a pure disease. And we use the term "Burger's disease" because doctors usually know what that means. But as far as etiology is concerned, I'm less certain of a causation or causative factors for Burger's disease than I was at one time.

04:54:59 Q Okay. Well, you, of course, are not a peripheral vascular specialist, are you?

04:55:08 A I don't -- Tom Whitsett is the only peripheral vascular specialist in Oklahoma City. I don't hold myself out as being a peripheral vascular specialist, but that body of knowledge is rather important to what I do in clinical medicine, and I think I'm reasonably familiar with some of the principles of peripheral vascular medicine.

04:55:31 Q Well, if an authority such as -- well, strike that.

04:55:37 If an expert board certified in peripheral vascular disease says that Burger's disease is always associated with cigarette smoking, would you yield to that opinion?

55:58

04:55:58 A I would like to see the data on which that opinion
56:01 is based.
04:56:01 Q Okay. So you're saying you wouldn't agree with
04:56:06 it?
04:56:06 A I would like to see the data. I'm not saying I
04:56:09 would agree or disagree. I would like to see the data.
04:56:10 Q How many Burger's disease patients have you seen?
04:56:20 A Over the years, nine or ten, ten or twelve.
04:56:28 Q Were the ten or twelve smokers?
04:56:32 A I don't recall.
04:56:33 Q Do you treat patients -- or do you have patients
04:56:57 who have lung cancer?
04:56:58 A Over the years I have treated a modest number of
04:57:02 patients with lung cancer. I have had the opportunity to
04:57:05 make that diagnosis and to participate in the care of those
04:57:09 patients.
04:57:09 Q Do you have any idea how many of those you've had
04:57:14 occasion to see and treat?
04:57:17 A In the 12 years I was at St. Anthony, I would
04:57:22 estimate that I either made the diagnosis or treated a
04:57:27 patient with lung cancer two to three times a month. And
04:57:32 during the time I was at the university for ten years, I
04:57:35 don't recall numbers. And even to this day I'm still
04:57:40 involved with the care of patients with lung cancers.
.57:43 Q Do you agree that in populations that cigarette

04:57:55 1 smoking is a cause of lung cancer?
57:57 2 A I don't agree with anything -- any agent causing
04:58:02 3 any disease in a population. I think that there are agents
04:58:05 4 that are associated with the development of disease in
04:58:08 5 populations.
04:58:10 6 Q Are you saying, then, that there's no causal
04:58:13 7 connection between cigarette smoking and lung cancer?
04:58:16 8 A I really want to make a distinction between terms
04:58:19 9 because you're using the term "causation." In my teaching,
04:58:24 10 in my reading it's clear to me that there is -- there are
04:58:28 11 associations which are different than causations.
04:58:30 12 In medicine I would speculate my opinion that
0' 58:36 13 agents causing disease are very few and limited to
04:58:41 14 infections. We're pretty clear on infections being caused
04:58:47 15 by specific agents.
04:58:48 16 When we get into diseases that have multiple
04:58:50 17 causes or could have multiple causes, then it's a question
04:58:55 18 of associations, which of the various risk factors, if you
04:59:00 19 will, are associated with the disease.
04:59:03 20 Q Okay. Do you believe that the association between
04:59:11 21 cigarette smoking and lung cancer is sufficiently high to
04:59:17 22 say that cigarette smoking is a cause of lung cancer?
04:59:21 23 A I -- that's a compound question. It has two
04:59:25 24 parts. The first part was that the association is
.59:30 25 sufficiently high to state there is an association. I think

04:59:35 1 that's true. The risk assigned to smoking in the various
59:42 2 studies have all been positive numbers, so there is an
04:59:46 3 association. Causation, I can only speculate on causation
04:59:52 4 of disease in populations.
04:59:54 5 Q Okay. Well, we hear the term, for example, or
04:59:58 6 read the term in the newspapers or hear it on TV, radio,
05:00:10 7 that 85, 90 or 95 percent of lung cancer is caused by
05:00:15 8 cigarette smoking. Is that a meaningful statement?
05:00:21 9 A In the true scientific sense, the answer is that's
05:00:27 10 not a meaningful statement. If one would say that there is
05:00:30 11 an association between smoking and lung cancers, then that
05:00:35 12 would be more meaningful.
05:00:36 13 And that's -- this whole area is a difficult area.
05:00:39 14 If you stop and think about it, the number of lung cancers
05:00:42 15 in our country is rising whereas the number of smokers is
05:00:46 16 declining. So I think the next challenge we're going to
05:00:51 17 have is to identify why there's more lung cancer while
05:00:56 18 there's less smoking.
05:00:58 19 This is -- this is a very tough question because
05:01:01 20 smoking is not the only risk factor for lung cancer,
05:01:06 21 especially in Oklahoma. We have some very unusual
05:01:09 22 industries and occupations in Oklahoma that put our people
05:01:13 23 at a different risk for lung cancer unrelated to smoking.
05:01:18 24 Smoking is associated, as are other risk factors
05:01:22 25 and occupations.

05:01:23 Q So you would not subscribe to a public statement
01:33 that says that 85 to 95 percent of lung cancers are caused
05:01:38 by cigarette smoking?
05:01:39 A I would contend that it would be more accurate to
05:01:43 use the term "associated".
05:01:46 Q Okay. Would 85 to 95 percent --
05:01:48 A That number of patients who have lung cancers also
05:01:52 smoke. Some of those patients have multiple other risk
05:01:55 factors as well; and, therefore, as a clinician, I cannot
05:02:00 look at the individual and his risk factors and state that a
05:02:03 specific agent or a specific risk factor caused his disease.
05:02:24 Q Okay. That's a very high association, is it not;
05:02:26 Doctor?
05:02:26 A If that 80 or 85 percent is accurate. I think the
05:02:28 numbers may be smaller today than they were a few years ago.
05:02:29 Q Do you know what the numbers are today?
05:02:30 A I've seen a declining -- declining rate of smoking
05:02:32 in the United States with an increasing rate of lung cancer.
05:02:36 Q Well, my question is: Do you know what the
05:02:40 percentage is at this time?
05:02:41 A As I've read that information, it seems like the
05:02:43 percentages varied, depending on the origin of the study.
05:02:47 For example, I think the 85 percent numbers were derived
05:02:50 from veterans' hospitals whereas if you look at public
02:54 hospital records, the numbers are lower than 85 percent.

05:02:57 1 Q Why would you think they would be higher in a
03:01 2 veterans' hospitals than in public hospitals -- other public
05:03:06 3 hospitals?
05:03:06 4 A Well, I think because -- I'm merely speculating.
05:03:10 5 I don't know the answer. I think one of the answers could
05:03:12 6 be that the population that avails itself of care at the
05:03:17 7 veterans' hospital has a higher number of smokers; and if
05:03:21 8 you have a higher number of smokers and a number of people
05:03:26 9 with lung cancer, then larger patients are going to be
05:03:29 10 smokers.
05:03:30 11 In a non-Veterans' Administration hospital
05:03:34 12 environment where there are lower populations of smokers, I
05:03:36 13 don't think the percentages are quite that high.
05:03:39 14 Q But they would still be high, wouldn't they?
05:03:44 15 A High -- I'm not sure I know what you mean by the
05:03:50 16 word "high."
05:03:52 17 Q You say it's declined. What's it declined to? 75
05:03:59 18 percent?
05:03:59 19 A Well, we're talking about two different sets of
05:04:03 20 numbers. One is the association of smoking and lung cancer,
05:04:07 21 and you quote 85 percent. And I think those numbers, higher
05:04:12 22 numbers are generated from Veterans' Administration
05:04:15 23 hospitals. The association or the percentages of smokers
05:04:20 24 with lung cancer in non-Veterans' Administration hospitals
04:24 25 is lower than the 85 percent.

05:04:26 Q How much lower?

04:27 A I don't know. I haven't reviewed that data, but I do recall seeing those numbers being lower.

05:04:30 Q If the number is 85 percent, isn't that sufficient to say that smoking cigarettes causes lung cancer?

05:04:32 A I need to know what else is happening to those people who have lung cancer, what else has happened in their lives, what occupations they have, what kind of underlying lung diseases they have.

I need to know their occupations. I need to know if -- if their homes are heated with wood-burning stoves. I need to know if they lived next to rock-processing plants.

And some of the patient records I've reviewed, I have one person who lived next to the cement plant in Ada; and she said that when she went out in the morning to move her car, she had a layer of soot on her car from the cement plant. Now, if that person winds up with lung cancer and also smokes, I have two significant -- or two associated factors. And it would be purely speculative to try to make a determination that one and not the other caused that lung cancer.

Q Okay. Now, do you know of any studies that ascribe the ventilation of cement as a risk factor for lung cancer?

A There are studies that address the issue of

05:05:59 1 industrial and environmental pollution as a risk factor for
06:03 2 lung cancer, and that's welders when they inhale those arc
05:06:09 3 fumes, it is -- I'm not certain it is cement processing, but
05:06:15 4 it's clearly related to petrochemical industries and
05:06:19 5 individuals living near petrochemical industries. Those
05:06:22 6 people --
05:06:23 7 Q Cement's not a -- I'm sorry. Go ahead.
05:06:26 8 A Cement is a particulate inhalant that can cause
05:06:30 9 scarring in the lungs. Scarring in the lungs can be a risk
05:06:33 10 factor for the development of cancer of the lung. So any
05:06:38 11 kind of industrial or petrochemical exposure can be
05:06:43 12 associated with cancer of the lung.
05:06:45 13 And in the records I've reviewed, I think there's
05:06:48 14 one man with cancer of the lung which is interesting because
05:06:51 15 the type cancer he had is not one we ordinarily associate as
05:06:59 16 being related to cigarette smoking, but he lived in Ponca
05:07:03 17 City adjacent to a refinery. And he was in the -- the
05:07:11 18 downstream wind from the refinery, and there were -- there
05:07:16 19 were chemical odors in the air.
05:07:18 20 Well, if I'm looking at that individual, the only
05:07:21 21 one of the 18 I had with lung cancer, and he smoked and
05:07:25 22 lived next to this petrochemical processing plant, whatever
05:07:29 23 it was, I'm hard pressed to try to assert cause for -- as
05:07:37 24 being related to one or the other. He's one of these 85
07:40 25 percent who has lung cancer, smokes; but in him there's an

05:07:44 1 enormous other risk factor for the development of lung
07:47 2 cancer.
05:07:47 3 Q How many petrochemical people come down with lung
05:07:51 4 cancer? I mean, that inhale petrochemicals.
05:07:54 5 A Well, again, I didn't review this data for this
05:07:58 6 presentation. But from my knowledge I know that in areas
05:08:04 7 adjacent to petrochemical industries, the incidence of lung
05:08:08 8 cancer is considerably higher than in areas that are not
05:08:11 9 related to petrochemical industries.
05:08:14 10 And I think this has been studied in Louisiana, it
05:08:18 11 has been studied in England, studying -- I remember reading
05:08:24 12 a study a while back. And what they did is they looked at
05:08:29 13 the radius from the petrochemical refinery -- and they
05:08:33 14 looked at a narrow radius, an intermediate radius and a
05:08:38 15 wider radius -- and found the incidence of lung cancer was
05:08:42 16 highest in the narrow radius, lowest in the wide radius.
05:08:45 17 And that was in England.
05:08:47 18 It has been studied in -- where I grew up on
05:08:50 19 Staten Island, New York, which is adjacent to the enormous
05:08:54 20 petrochemical industry in New Jersey. And the -- the
05:08:59 21 downstream wind from the petrochemical industry is directly
05:09:05 22 over a portion of Staten Island.
05:09:07 23 Now, that portion of Staten Island which is the
05:09:10 24 north shore is separated from the south shore by a range of
09:13 25 mountains. We call them mountains. They're hills. But the

hills keep the wind on the north side of the island, not the south side of the island. And just before I left Columbia I recall seeing a study of the rate of lung cancer in the north side of Staten Island as opposed to the south side of the Staten Island, and there were enormous differences.

Q On what magnitude?

A I -- I don't recall. This is many years ago. But it was very clear that there was a difference in the number of people with lung cancer on one side of the mountains versus the other side of the mountains, and the logical conclusion was that the lung cancer could be associated with the petrochemical industry and the -- the downstream wind from the petrochemical industry.

I think that there were probably some who would like to say that there's a cause-and-effect relationship. Again, I would think there's an association that deserves our attention and further investigation.

Q Have you made a -- any historical type of study of the relationship of cigarette smoking to lung cancer?

A That body of literature encompasses tens of thousands of articles. I can say that I have -- I have read that body of knowledge -- that body of information sufficiently to the point where I can use that information and apply it to the doctors I teach, the students I teach, the patients I treat. I think I'm familiar with that body

of information and the results from it.

Q When was the -- when did there seem to be occurring in England and in America an epidemic of lung cancer? When did this come to the attention of the medical professionals?

MR. COX: Let me object to the form of the question in that it assumes that there was an epidemic. Subject to that, you may answer.

THE WITNESS: I don't think I said that. My comment was that there have been studies done of the rates of lung cancer related to industry.

Q (BY MR. WALLACE) When did that -- the study of cigarette smoking in relation to lung cancer begin?

A I don't specifically know the date.

Q Do you know the era that this occurred in?

A 1960s and '70s. I think there were a fair number of studies done at -- in those decades.

Q Do you know of any studies that were done in the late '40s, early '50s?

A No. The only studies I'm aware of in that period of time related to lung cancer were studies out of Bellview Hospital that linked lung cancer to tuberculosis. Those are -- for those of us who read medical history, that was an interesting series of observations. And I think they were in the '50s or '40s.

05:13:02 Q You're not acquainted, then, with any English
13:07 studies that studied the rate of lung cancers in English
05:13:13 physicians?
05:13:14 A No. I don't believe I'm familiar with that study.
05:13:18 Q English nurses?
05:13:19 A Don't believe I know that study.
05:13:22 Q Doctor, would you tell us what procedure you used
05:13:42 in reviewing the medical records and the depositions of the
05:13:48 18 Medicaid patients that you reviewed. What was the
05:13:53 process?
05:13:53 A I received cases, and the cases were probably
05:14:01 similar to the size of the cases of documents you brought.
05:14:06 And within the cases were notebooks, loose-leaf notebooks;
05:14:12 and the patients' medical records were divided within these
05:14:16 volumes. Some medical records spanned a single volume; some
05:14:22 spanned -- oh, there was one person whose records spanned
05:14:27 seven or eight or nine volumes. Rather significant sized
05:14:33 volumes.
05:14:33 And I went through them page by page, took notes
05:14:36 on what I thought was pertinent medical information and then
05:14:41 had an individual take my notes and put them into a time
05:14:47 sequence because in those medical records, the documents
05:14:50 that appear are not in a time sequence. And I needed a time
05:14:54 sequence so that I could get a full appreciation of the
.14:58 nature of the problems faced by the patient and the care

05:15:01 1 rendered. So I had all that put into a time sequence, and I
15:06 2 think those -- those summaries have been submitted.
05:15:26 3 MS. COY: Off the record at 05:15:30.
05:15:31 4 (A recess was taken.)
05:31:47 5 MS. COY: Okay. We're back on the record at
05:35:23 6 05:35:23. This begins tape two -- excuse me. This begins
05:35:27 7 tape number three.
05:35:28 8 Q (BY MR. WALLACE) Doctor, I'm going to hand you a
05:35:33 9 medical record that has been represented to me to be that of
05:35:37 10 a Medicaid patient. This is not one you examined, but I
05:35:42 11 want to -- without burdening the record, I'm not going to
05:35:45 12 mark it as an exhibit, but only as an illustration. I'll
05:35:49 13 ask you about, is this the type of record that you
05:35:58 14 examined -- medical record that you examined?
05:36:01 15 A Yes. This is the -- this is a -- similar to the
05:36:34 16 material I received on the other files that I reviewed.
05:36:38 17 Each rubber band full of material represented the medical
05:36:43 18 records from a single provider location, either a
05:36:47 19 physician's office or a hospital or a pharmacy. And the
05:36:51 20 records were similar to this.
05:36:55 21 There was a -- the top page was usually an index
05:37:01 22 of the -- the separators for all of the subsequent sections.
05:37:05 23 And frequently there was a patient questionnaire. I don't
05:37:09 24 see the patient questionnaire here, but it's that standard
37:14 25 questionnaire that everyone completed before being selected

as a participant. So those are the only two differences.

Q How does that -- the size of that record compare with the other records or with the records you did examine?

A Of the 18, I probably had three or four that were this size. Most of which -- I would say this is about one volume, perhaps that would be one volume. So this is slightly more than one volume. And most of the files I reviewed had two or three volumes. I have one that had seven or nine or eleven volumes of paper.

Q Would it be fair to say that this is a smaller volume, then, or a smaller record than most of them you examined?

A This would be the lower one-third of the records I examined in terms of quantity of paper. And then it also depends on the quality of the documentation. On occasion there were patients admitted to the hospital where large sections were not really germane to any clinical information. And most of the clinical information was contained in half a dozen pages out of 100 pages.

So it's both quality and quantity of pages. And I didn't look through this in any detail to determine quality or content.

Q Okay. What -- what would you regard as not being significant for your examination in, say, a hospital record?

A Well, this is a hospital record. If this is a

lengthy hospitalization, there would be some nursing notations, vital signs. Here there are clinic notations. And there could be many, many pages of clinic notations which would not be pertinent. There were some pages of laboratory data which were not pertinent. Here is a page which is called a pediatric day sheet. The patient was in the hospital as an inpatient, and this is a record of his medication, his pulse and his activity. And some of that information would not be extremely germane to what I was looking at. Temperatures. There were a lot of notations that were not germane.

Now, here's a notation which is the physical examination. That would be highly important. And some would be more legible than others. Here is a -- a sheet which indicated the amount of fluid the individual consumed in 24 hours. And there could be a dozen of these in a hospital stay, and most of that was not particularly germane. I was looking for, principally, information regarding risk factors.

Frequently I would pay attention to the quality of care delivered, although that wasn't an issue at stake here; but you can't help but address quality of care delivered on some occasions.

Q When it was noteworthy, was it a below standard of care?

05:40:47 A I think that there were some examples of care that
40:51 I would consider as not standard of care.
05:40:57 Q Okay.
05:41:00 A Especially in individuals who frequented the
05:41:03 emergency room. There were several who appeared to use the
05:41:06 emergency room as their principal source of obtaining
05:41:11 medical care, and emergency rooms are probably not the place
05:41:15 for patients to obtain routine medical care. Probably
05:41:21 useful for emergencies, but I contend that most of those
05:41:25 emergency room visits were not emergency illnesses.
05:41:30 Q Emergency what?
05:41:31 A Were not illnesses that required emergency care.
05:41:34 Q Okay.
05:41:35 A And I think that the intensity of services
05:41:38 delivered to those patients was excessive relative to the
05:41:42 symptoms and findings of the patient, but that's pretty
05:41:46 standard of what happens in emergency rooms.
05:41:48 Q Whether it would be a Medicaid person or
05:41:53 non-Medicaid person?
05:41:55 A I think that the overtreatment of symptoms and
05:42:04 diseases by emergency rooms has been addressed in
05:42:06 publications that refer to not just the Medicaid population,
05:42:10 but to a broad spectrum of patients who obtain care from
05:42:13 emergency rooms.
42:14 Q I'm finished asking you questions, but this is

available if you want to refer back to it.

A Okay.

MR. COX: Just for the record, Tom, could you advise us as to whose medical records those were.

MR. WALLACE: Yes.

MR. COX: That you've shown to the doctor.

MR. WALLACE: This is the medical record of [DELETED]

MR. COX: I think that significantly identifies it because we know the rest of the information, I think.

MR. WALLACE: Okay.

MR. COX: I'm assuming that he was one of the 35.

MR. WALLACE: I think so.

Q (BY MR. WALLACE) For the record, I would like to show Dr. Coniglione Plaintiff's Exhibit 4 which has been furnished to me, but I would like to refer to his file, if I may.

MR. COX: Certainly.

MR. WALLACE: But I don't want to make -- get his record into the --

Q (BY MR. WALLACE) Well, Doctor, would you take a patient that you considered to be illustrative of the patients records that you examined and find that particular patient's case note, please.

05:44:18 1 A Illustrative of any particular point or any
44:23 2 particular issue to be addressed or --
05:44:26 3 Q Well, let's go to your seven-day notice. How
05:44:46 4 about number 3, the, "Risk factors are encountered at higher
05:44:51 5 rates in certain populations such as low socioeconomic
05:44:55 6 groups and American Indians. Risk factors tend to cluster
05:44:59 7 in these populations due to financial, social, cultural and
05:45:03 8 other factors."
05:45:09 9 A Let's see if we can find an American Indian. How
05:45:12 10 would that be?
05:45:13 11 Q Fine.
05:45:15 12 A I don't recall if this lady was American Indian.
05:45:55 13 For the sake of expedience, we can just pick any one. I
05:46:00 14 mean, it doesn't matter to me.
05:46:01 15 Q How about Marsha Harris?
05:46:03 16 A I had Cynthia Hubenak. You want Marsha Harris?
05:46:08 17 Oh, Rosetta Hyatt. What about Rosetta Hyatt. She should be
05:46:13 18 second from the top, if these are in sequence. She's the
05:46:17 19 one who lived next to the cement plant.
05:46:24 20 The second section has to do with residence. She
[DELETED] [DELETED]
05:46:30 21 lived in and moved to at eight years of age. And
[DELETED]
05:46:35 22 in she lived adjacent to the cement plant. And she
05:46:40 23 described her home environment as dusty. Now she lives in
[DELETED]
05:46:44 24 adjacent to or in some proximity to a sand-processing
05:46:52 25 plant and says that she breathes air which has a chemical

05:46:57 odor.

05:46:58 Under lifestyle, we indicate that she does --

05:47:03 well, she indicated at one point in her deposition that she

05:47:07 does not use seat belts. She indicated that on page 55 of

05:47:11 her deposition. And then on page 123 of her deposition

05:47:15 indicated she did use seat belts. And this is probably

05:47:18 illustrative of a problem physicians and I have had for

05:47:22 decades in dealing with this particular population of

05:47:27 patients. Getting candid, truthful information is not

05:47:31 always possible.

05:47:35 And in the medical records -- and there are others

05:47:38 where the medical records, the patients repeatedly tell the

05:47:42 doctors they don't smoke. As a matter of fact, I thought I

05:47:46 had the wrong records of the wrong patients when I first got

05:47:49 them and mentioned that to the -- to counsel. And I was

05:47:53 assured that I was to review the record because the record

05:47:56 was indeed that of a smoking person. And, indeed, when I

05:48:22 eventually got the deposition, I learned that even though

05:48:24 this person told his doctors he never smoked, he was indeed

05:48:25 a smoker. So getting accurate, candid information is

05:48:27 sometimes a challenge.

05:48:27 And I think the -- the original question that led

05:48:29 to these summaries was that of high-risk behavior in this

05:48:31 population of patients; is that correct?

05:48:32 Q Yes.

05:48:33 A Okay. If you could look at personal information,
48:39 it talks about her being divorced and her second house and
05:48:43 that she was arrested for a break-in. And on the fifth line
05:48:47 she admitted that she knew the risks of a high-fat diet, but
05:48:51 she eats it anyway. And then her dietary history is defined
05:48:55 there in some detail. And all of this is derived from the
05:49:00 deposition where she seems to eat beef and pork, bacon,
05:49:06 french fries, fried foods, ice cream. Obtains no regular
05:49:19 exercise. And this would be an example of that statement
05:49:24 that risk factors tend to cluster in individuals. So here's
05:49:28 an individual in whom we have already identified several
05:49:31 significant risk factors.
05:49:40 The bottom under smoking history or statements --
05:49:44 and these are all directly from the depositions. So none of
05:49:47 this is my editorial of what she said. In the depositions
05:49:51 she said that cigarettes were relaxing. She also said that
05:49:55 she had quit smoking when the children were young and she
05:49:58 had quit cold turkey.
05:50:05 Q You note she says, "Husband refers to cancer
05:50:08 sticks." What does that mean to you?
05:50:10 A Well, that -- that occurred in many of the
05:50:14 depositions, and apparently it's -- cancer stick is a slang
05:50:18 term that is sometimes used to define or refer to
05:50:22 cigarettes. That's my interpretation based on reading the
50:28 depositions. The top line, that should be Winston.

05:50:48 MR. COX: Before we go further, I think I should
50:50 make a clarification for the record. Or, Doctor, you may do
05:50:54 it, too. There is some printing on the back of these pages
05:50:57 in your exhibit, the exhibit that has been marked.
05:51:00 THE WITNESS: Yes.
05:51:01 MR. COX: I think you ought to explain what that
05:51:03 is, since there is no confusion.
05:51:05 THE WITNESS: You have the original set that I
05:51:07 printed off my computer. I ran out of computer paper so I
05:51:10 used any kind of scrap paper that had a blank side, which is
05:51:14 why if you look at some of these, it has my name up at the
05:51:17 top. This is patient information, questionnaires that I
05:51:21 have patients complete when I'm examining runners with
05:51:24 injuries and some of these other back sides are just
05:51:29 documents that I had been given that I was supposed to read,
05:51:33 have read. And I was desperate for paper and time so I just
05:51:40 used anything I could find. I'm surprised we copied both
05:51:42 sides.
05:51:43 MR. COX: I asked them not to do that, but just to
05:51:46 make sure, the back pages of anything in Plaintiff's Exhibit
05:51:50 Number 4 or anything that appears on the back side of a
05:51:54 sheet of paper has nothing to do with this case; is that
05:51:57 right?
05:51:58 THE WITNESS: Correct.
51:58 Q (BY MR. WALLACE) Doctor, the reason -- let me

state the reason in question and answer form for this, but in your seven-day notice or the notice provided by Mr. Cox's office, there are your notes attached to it. And it's my understanding that there have been certain additions and interlineations made by -- I mean, certain additions made by interlineation or otherwise in the case notes. Is that correct?

A I'm not sure I understand your question.

Q Let me start again, then. In the seven-day notice furnished to the plaintiffs by Mr. Cox, there are the case notes that I believe are made in this case.

A And these are the case notes?

Q Yes.

A Okay.

Q Now, Mr. Cox informs me that since those were furnished to you, that you have been furnished additional data that has been incorporated into the case notes; is that correct?

A That's correct.

Q And that's the reason I'm going through these particular notes rather than the ones that were originally provided.

A Correct. There are minor differences, and I still have more patient information files that I have not yet opened that I have been receiving up until -- last Friday I

received another packet. So I've not looked at that. So, yes, that's correct.

Q Now, would you say that the diet that Ms. Hyatt has is typical of the Medicaid population you examined?

A Yes. I -- yes. I think it's, in general, typical. Actually, she says she eats a high-fat diet and many of these foods are high fat. Some of the descriptions of the other Medicaid recipients I reviewed were far more explicit in the fat component of their diet. For example, she does eat fried potatoes and pork chops and ice cream three times a week, but some of these individuals have fried foods every day, all day every day. And the fact that there is no fish and from what I can see no green vegetables is, again, rather characteristic.

Q She's got okra and fruit often, bran type cereals every day. Those would be healthy diet foods, wouldn't they?

A Those would be a step in the right direction, I would agree.

Q And she only eats two eggs a week. That would be acceptable, wouldn't it?

A Eggs are not the problem. It's the saturated fat in all the other foods which cause the body to make cholesterol. Those are the real culprits.

Q In the medical summary, then, in the lower --

lower left-hand corner of the second page, there's a column headed "YR." What is that?

A That's the date and year in which services were provided. The middle panel under "INFO," information is usually the site of service. And you'll see there emergency room and sometimes you'll see office and sometimes you'll see an admission to the hospital. So the bottom of page 2, those are mostly emergency room visits. And off to the right, Roman numerals I, II and III --

Q Yes.

A -- refer to the volume of medical record where that information is contained; and the numbers refer to the Bates numbers, I believe you call them. Those are the numbers in the lower right-hand corner of the page. So that in case we wanted to find the specific page that addressed this question, we could do that. I think that -- that the key issues to address are the frequency of emergency room visits.

Q However, that would not be a risk factor, would it?

A I think that addresses the question of this individual's perception of the mechanism by which to obtain medical care or health information. There are also -- and you had asked earlier about quality, and we can address that if you wish to. There are examples scattered throughout

this where that is appropriate to address.

Q On the last page of Ms. Hyatt's notes over in the left-hand column you have a quarter of the way down the page "DX." What does that stand for?

A Diagnoses. Those are the major diagnoses that appeared in the record.

Q Are there any -- in this particular record are there any diseases that are associated with the risk factor of cigarette smoking?

A Are there any diseases in this grouping for which cigarette smoking could be a risk factor?

Q Yes.

A Anxiety, I'm not aware that cigarette smoking is a risk factor for anxiety. The abdominal pain, the constipation and the inflammation in her stomach, I'm not certain that cigarette smoking -- I'm quite certain cigarette smoking is not a risk factor for any of those. URI, the cold, upper respiratory infection. Alcoholism, cigarette smoking is not a risk factor for alcohol abuse or alcohol excess. PID refers to pelvic inflammatory disease. That's an infection of the female ovaries and tubes, and that's a pure infection. I see no potential alcohol -- I'm sorry. No potential smoking-associated illness in this list.

Want to try Roger Hurley or Hubenak?

06:00:04 Q First one, Roger.

00:06 A Let's see, one, two, three, four, fifth staple. We need to turn these over. You have the back side.

06:01:01 Q Roger Hurley?

06:01:04 A Sure. Up at the top are his date of birth and his age.

06:01:21 Q His smoking history, he started at age 13?

06:01:24 A Yes.

06:01:25 Q Is that correct?

06:01:26 A Yes.

06:01:27 Q Does he have any smoking-related diseases?

06:01:39 A Those diseases which he has for which smoking is identified as a risk factor possibly could be his coronary artery disease. His other risk factors for coronary artery disease are his hypertension, his family history and his alcoholism. There is one assertion in the record that he has diabetes. If that were true, that would be another risk factor; and that is only mentioned once in the record, and then his diet.

06:02:23 Q Okay. Were you able to confirm he had diabetes?

06:02:27 A There is one -- I recall there was one recording in the record where a physician history indicated that he had diabetes.

06:02:41 The other problem with this one is that he was

.02:44 non-compliant with his doctor's recommendations. He

repeatedly had medical illnesses because he stopped or discontinued his medication, and he was asked repeatedly to adhere to his medication regimen.

Q Would you refer to the medical -- your medical notes on Clifford Headley.

A (Witness complies.) He's the third, fourth from the bottom. Let's see. Oh, okay. I remember this.

Q He is a smoker, is he not?

A I think by definition all these individuals were smokers to some extent.

Q Okay. To what extent was he a smoker?

A There is a smoking history, started at age 10. Oh, this is a man who had stopped for two or three months at a time. His mother was in a nursing home; and when he went to visit his mother in the nursing home, he couldn't smoke there. And because he was disabled, unemployed, he had adequate time to spend with his mother, spent considerable periods of time with her; and during the time she was in the nursing home he did not smoke.

And then during the deposition he was asked why he went back to smoking and said that it was a nerve-calming exercise or a nerve-calming experience, which is why he returned to smoking.

Q Now, he has what chronic diseases?

A If I'm not mistaken, he has heart disease, he has

coronary artery disease. He's disabled because of a back injury and surgery to his back. He does have heart disease and, if I'm not mistaken, had been treated for myocardial infarctions or had -- yeah, angiograms. He has had angiograms which have indicated that he does have heart disease, and he eventually had an angioplasty.

Now, his risk factors were that heart disease runs in his family. Both his mother and father died at ages less than 65 because of heart disease. He has a high cholesterol, had a bad diet until very recently when after repeated admonitions from his physicians, he finally changed his diet, but prior to that time had a diet that was rich in fried and fatty foods.

And his cholesterols were rather significantly elevated.

Q Does the record reflect that he has chronic obstructive pulmonary disease?

A At one point I think that his history was that he said he had chronic obstructive pulmonary disease because he had trouble sleeping laying flat in bed. I don't think he ever had a test that showed chronic obstructive pulmonary disease.

The other problem with this man is that he is 250 pounds, and it was stated in the record on a number of occasions that he was quite large.

06:07:38 Q On the last page, the last entry just above
07:42 summary, "11/14 CP h/o angioplasty A-COPD."
06:07:52 A That was an entry that was made in his record.
06:07:55 Q And what does the A-COPD mean?
06:07:59 A The assessment at that time was that he had COPD.
06:08:03 Q That's chronic obstructive pulmonary disease?
06:08:06 A That was the assessment that was made by the
06:08:09 physician who examined him. We just looked at another one,
06:08:14 I think Rosetta Hyatt's. Hers and his both, there were
06:08:47 diagnoses that appeared without substantiation from the
06:08:49 physical examination. For example, in her case she was said
06:08:50 to have asthma on several occasions. When on those
06:08:51 occasions when examined, her lung examination was normal.
06:08:53 On this one, his chest X-ray, as I recall, was
06:08:54 always normal and there were -- I don't believe he ever had
06:08:56 a lung function test. Besides, with his size, it's probably
06:08:58 better he didn't have a lung function test because that
06:08:59 would be very difficult to interpret because the size alone
06:09:01 is enough to make his lung function test not normal.
06:09:02 That's another example of what I had mentioned
06:09:07 earlier, that frequently diagnoses appeared in the records
06:09:11 without substantiation. The other interesting thing to look
06:09:19 at in his record as you flip through those pages are all the
06:09:22 visits to the doctors in order to obtain narcotics.
06:09:35 Q On 6-27-95 I see the note, "Continues to smoke

06:09:42 1 despite admonitions."
09:44 2 A Warnings by physicians to stop. And it looks like
06:09:49 3 in that same hospital admission he had an angiogram that
06:09:52 4 showed occlusion of one coronary artery, and the next entry
06:09:56 5 for that date was the discharge plan, and there's a lot of
06:10:02 6 my abbreviations here. The discharge plan was weight
06:10:05 7 reduction, diet, stop smoking, low-fat diet.
06:10:08 8 Q Why would the doctor admonish him not to smoke?
06:10:12 9 A It seemed -- my -- again, I can't speak for the
06:10:19 10 doctor. I can only give you my interpretation of what the
06:10:26 11 doctor was thinking, and that's purely conjectural. And my
06:10:33 12 response would be that the doctor was attempting to address
06:10:35 13 the various risk factors in this individual.
06:10:39 14 Q And smoking would be one of the various risk
06:10:43 15 factors in this individual?
06:10:44 16 A Smoking would be a risk factor in a population
06:10:48 17 that would be associated with disease. You would try to
06:10:52 18 extrapolate from the population data to individuals, and
06:10:55 19 your conclusion is that you should change all those things
06:10:58 20 that could potentially contribute to your disease.
06:11:02 21 Q And smoking would be one of -- in this particular
06:11:06 22 case?
06:11:06 23 A As you can see, smoking was one of the several
06:11:10 24 mentioned, yes.
11:10 25 Q Okay. Here is one that I have not seen, Doctor.

It's on Joe "Beau" Harrison, III.

A Yes.

Q What is that?

A This is an individual who we have seven volumes of his medical record here. Here is a person who was born with spina bifida -- no, I'm sorry. His wife had spina bifida. He is a gentleman who at a young age had a motor vehicle accident. He was 16 years of age, I believe, when he had his accident. And from his accident he was then quadriplegic.

Q He's now age 42?

A I believe that -- no. He was born in 1942. So his age would be 55, 56.

Q Okay.

A His wife had spina bifida. No, I'm sorry. He had spina bifida and then had the auto accident and he was quadriplegic from the auto accident. His wife took care of him for a long time, and that renal failure up above was not correct. This is not in the final form.

In any event, he had multiple ulcers of his skin from his quadriplegic, and all of his medical care was related to treatment of his skin ulcers. And all of these volumes are the records of the home health nursing company that visited him.

Interesting thing about him, he's very unusual.

06:13:51 He was the one who smoked for five years, and then a friend
13:55 of his prayed with him, and it was a religious experience,
06:14:00 and he stopped cold turkey after smoking for five years.
06:14:06 And he stopped smoking, as I recall, 20 plus years ago.
06:14:36 MR. WALLACE: Let's take a break here.
06:14:38 MS. COY: We're off the record at 06:14:39.
06:14:51 (A recess was taken.)
06:27:27 MS. COY: We're back on the record at 06:27:39.
06:27:41 Q (BY MR. WALLACE) The -- putting aside
06:27:53 Mr. Harrison, would you refer to the record of Carolyn Rae,
06:28:00 R-A-E, Harvey of Tulsa.
06:28:04 A (Witness complies.)
06:28:41 Q Is it true that Ms. Harvey has acute congestive
06:29:14 heart failure and severe COPD from smoking?
06:29:15 A At one point in her more recent medical history a
06:29:17 diagnosis of congestive heart failure was made. That's a
06:29:19 diagnosis that was made on one occasion, and that looked
06:29:20 like it was August of 1996. On your summary, it's the third
06:29:25 page, the top item of the third page. The diagnosis of
06:29:27 congestive heart failure, to the best of my recollection,
06:29:28 was made during that one-month period of time or about a
06:29:32 year or so in that time frame and subsequently there have
06:29:36 been no further diagnoses of congestive heart failure.
06:29:42 Q There were no diagnoses of acute congestive heart
29:55 failure and severe COPD from smoking in 3-21-95?

06:30:02 1 A During that one-year time frame I think there were
30:06 2 several instances when she was diagnosed as having
06:30:09 3 congestive heart failure. I think the last notation is
06:30:13 4 1996. Now, the COPD has been carried as a diagnosis in the
06:30:20 5 majority of the records that I reviewed.
06:30:26 6 Q And in August of '96 she had severe COPD secondary
06:30:35 7 to heavy smoking?
06:30:37 8 A In August of '96, the diagnosis of severe -- and
06:30:42 9 that's the -- the physician or the patient's terminology.
06:30:48 10 That diagnosis was made in August of '96.
06:30:52 11 Q August 15th?
06:30:53 12 A Yes. 8-15-96 is my notation. I did not see any
06:30:59 13 notation in there of anyone's interpretation of a causation
06:31:03 14 of her COPD.
06:31:07 15 Q How much does she smoke?
06:31:23 16 A She discontinued smoking in 1985 and between 1949
06:31:33 17 and 1985 smoked to a variable degree. And at somewhere in
06:31:40 18 the record or in her deposition she stated that her average
06:31:45 19 was approximately one and a half packs per day.
06:31:48 20 Q Okay. You show in your record here 30 cigarettes
06:31:52 21 a day.
06:31:53 22 A That's from the deposition, it appears, yes.
06:31:56 23 Q Okay. Doctor, is smoking as a risk factor, is
06:32:05 24 that related to dose?
32:11 25 MR. COX: Objection. Vague as to dose as to --

related to what disease? I think the question is vague.

Q (BY MR. WALLACE) To coronary artery disease, lung cancer. In other words, if you smoke more cigarettes per day, are you more likely to have lung cancer?

MR. COX: Objection to the form of the question. Compound.

THE WITNESS: The question was about dose-disease relationship between smoking and heart disease and smoking and lung cancer?

Q (BY MR. WALLACE) Yes, sir.

A Well, the question implies that there is a causative relationship of one to the other. And as we've discussed, I think there is an associative relationship, but not a causative relationship that has been established. So, first of all, I think that our terminology needs to be in terms of association rather than causation.

Second, the dose-disease relationship, I don't know that -- if that has been done in the literature. I do know that from my experience and from reviewing these -- these medical records, there are some individuals who smoke very heavily -- and that's a relative term -- who have neither COPD nor heart disease nor anything else. Then there are other individuals with a more meager smoking history that seem to have those diseases.

I don't think that we can say there's a

dose-disease relationship, certainly not from a causation standpoint.

Q What risk factors does Ms. Harvey have among the multitude of risk factors that you -- or that your statement says exist?

A Risk factors for which condition?

Q For disease.

A Her risk factors for disease? Alcoholism, bipolar depression, allergies, smoking, esophageal reflux, hepatitis, chronic hepatitis. I believe she had hypertension.

Q Where does that appear, Doctor?

A One of the drugs she is taking is a drug used to treat hypertension.

Q Which drug is that?

A Lotensin.

Q And where does that appear in the record?

A On the second page -- well, it's on the first page, as well. Down at the bottom of the first page next to the last line.

Q Says Lotensin?

A Yes. And then that appears again on the top of the second page for eight or so lines down. You asked earlier about her congestive heart failure. I wonder if I could clarify that to some extent.

06:36:28 Q Surely.

06:36:29 A Again, on the second page, look at the notation on 3-21-95. There are half a dozen notations on 3-21-95.

06:36:39 Q Yes.

06:36:40 A Third from the bottom, "Echo," E-C-H-O.

06:36:44 Q Yes.

06:36:45 A The end of that line, "EF 62 percent." That's a significant number. Now, here's what that means. EF stands for ejection fraction. That's the doctor's way of saying each time your heart beats, it pumps out a certain percentage of the blood that it contains. Normally it should pump out about 65 percent of the blood that's in there. If someone has congestive heart failure, invariably that number, that percent of blood pumped each time is down in the 40s, 30s and 20s.

She ejects 62 percent of the blood that's in her heart. Normal is 65, plus or minus 10 percent. So she's ejecting a normal amount of blood each time her heart beats. It's very hard to say there's a diagnosis of congestive heart failure with that number.

Now, that's part of the problem of this particular case because she has a lot of swelling of her feet which she probably has for any one of several different reasons. As I reviewed this, it seems to me that someone looked at the swelling of her feet and said that this is due to congestive

heart failure. They then did that test. The test was normal and yet they persisted in diagnosing her as having congestive heart failure up until the summer of the following year, 1996.

Subsequent to that, there are no other notations regarding congestive heart failure that I could recall. Which to me means that that was not a diagnosis that was continued in her record. And we have another risk factor I just identified that's left off my summary. It appears that she's diabetic, as well.

Yes. And the diagnosis of hypertension is made on 8-15-96. Top of the second page. So it's not just the medication. There appears "HTN" at the bottom of the second line. That is hypertension. Oh, my, her cholesterol's high, as well.

Q Is there a finding there at the bottom of your first page of notes in the left-hand column, says "PMH"? What is that?

A Past medical history.

Q Okay.

A And, there again, is hypertension.

Q Fourth line down?

A Yes.

Q "CXR '76, emphysema." What is that, Doctor?

A Chest X-ray done in 1976 was interpreted as

showing emphysema.

Q Okay. And what does that mean?

A It means to me that a radiologist looked at an X-ray and said the X-ray shows emphysema without any correlation with the patient.

Q Okay. Do you have some doubts that a radiologist could make that assessment?

A Perhaps in 1976 the radiologist may have been confident to make that assessment, but today I know of very few radiologists who would venture into a physiologic diagnosis based on a chest X-ray.

As a matter of fact, it's quite clear that over the years the radiologists have refrained from making that diagnosis based on a chest X-ray because their inaccuracy rate was quite high. And, essentially, that diagnosis cannot be made from an X-ray.

Q She -- there's no question that she had diagnoses made of COPD, is there?

A No, sir. There is no doubt she has COPD.

Q That's chronic obstructive pulmonary disease?

A Yes.

Q And so that she has that, that would tend to reinforce the diagnosis of emphysema, would it not?

A I think most of us use those terms interchangeably. Emphysema is COPD.

06:41:56 Q What does COPD, the diagnosis, add to the
42:04 diagnosis of emphysema?
06:42:06 A I think it adds nothing. I think they're
06:42:10 different generations of physician who learned one term and
06:42:14 another generation of physicians that learned another term.
06:42:17 We use them interchangeably.
06:42:21 Q Okay. So that if you see a discharge summary
06:42:29 today, it would say COPD, possible COPD, possible emphysema,
06:42:37 or would you have a multi-generation doctor?
06:42:42 A In all likelihood. To be technical about it,
06:42:45 emphysema is a diagnosis made by a pathologist who looks at
06:42:49 a slide of a lung under a microscope. So emphysema is the'
06:42:55 pathological diagnosis.
06:42:56 We don't make pathological diagnoses by examining
06:43:02 patients. So to be technical, it's a semantic issue.
06:43:07 Emphysema is a term that I would expect only a pathologist
06:43:11 to use. COPD is a term we use which is more descriptive of
06:43:16 the biology of the lung disease. It's chronic; it's
06:43:21 characterized by obstruction of the lungs and, thereby, the
06:43:25 obstructive pulmonary disease component.
06:43:28 Q There are specialists in the area of lungs, are
06:43:35 there not?
06:43:35 A Correct, yes.
06:43:36 Q They're pulmonologists?
06:43:40 A Correct.

Q And they are a specialty in their area just as you are in yours; is that correct?

A They are specialists who deal with treatment of lung diseases, yes.

Q Okay. Are you acquainted with Dr. Robert McCaffree?

A I know who he is.

Q Do you know his reputation in the community for -- as a medical doctor?

A No, sir, I don't.

Q Do you know that he is the chief of staff at the Veterans' Administration in Oklahoma City?

A Yes. I'm aware of that.

Q And do you know he's on the faculty of the University of Oklahoma Medical School?

A Yes.

Q Have you had any patients referred to you by Dr. McCaffree?

A No, I haven't.

Q Has he referred any patients to you?

A Not that I can recall.

Q Did we go into the risk factors completely on Carolyn Ray Harvey?

A Your question, I believe, was if I could identify the risk factors that existed in her that would predispose

06:45:36 1 to disease. And I gave a list, and I've subsequently added
45:42 2 to that list.
06:45:42 3 Q Okay. Can we limit that, now, to chronic diseases
06:45:48 4 such as COPD, coronary artery disease, chronic sinusitis?
06:46:20 5 Now, this lady's on oxygen, is she not?
06:46:23 6 A I believe that is correct.
06:46:24 7 Q Twenty-four hours a day?
06:46:29 8 A I believe that's correct. Yes.
06:46:37 9 Q How old is this lady?
06:46:49 10 A She was born in 1934, therefore she is 65,
06:46:57 11 approximately.
06:46:58 12 Q Okay. And apparently she's totally disabled, did
06:47:04 13 you say, since she's at home on oxygen?
06:47:11 14 A She was -- she has been disabled because of a
06:47:14 15 motor vehicle accident from which she sustained an ankle
06:47:17 16 injury in 1981.
06:47:21 17 Q Did you discover why she's on the oxygen 24 hours
06:47:30 18 a day?
06:47:30 19 A Did I discover why --
06:47:36 20 Q Yes.
06:47:37 21 A -- she's on the oxygen?
06:47:39 22 Q In the reading of the records.
06:47:41 23 A She's on the oxygen because of the diagnosis of
06:47:44 24 COPD and the fact that she has inadequate oxygen in her
.47:50 25 blood and, therefore, the oxygen content of her blood is

supplemented by the oxygen she receives.

Q And what are the risk factors that you see in her medical record for the COPD?

A The risk factors for COPD in her would be, one, smoking; two, asthma; three, allergies; four, what we've abbreviated there as GERD.

Q What does that mean?

A It's G, gastroesophageal reflux disease. It's the spillage of acid from the stomach into the esophagus which predisposes to an asthma-like illness which can develop into COPD.

Q Does the record reflect when the onset of that gastric whatever was commenced?

A I'm certain it does. I -- yes. January, 1994, was -- January 14, 1994, there was a diagnosis of GERD made at that time and based on the rest of the words on that first and second line. The second line in particular, that would suggest to me that she has had that, GERD, for a considerable period of time.

Q Any other risk factors?

A Those are three or four, however many they are.

Q Now, in the -- your seven-day disclosure under number -- number 4, "Risk factors tend to cluster in individuals because of genetic, psychosocial and environmental factors." Are you with me on those so far?

A Yes, sir.

Q Then it says, "For example, smokers tend to be different than non-smokers in the sense that they tend to also exhibit many other risk factors for chronic multifactorial diseases." What -- in connection with that second sentence, what are the risk factors that smokers have that non-smokers don't have?

A There are some general differences between smokers and non-smokers in terms of risk factors.

Q Okay.

A The general differences are related to diet in that smokers tend to have diets that reflect higher fat, lower vegetable content of food. Smokers tend to engage in behaviors that we would identify as being riskier to health, behaviors such as not using seat belts, risky sexual behavior that can be associated with the development of sexually-transmitted diseases. Those would probably be the major ones.

We should probably add to that while we're at it the inactivity issue in that smokers tend to be less active. So the differences would be in lifestyle, diet, risky behaviors. And I think there's even some data out there to suggest that smokers tend to more frequently experiment with illicit drugs. I think there's some information out there that would suggest that smokers are more likely to be

06:53:17 engaged in riskier occupations.

53:24 Q Okay. And in your authority for the first risk

06:53:39 factor, what authority do you cite for smokers having a

06:53:44 higher fat diet?

06:53:45 A Well, there are several. We can start with the

06:53:54 depositions of the patients under discussion. I think that

06:54:01 the general dietary theme in that 18 individuals would be

06:54:07 that the diet was a high-fat diet. High fat, low vegetable

06:54:13 diet. Second, we can look at our -- my experience as a

06:54:20 clinician in dealing with patients for 25 years; and my

06:54:26 experience is exactly identical to what I learned from the

06:54:29 depositions and the medical records.

06:54:31 Then, finally, there have been studies performed

06:54:39 to -- studies performed that specifically look at these

06:54:43 issues. And those studies are cited in my references. That

06:54:49 would be reference number 10. That would be the Lantz,

06:55:00 L-A-N-T-Z, article. And actually the editorial that

06:55:07 followed that article would also be a useful piece of

06:55:13 reading.

06:55:14 It was written by Dr. Redford Williams who I know.

06:55:20 And he takes the data from this article and puts it in a --

06:55:25 in a different light and makes it a little more

06:55:27 understandable to the everyday reader.

06:55:33 Q You found in your review of these records that

06:55:39 these people -- the 18 medical records, that they had a

higher fat diet than whom?

A Than -- a higher fat diet than my typical SCORE participant, a higher fat diet than the runners that I've questioned. I've taken questionnaires of runners and studied their diets. I've interviewed Africans and reviewed their diets. I think that over the years I've taken several dietary surveys of different groups.

Q You have taken those surveys yourself?

A Yes, yeah.

Q Okay. When and where?

A In the 1980s with a medical student we did a dietary questionnaire survey of runners. I think we had some 300 odd runners that we surveyed. And I subsequently wrote that in some running magazine. I didn't include it in my CV because it was not in a peer reviewed, refereed journal. It was in a -- more of a lay publication.

A number of years ago I had the opportunity to serve Africans -- actually African athletes, and I've spoken and -- not true. I have written, but I certainly have spoken of my interviews of African athletes on a number of occasions. A number of years ago I had an opportunity to interview a number of ex-collegiate athletes, ex-collegiate athletes by two decades or so. And I looked at their dietary habits.

I have reviewed dietary habits of Native

06:57:44 Americans. In the '70s when I was involved in all those
57:50 studies at the Lawton Indian hospital, we took extensive
06:57:55 dietary histories.
06:57:55 Q Okay. Well, among the non-smokers, among the
06:57:59 Native Americans did you find that they had a higher fat
06:58:04 diet?
06:58:04 A In general, Native Americans have a higher fat
06:58:08 diet than non-Native Americans. And then smokers in general
06:58:13 have a higher fat diet than non-smokers.
06:58:16 Q Now, all of these groups that you talked about are
06:58:24 very selective, are they not? Highly selected?
06:58:28 A Selected, yes, I would agree. All these groups
06:58:33 are selected, the Native Americans and the diabetic, as
06:58:38 well.
06:58:38 Q Well, for example, runners wouldn't be typical of
06:58:41 your general American population, would they?
06:58:43 A No. The SCORE population probably were more
06:58:46 reflective.
06:58:47 Q Okay. And African American athletes wouldn't be
06:58:51 typically, would they?
06:58:52 A No. The purpose was to answer a specific question
06:58:57 which is why those populations were selected.
06:58:59 Q What was the specific question?
06:59:01 A The dietary habits of athletes, the dietary habits
.59:08 of former athletes, hopefully, to make some correlation

06:59:12 between diets and athletic performance. That was the
59:17 original intent.
06:59:20 Q Well, it wouldn't be surprising to find that a
06:59:23 smoker had a higher fat diet than a runner, would it?
06:59:28 A A smoker had a higher fat -- I think smokers have
06:59:34 higher fat diets than anyone I've ever talked to.
06:59:38 Q All right. Take another person in the Medicaid
06:59:45 population. Have you done a study or survey of the Medicaid
06:59:51 population or persons in it to ascertain the level of fat in
06:59:56 their diet?
06:59:57 A No. I'm referring to personal experience and the
07:00:02 18 records I reviewed.
07:00:04 Q So you really don't know what the non-smokers in
07:00:17 the Medicaid population had by way of diet that would be
07:00:22 less fatty?
07:00:24 MR. COX: Objection to the form of the question.
07:00:27 Misstates the prior testimony. You may answer.
07:00:29 THE WITNESS: I've treated Medicaid recipients for
07:00:37 more than 25 years. I've taken dietary histories on most,
07:00:43 if not all those patients. And I think I can base my answer
07:00:50 on 25 years of treating Medicaid recipient patients.
07:00:56 And my opinion is that the fat content of the diet
07:01:02 is, I think, in general, higher in the Medicaid population
07:01:06 and, I think, higher in the smoking Medicaid population; and
01:10 that is just not only my interpretation, but this article,

07:01:16 1 the June 3rd, 1996, JAMA article, I believe, says the same
01:23 2 thing.
07:01:25 3 Q (BY MR. WALLACE) Did they go into the study of the
07:01:28 4 Medicaid population --
07:01:29 5 A I don't --
07:01:30 6 Q -- in the Lantz article?
07:01:31 7 A I don't believe they studied the Medicaid
07:01:34 8 population. I think they talked about socioeconomic factors
07:01:41 9 and how they related to diet and indicated that those who
07:01:46 10 were socioeconomically deprived tended to have a higher fat
07:01:50 11 diet.
07:01:50 12 Q Does it distinguish in there between smokers and
07:01:56 13 non-smokers by way of diet in the Lantz article?
07:01:59 14 A I'm not sure that article does. There are other
07:02:02 15 articles that do address those differences, however.
07:02:21 16 MR. COX: I think you may be looking for the one
07:02:23 17 right above the Lantz article.
07:02:25 18 THE WITNESS: I know there's one -- oh, there it
07:02:27 19 is. That's the title of it. Sure. Thornton's article. I
07:02:31 20 was looking for that and couldn't find it. I'm sorry.
07:02:34 21 Yeah, the differences between smokers and non-smokers. And
07:02:38 22 then they have different categories in between. That's the
07:02:43 23 one.
07:02:43 24 Q (BY MR. WALLACE) Going back a moment to -- my eye
03:07 25 is caught by this article by Hopkins, Paul N. And that's

07:03:11 1 number 8. A survey of suggested -- "A Survey of 246
07:03:16 2 Suggested Coronary Risk Factors." Now, that's for
07:03:27 3 atherosclerosis; is that correct?
07:03:28 4 A Yes. These would be risk factors for the
07:03:32 5 development of coronary heart disease, atherosclerosis.
07:03:37 6 Q Did you -- in reviewing those 246, did you find
07:03:43 7 any that you disagreed with as being a risk factor from
07:03:51 8 based on your 25-year experience as a medical doctor?
07:03:55 9 A No, sir. Not that I disagreed with, no.
07:03:59 10 Q Were there any among the 246 that had never
07:04:06 11 occurred to you before as being a risk factor?
07:04:08 12 A There were a few in there that are instances that
07:04:18 13 are rather uncommon in medicine, and either I wasn't aware
07:04:22 14 or had forgotten. But what he did was that he took much of
07:04:27 15 what I already know. For example, take high cholesterols,
07:04:30 16 and he broke down the high cholesterols into multiple
07:04:34 17 subsections or subdivisions of high cholesterol and
07:04:39 18 enumerated each one as a separate risk factor for the
07:04:43 19 development of coronary atherosclerosis.
07:04:47 20 And ordinarily when I would think about that, I
07:04:49 21 would think about two or three of those subdivisions of
07:04:52 22 cholesterol. And, as I recall, he must have had eight or
07:04:54 23 ten subdivisions of cholesterol. So it was not something I
07:04:57 24 didn't know, but hadn't looked at it in exactly that outline
05:00 25 form in the past.

07:05:01 Q Well, did he suggest that, for example,
05:10 non-attendance in church is a risk factor for coronary
07:05:17 artery disease?
07:05:18 A I'm not sure if he did or if the Welty article
07:05:24 did. Should we review that list?
07:05:28 Q Well, no. I'm just asking you if that had ever
07:05:32 occurred to you to ask a patient if you have a risk factor,
07:05:38 not going to church.
07:05:39 A Well, there are two issues at stake here. One is
07:05:42 the socialization issue, and the other is the spiritual
07:05:45 issue. Lack of spirituality, I think, is recognized as a
07:05:50 risk factor for a variety of diseases; and socialization is
07:05:54 also a risk factor for the development of coronary disease.
07:05:57 Specifically, lack of socialization is a risk factor for
07:06:02 coronary disease. That has been well recognized in the
07:06:05 literature.
07:06:05 Q So that going to church would be a -- one of the
07:06:12 things about going to church would be the social risk
07:06:16 factor?
07:06:16 A No. I said that there are two issues at stake
07:06:19 here. One is a socialization issue. Going to church is a
07:06:24 form of socialization for some people. The second issue is
07:06:27 a spiritual issue. For example, we know that nuns and
07:06:31 priests have a much lower incidence of hypertension and
06:36 heart disease, and they're associated. And people have

07:06:43 1 tried to speculate as to the causation or the specific
06:47 2 interaction between spirituality and a decreased incidence
07:06:52 3 of heart and blood vessel diseases. So they are associated,
07:06:57 4 but the specific causal relationship has not been
07:07:01 5 identified.
07:07:01 6 Q So that that is speculative?
07:07:06 7 A There seems to be a statistical association. And,
07:07:11 8 again, as we discussed earlier, a statistical association
07:07:15 9 would apply to populations of priests or clergy or nuns, and
07:07:21 10 that's important in understanding the potential mechanisms
07:07:24 11 of disease.
07:07:27 12 Q Okay. But I understood you to say that there had
07:07:32 13 been speculation about this.
07:07:38 14 A The -- the inverse correlation that has been made
07:07:43 15 is that higher spirituality equals lower disease. That's
07:07:48 16 the association. And people have speculated as to -- as to
07:07:52 17 the potential mechanism by which one could lead to the
07:07:56 18 other, getting to causation in individuals. But that
07:07:59 19 linkage and that explanation has never been clearly
07:08:03 20 identified.
07:08:04 21 Q There would be no way to measure spirituality of
07:08:08 22 an individual, would there?
07:08:08 23 A Well, it's a little more difficult to measure than
07:08:12 24 a blood pressure or a blood cholesterol level. It's a
.08:15 25 little more difficult to measure. I think you can look at

it in terms of numbers of hours engaged in individual prayer. And I think that has been specifically addressed in some study that addressed nuns and prayer and high blood pressure. I think that has been addressed; and I, obviously, haven't reviewed that, but I know that that has been a topic of research.

Q And would you measure their spirituality by the hours the individual spends in prayer?

A I believe that was the measure that was used in that study, although I have not read that study in a number of years.

Q And what other measure would -- would you use to measure a person's spirituality?

A If I were to design that study today?

Q Yes.

A What would I use as a measure?

Q Yes.

A I would measure hours in prayer, hours in church, hours in prayer alone, hours in prayer in a group prayer. I would probably try to measure as many variables as possible.

Q And you would do that both in -- in the population generally?

A If I were to speculate on how I would design a study and the objective was to determine the interrelationship of prayer to an end point, hypertension, I

07:10:11 would probably do several things. I would probably look at
10:13 a population of hypertensive people and measure all those
07:10:14 variables in them.
07:10:15 I would probably look at a population of people
07:10:16 with normal blood pressures and measure those variables in
07:10:21 that population. I would probably look at nuns with and
07:10:26 without hypertension and measure all those variables and
07:10:27 then see if there were differences in the populations.
07:10:28 I would attempt to identify a population as pure
07:10:30 as possible. That is a hypertension with only two
07:10:31 variables, prayer and hypertension, and no other potential
07:10:33 confounding risk factors for hypertension. Wouldn't be
07:10:36 easy. It would be very interesting.
07:10:37 Q You make the statement in -- or the statement is
07:11:03 made here, and I assume it's with your approval in the
07:11:09 seven-day disclosure under number two, "Even if the
07:11:15 individual has only one acknowledged risk factor for the
07:11:20 disease, it is currently impossible to determine if that
07:11:26 risk factor actually caused the disease because it is
07:11:29 readily apparent that there are unknown risk factors for
07:11:34 these diseases." Is that your opinion?
07:11:38 A Yes. I think that opinion is based on medical
07:11:45 history.
07:11:49 Q So if you have an individual with COPD and the
12:20 only risk factor is smoking, you would be unwilling, then,

07:12:28 1 to make a judgment that the smoking caused the COPD because
12:36 2 there are unknown risk factors for these diseases? Would
07:12:40 3 that be your position?
07:12:42 4 A I would like to use the example you gave earlier.
07:12:46 5 You said that 80 or 85 percent of people with COPD smoke.
07:12:53 6 Q No. Lung cancer.
07:12:54 7 A I'm sorry. That was lung cancer. We can use the
07:12:58 8 same analogy. A certain percentage of people with COPD
07:13:02 9 smoke or live next to smokestacks or whatever. There's a
07:13:08 10 population that has COPD and a second risk factor, but then
07:13:14 11 on the periphery of that population there are other people
07:13:17 12 with the same disease with no known risk factors.
07:13:21 13 The question is: What caused their disease? I
07:13:24 14 think the answer is: We don't know because there are other
07:13:28 15 risk factors that we have not yet identified.
07:13:32 16 So when faced with an individual with a disease, I
07:13:36 17 never know if that disease was associated with what I know
07:13:40 18 in terms of risk factors or if that disease is a disease
07:13:44 19 that could have occurred without known risk factors. And
07:13:49 20 probably the best example is heart disease.
07:13:51 21 For a number of years from Framingham we knew that
07:13:55 22 there were several risk factors for heart disease. And then
07:13:58 23 all of a sudden someone finds this substance called
07:14:00 24 cholesterol and asks, well, I wonder if this is related to
14:04 25 heart disease. And then they go back and analyze thousands

07:14:08 1 of blood specimens that they have been accumulating over the
14:11 2 years and, oh my gosh, cholesterol's associated with the
07:14:16 3 development of heart disease.
07:14:17 4 So there were people who had heart disease with no
07:14:19 5 known risk factors. And the question is: What caused their
07:14:24 6 heart disease? And the answer is: No one knows. But over
07:14:29 7 the years we've developed more and more associated factors
07:14:33 8 so that it was cholesterol and it was hypertension, diet, et
07:14:38 9 cetera, I think were pretty well known. And now it's
07:14:40 10 homocysteine.
07:14:41 11 So the longer we go, the more risk factors we
07:14:45 12 identify which help us to understand the association of a
07:14:50 13 disease in someone who has -- has an absence of what we
07:14:54 14 would identify as known risk factors. There were always
07:14:58 15 things that we need to know and don't know.
07:15:00 16 Q Okay. So I'm trying to understand this, Doctor.
07:15:06 17 Are you saying that -- that before you can say that a risk
07:15:11 18 factor caused a disease, that you have to know that 100
07:15:19 19 percent, that everyone that has this disease has this
07:15:23 20 particular risk factor?
07:15:24 21 A I think we addressed this earlier when we talked
07:15:28 22 about causation of disease. And I said that we can
07:15:31 23 confidently or reasonably confidently talk about causation
07:15:35 24 in terms of infections with specific agents that cause
15:38 25 infection, and beyond infections we can only speculate on

causation.

And we can only do that with individuals after gaining a full understanding of the potential risk factors -- environmental and genetic factors involved. And my comment was that still after understanding all of that, attempting to assign causation is more speculation than science.

Q Well, and, of course, in the practice of medicine you have a lot of speculation, do you not?

A Yes, sir.

Q In other words, it's not only scientific, but there's an art to it, is there not?

A Yes, there is.

Q And in your practice of medicine, don't you regularly make statements that are part scientific and part art in assigning a diagnosis?

A In assigning a diagnosis? Yes.

Q Okay. So if a doctor says that this person has COPD because of smoking, that doctor is making that -- rendering that opinion based upon both the art of medicine and the science of medicine, is he not?

A I think he's rendering that diagnosis based on his opinion. But what he's doing here is two things. He's making a --

Q Can you answer the question.

MR. COX: Would you, please, let the witness finish his answer.

MR. WALLACE: Well, go ahead. Answer your --

THE WITNESS: I think what the doctor is doing, this scenario you've created is that the doctor is doing two things. He's making a diagnosis, and he's attributing causation -- he's assigning causation.

I think that the prudent clinician will make a diagnosis and will attempt to identify risk factors. I don't know of many physicians who are that bold as to be able to state with confidence the specific causation of any disease other than an infectious disease. Because I think that's more speculation than we should be exercising.

Q (BY MR. WALLACE) Would you agree that doctors do exercise that amount of speculation?

A I think sometimes doctors do exercise or utilize a fair amount of speculation. I think it all depends on the question, the patient, the circumstances. No, we don't go around speculating because we have nothing better to do. Our job is diagnosis and treatment.

Q That's not -- excuse me. Go ahead.

A Our job is simply to evaluate the patient, assess the nature of the problem, prescribe some intervention or some therapy that we hope would alter the disease.

Q And if you have a COPD patient and that COPD

patient smokes, part of the intervention would be to recommend they not smoke, would it not?

A Part of the intervention would be to recommend not smoking or to eliminate any other risk that I think could be associated with that disease or could interfere with treatment of that disease.

Q Okay.

A And in the case we cited, we have asthma and dust and this GERD.

MR. COX: When it gets convenient, I would like to take a break, if we could.

MR. WALLACE: Okay. Let's do.

MS. COY: Off the record at 07:19:37.

(A recess was taken.)

MS. COY: We're back on the record at 07:33:59.

Q (BY MR. WALLACE) Doctor, in opinion number 6 on page 1 of your seven-day disclosure, would you read that, please.

A "The Oklahoma Medicaid population differs from the national Medicaid population in part because of the high percentage of American Indians in the Oklahoma Medicaid population. (Approximately 9 percent in Oklahoma as opposed to .9 percent in the national Medicaid population.)"

Q Now, you say in there in part it differs. Other than the high percentage of American Indians in the Oklahoma

07:34:58 Medicaid population, do you have an opinion as to how the
35:04 Oklahoma Medicaid population differs from the national
07:35:07 Medicaid population?
07:35:08 A Some of this that I'm -- some of my opinion's
07:35:20 based on extrapolation because the specifics of the Oklahoma
07:35:24 Medicaid population have really not been well defined,
07:35:28 they've not been well studied. The Oklahoma population in
07:35:34 general has been reasonably well studied, and there are some
07:35:38 specifics about the Oklahoma Medicaid -- Oklahoma population
07:35:43 which I think we can carry over to the Medicaid population.
07:35:48 Q Okay.
07:35:49 A For example, Oklahoma has some challenges in its
07:35:56 health care by virtue of the fact that we're a rural state.
07:36:00 That is, the percentage of people who live in rural areas in
07:36:05 Oklahoma is greater than the national average. I think the
07:36:09 numbers would show that we have 20 -- I'm sorry. 32 percent
07:36:14 of Oklahomans are rural, and national average for rural is
07:36:18 down in the 26 percent range or 25 percent range. So we
07:36:22 have a higher number of our people who live in rural areas.
07:36:28 Oklahoma has a higher percentage of people whose
07:36:33 income is below the federal poverty level. Not the highest
07:36:38 in the country, but certainly much higher than other states.
07:36:50 The Native Americans are different and the Native Americans
07:36:54 bring a whole separate set of risk factors.
36:59 Additionally, Oklahoma has one of the highest teen

pregnancy rates in the United States, although it varies. I think we're eighth or tenth highest in the United States. And conversely we have one of the lowest rates of prenatal care in the United States. I think we're fourth.

So these are rather unique situations to the Oklahoma population.

Q Do you think that an epidemiologist could adjust the Oklahoma Medicaid population numbers from the national Medicaid population numbers to take into account the larger numbers of Native Americans in Oklahoma as contrasted with the national population?

A Well, that -- that requires a fair amount of speculation on my part, and I would be pleased to speculate to attempt to answer that question. The question is whether or not I think an epidemiologist can correct for the Native American population in Oklahoma. I think that would be extremely difficult without studying the Oklahoma Medicaid population. I don't know if any of those adjustments can be made.

And here's why I say that. The magnitude of the problem of diabetes in the Native American was unknown until we actually started studying it back in the early '70s. The differences in risk factors in diabetics I think was not fully appreciated until 1996 when the Strong Heart study was produced.

07:39:17 1 And, mind you, now, the Strong Heart study is not
39:20 2 at all representative of the medication population. Because
07:39:24 3 of these enormous surprises that have come upon us over the
07:39:29 4 years, my answer would be that we really shouldn't be
07:39:35 5 speculating, but we should be looking at the population in
07:39:39 6 great detail to answer those questions.
07:39:42 7 Q All right. Well, Doctor, it wasn't a surprise to
07:39:45 8 you in the -- that there was a high percentage of diabetes
07:39:50 9 in the southwestern Oklahoma Indians studied in the Strong
07:39:57 10 Heart article, was it?
07:40:00 11 A No. Because I had already completed those studies
07:40:03 12 when I was there, and I knew that fact. But to look at the
07:40:08 13 number of Native Americans in Oklahoma with diabetes, that
07:40:11 14 was relatively new back in the early '70s. The Strong Heart
07:40:16 15 study also showed us that Native Americans in Oklahoma have
07:40:19 16 more hypertension than non-Native Americans elsewhere. Now,
07:40:25 17 that was a surprise, and that confers more risk to that
07:40:29 18 particular population. So the more we look at this
07:40:34 19 population, the more differences we recognize.
07:40:38 20 Q You had not recognized the higher hypertension
07:40:44 21 rate in the Native American population in your treatment of
07:40:52 22 these people in the '70s and '80s?
07:40:55 23 A I knew that we were treating a fair number of
07:40:58 24 patients with hypertension, but what I didn't know is
41:01 25 whether I was treating or I was examining a select group of

people or if I was treating a -- a number of people who represented a cross -- cross section or a spectrum of the population. I did not know that at the time.

If I were treating a -- a select population of patients, then it's more likely that I would be treating the more severely diseased patients, therefore more of my patients would be hypertensive. So I couldn't tell if this was selection bias or if this was a cross section and there was no bias involved.

I think the Strong Heart study more so than the studies we did in diabetics showed that Oklahoma Native Americans have more hypertension than non-Native Americans. So one to me was a surprise. The diabetes I already knew.

Q The Strong Heart article also goes into lipids and fibrinogens. Is there anything about fibrinogens in the Oklahoma population that -- says here, the last sentence, "Mean fibrinogen levels were over 30 MG/DL, higher in Arizona participants than those in the other two sites." What significance, if any, does that have?

A Well, that's very interesting. Again, we keep talking about risk factors; and the longer we go, the more risk factors we have. Well, fibrinogen has been recently identified as a risk factor. And I think the point here was to measure fibrinogens in the Native Americans to see if they're higher, lower, the same and to try to develop some

07:42:59 1 associations from those observations.
43:01 2 I think that the fibrinogen story in Native
07:43:04 3 Americans has not yet been written. I think the homocystine
07:43:08 4 story in Native Americans has not yet been written. I think
07:43:11 5 the whole lipid story in Native Americans, to my reading of
07:43:15 6 the literature, has not been well identified. We have an
07:43:19 7 awful lot to learn in those areas.
07:43:22 8 Q What role does the fibrinogen play in coronary
07:43:30 9 artery disease?
07:43:31 10 A The current state of knowledge is that it appears
07:43:36 11 that a high fibrinogen level is associated with the
07:43:41 12 development of cardiovascular disease. So it is another
07:43:44 13 risk factor for the development of cardiovascular disease.
07:43:48 14 Some Native Americans seem to have high fibrinogen
07:43:51 15 levels. Well, that's a risk factor. The question is: Why
07:43:55 16 do they have the high fibrinogen levels? I think some of
07:43:59 17 the high fibrinogen levels are understood, and some are not
07:44:03 18 understood. So I think this is an evolving area of science.
07:44:08 19 Q Is there a correlation between the fibrinogen
07:44:13 20 levels and smoking in the general population?
07:44:17 21 A Not that I'm aware.
07:44:19 22 Q Now, in paragraph number 5 you say, "The
07:44:46 23 prevalence, mix and distribution of risk factors for
07:44:50 24 smoking-associated diseases in Oklahoma's Medicaid
44:54 25 population is significantly different than that found in

other populations including the national Medicaid population."

Now, my first question in relation to that particular paragraph -- well, first of all, do you agree with that statement?

A Yes.

Q Okay. Now, what study have you made of the national Medicaid population?

A That would be -- I think that would be reference 5.

Q Those would be the --

A Those would be reports from the Department of Health and Human Services.

Q Okay. Oh, I see what you're --

A Reference 5, there are several subsections of 5.

Q Okay. That's on the HCFA reports?

A Yes.

Q Okay. And you made a study of those HCFA reports?

A I've reviewed those HCFA reports, yes.

Q Okay. Now, to what extent -- when you say you reviewed them, what did you do in reviewing?

A The HCFA reports, these HCFA reports relate to race and ethnicity of Medicaid recipients, and I looked at the national data relative to percentages of Native Americans in the database. And that number was .9 percent.

07:47:15 Then looked at the Medicaid recipients in Oklahoma
17:20 who were Native American over the past decade, and I found
07:47:25 that that percentage started at 6 or 7 and went up to 10.4
07:47:32 or 10.6 percent for the last year that data is available.
07:47:37 And it averages out to be about 8.9 percent for the last
07:47:41 decade.
07:47:43 Q Now, is that the significant difference that you
07:47:48 find that the mix and distribution of risk factors for
07:47:54 smoking-associated disease in the Oklahoma medical --
07:48:00 Medicaid population from the national Medicaid population?
07:48:04 A That would be one.
07:48:05 Q Okay. What else?
07:48:07 A Well, the others would address some of the issues
07:48:12 that we have been discussing. And I refer to many of my
07:48:17 former answers where we discussed teen pregnancy rates,
07:48:27 prenatal care, diet, inactivity, the diabetes, the
07:48:45 hypertension, and some of the more unique occupations found
07:48:55 in Oklahoma such as the handling of peanuts, cotton,
07:49:00 proximity to the petrochemical industry.
07:49:04 Q Well, isn't it true, Doctor, that in other areas
07:49:10 of the country they have similar industries?
07:49:15 MR. COX: Object to the form of the question as to
07:49:18 what similar means in this context. It's vague. You may
07:49:22 answer.
49:23 THE WITNESS: I think each area of the country has

its own industrial base. Some areas of the country have more petrochemical industry than we have; some have less. Without knowing the specific environment of any other area of the country, I can't address the little bit I know about the Oklahoma occupational exposures.

But I think that to understand the prevalence, distribution and risk factors of the Medicaid population, one needs to look at the Oklahoma Medicaid population and answer those questions specifically to see if they're a difference from the national data.

Q (BY MR. WALLACE) Did I understand you to say that you had little knowledge of -- of something there?

A I have a little knowledge of the industrial exposures we have in Oklahoma, and my knowledge comes about from first reading the depositions and seeing where these people lived and the pollutants to which they are exposed and knowing a little bit about the distribution of industry in Oklahoma. My point is that I'm not an expert on industrial development in Oklahoma.

Q Okay. So other than saying that it might be different from another state, would you be prepared as an expert to say that these -- what these differences are?

A I'm prepared to talk about the differences in risk factors in smokers, differences in risk factors in the Oklahoma Medicaid population versus the national Medicaid

07:51:19 population.

51:20 Q Okay. Well, for example, you mentioned peanuts.

07:51:25 Do you know, Georgia, for example, has a lot of peanuts.

07:51:29 Okay? Wouldn't those risk factors connected with peanuts be

07:51:36 the same in the Oklahoma Medicaid population and in the

07:51:42 Georgia Medicaid population?

07:51:43 A I don't think we're comparing the Oklahoma and the

07:51:45 Georgia Medicaid populations. I think we're comparing

07:51:48 Oklahoma with the national numbers. And I think that if

07:51:52 Georgia has peanuts and Oklahoma has peanuts and then the

07:51:56 other 48 states don't have peanuts, I think that the peanut

07:52:01 exposure, the peanut dust exposure is then diluted out in

07:52:05 the national data. Whereas I think if you would look at one

07:52:09 state's specific data, it's going to be different than that

07:52:12 in the national data.

07:52:15 Q Would you say that is -- would be true as to every

07:52:19 state in the union, that that particular state's Medicaid

07:52:23 population would differ significantly from the national

07:52:27 Medicaid data?

07:52:28 A Staying with the peanut analogy, if we can, if

07:52:33 there are two or three states in the country with a high

07:52:36 rate of peanut dust exposure and then there are 47 states

07:52:39 with a low rate of peanut dust exposure, the national norms

07:52:45 are going to be much lower than those three states. And yet

52:50 the other 47 states, the national norm is going to be

07:52:54 1 minimally higher because of the averaging issue.
53:00 2 So I think if you live in one of these three
07:53:03 3 states with a high level of peanut dust exposure or any
07:53:06 4 other risk and you wanted to understand that risk in your
07:53:10 5 population, you have to look at your population and not the
07:53:14 6 national statistics.
07:53:18 7 Q How would you use national statistics in the study
07:53:22 8 of a local population, then?
07:53:26 9 MR. COX: Object to the form of the question in
07:53:28 10 that it assumes that he even would.
07:53:31 11 THE WITNESS: I think that's the answer. I would
07:53:33 12 not use national statistics. If I wanted to study blood
07:53:37 13 pressure in nuns, I would study blood pressure in nuns. If
07:53:42 14 I wanted to study blood pressure in nuns in Oklahoma, I
07:53:46 15 would study blood pressure in nuns in Oklahoma. I wouldn't
07:53:49 16 study blood pressures in office workers in Chicago. I would
07:53:52 17 make the study very specific to the population in question
07:53:57 18 so that I could answer the questions and address the issues
07:54:00 19 as specifically as possible.
07:54:01 20 Q (BY MR. WALLACE) If I have national statistics on
07:54:23 21 the incidence of smoking and lung cancer, can those national
07:54:37 22 statistics be applied to the Oklahoma population?
07:54:41 23 A Now, we're talking about national statistics on
07:54:47 24 smoking as an associated risk for lung cancer?
.54:50 25 Q Right.

07:54:54 1 A Well, those risk values cause us to bring up
55:00 2 another topic. When you look at those risk factors, the
07:55:05 3 relative risk values assigned to smoking and lung cancer,
07:55:10 4 the values are highly divergent. There is a wide risk of
07:55:15 5 relative risks addressing smoking and lung cancer.
07:55:21 6 The reason for the divergent relative risks would
07:55:25 7 be the heterogeneity of the populations being studied and
07:55:29 8 the confounders. Which means to me that if one wanted to
07:55:36 9 study a potential association, one would have to use a pure
07:55:42 10 population to eliminate all the confounders to determine the
07:55:47 11 risk.
07:55:50 12 Q So you're saying it can't be done?
07:55:54 13 A I'm saying it -- it can be done if the studies are
07:55:58 14 well structured. If you use national data, the -- the
07:56:04 15 mixture of covariables, the mixture of other risk factors in
07:56:08 16 the population would be so great that the data will not have
07:56:13 17 significance.
07:56:34 18 Q I'm looking for the letter of Charles Brodt here.
07:57:52 19 A I'm sorry.
07:57:53 20 Q The letter of Charles Brodt.
07:58:03 21 A Is that one of my references?
07:58:05 22 MR. COX: Yeah. It's --
07:58:07 23 THE WITNESS: Which one is that? The letter of
07:58:10 24 Charles Brodt; okay.
58:14 25 MS. COY: Counsel, I have about three minutes

worth of tape left before we need to change.

MR. COX: I think I've got a copy of that letter, if you would like it.

Q (BY MR. WALLACE) Well, I believe it's -- is this the cabinet review team?

MR. COX: The doctor has it there. I just handed it to him.

THE WITNESS: The Charles Brodt letter was the presumptive eligibility for pregnant women letter.

Q (BY MR. WALLACE) Okay.

A I know what it was.

Q We got that separately. Okay. What is the significance of the Charles Brodt letter?

A The significance of the Charles Brodt letter, prior to 1991 Oklahoma did not approve pregnant women for Medicaid benefits for pregnancy until after the delivery.

Q Okay.

A We were one of the last states to address this question. Now, this is a question that had been addressed in Oklahoma since the early '80s. And criticism was lodged at the state repeatedly for not certifying medical benefits for pregnancy until the termination, completion of the pregnancy.

The argument was made by multiple state agencies and reports that if the state paid for prenatal care, that

07:59:47 1 investment in prenatal care dollars would be more than
59:50 2 offset by a decrease in the need for payment for intensive
07:59:55 3 care for newborns. That is, that if you provide adequate
08:00:00 4 prenatal care, you will decrease the prematurity rate and,
08:00:02 5 therefore, improve the health and decrease health care
08:00:05 6 costs.
08:00:06 7 In 1991 Oklahoma -- the Oklahoma Medicaid system
08:00:12 8 agreed that they needed to pay for prenatal care. The
08:00:19 9 process was developed that if a woman were pregnant, she
08:00:23 10 would then be determined as eligible for Medicaid services;
08:00:31 11 and then once she's eligible for Medicaid services, her
08:00:32 12 prenatal care can be financially sponsored by Medicaid.
08:00:36 13 The process by which pregnant women became
08:00:40 14 certified for Medicaid was called the PE process. The
08:00:44 15 presumptive eligibility process. The 1991 Charles Brodt
08:00:48 16 letter is a letter to physicians stating that they,
08:00:52 17 physicians, can perform the presumptive eligibility in their
08:00:58 18 offices in an effort to hasten the process so that a
08:01:02 19 pregnant woman gets in to receive prenatal care as soon as
08:01:06 20 possible. That's the purpose of the Charles Brodt letter.
08:01:09 21 Q Okay.
08:01:09 22 A It's presumptive eligibility.
08:01:11 23 Q What is the purpose of your citing the Charles
08:01:14 24 Brodt letter?
01:15 25 A Well, first of all, the Charles Brodt letter

doesn't work. This is a letter saying, "Doctor, you can do presumptive eligibility in your office." The fact of the matter is that this is a highly impractical process that is exercised by very few hospitals and clinics. I know of no doctors that attempt to perform presumptive eligibility in their offices, first of all.

Secondly, --

Q Secondly, what?

A Secondly. I was waiting until you finished writing your notes.

Q Oh, no. That's okay.

A I'm sorry. Secondly, the whole intent of this process is to enable women to get in to -- get in to obtain prenatal services early on in their pregnancies because it was very clear that unless Medicaid financially sponsored that care, it wasn't being delivered.

Well, in 1991 the decision was made to cover prenatal care. And until this day -- at least the last I was involved with it, which was July of 1997, still pregnant women in Oklahoma did not receive prenatal care until the fifth month of their pregnancy which is still not very good prenatal care.

MS. COY: Excuse me. Counsel, I'm going to run out of tape. We're off the record at 08:02:48. This is the end of tape three.

08:02:51

MR. WALLACE: I'm ready to stop with that.

(The deposition of Thomas C. Coniglione, M.D., was adjourned, to be reconvened the following day, Tuesday, September 29, 1998.)

J U R A T

I, Thomas C. Coniglione, M.D., do hereby state under oath that I have read the above and foregoing deposition in its entirety and that the same is a full, true and correct transcription of my testimony so given at said time and place.

_____
Thomas C. Coniglione, M.D.

Subscribed and sworn to before me, the undersigned Notary Public in and for the State of Oklahoma by said witness, Thomas C. Coniglione, M.D., on this _____ day of _____, 1998.

_____
NOTARY PUBLIC, STATE OF OKLAHOMA
MY COMMISSION EXPIRES:_____

(JLM)

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Jody McAnally, CSR, RPR, RMR, do hereby certify that on September 28, 1998, at 9:00 a.m. at the offices of Professional Reporters, Oklahoma City, Oklahoma, there came before me Thomas C. Coniglione, M.D., who was duly sworn to testify the truth, the whole truth, and nothing but the truth; and that the foregoing 185 pages constitute a full, true, and correct transcript of Volumee I of the deposition of said witness on the date as indicated.

I do further certify that I am not counsel, attorney, or relative of either party, or otherwise interested in the event of this suit.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal at my office in Oklahoma City Oklahoma County, Oklahoma, this 7th day of September, 1998.

Jody Graham McAnally CSR, RPR, RMR
CSR No. 203

ERRATA SHEET

DEPOSITION OF THOMAS C. CONIGLIONE, M.D.

REPORTER: Jody McAnally, CSR, RPR, RMR

TAKEN ON: September 28, 1998

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