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IN THE CIRCUIT COURT OF THE 17TH JUDICIAL CIRCUIT, IN AND FOR BROWARD COUNTY, FLORIDA

COMPLEX LITIGATION UNIT
CASE NO. 08-80000 (19)

IN RE: ENGLE PROGENY CASES TOBACCO LITIGATION,

Pertains to: Loretta M. Vasko as Personal Representative of the Estate of John A. Vasko, Jr., Broward County Case No. 08-001124 CACE (19)

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DEPOSITION OF I. JACK ABRAMSON, M.D.

October 13, 2010
1:14 p.m.
1000 S. Federal Highway
Hallandale, Florida

Stenographically Reported By:
Lynda Royer, R.P.R.
Registered Professional Reporter

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APPEARANCES

ON BEHALF OF THE PLAINTIFF:

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TESTIMONY OF I. JACK ABRAMSON, M.D.

EXHIBITS

Exhibits 7-9 were not given to the court reporter.

Deposition taken before Lynda Royer, Registered Professional Reporter and Notary Public in and for the State of Florida at Large in the above cause.

P R O C E E D I N G S

COURT REPORTER: You do swear the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes, I do.

I. JACK ABRAMSON, M.D.

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

DIRECT EXAMINATION

BY MR. ZEBERSKY:

Q. Sir, would you tell us your name and spell your last name?

A. Israel Jack Abramson. A-B-R-A-M-S-O-N.

Q. And do you know why you're here today, Dr. Abramson?

A. I guess you want my opinions regarding the Vasko case.

Q. I do. Have you had your deposition taken before?
A. Yes, I have.
Q. How many times?
A. Many times. I don't know how many.

Q. More than 100?
A. No.
Q. More than 50?
A. Probably around 50 times.
Q. Great. So I don't need to explain to you the rules of a deposition. You're kind of worldly in that craft?
A. Well, that's up to you. If you would like to explain them to me, I'm happy to hear them.
Q. Great. Well, a deposition is my opportunity to ask you questions about what you know about this case. Okay?
A. Yes.
Q. Do you understand that?
A. Yes.
Q. Wonderful. Now, in a deposition we have a court reporter and a court reporter will take down what you say and what I say. Do you understand that?
A. Yes.
Q. And that in order for the court reporter to take down what you say, you need to give verbal responses to the questions. Fair enough?
A. Most people go "uh-huh" when asked that question, but I'll say "yes."
Q. Thank you. Now, one other thing is the

questions that I ask you, I'll expect that you understand the question that I ask you if you answer it. Is that fair enough?
A. Yes, it is.
Q. So if you don't understand one of the questions that I ask, you'll ask me to rephrase the question so you better understand it?
A. Yes.
Q. Wonderful.
(Thereupon, Plaintiff's Exhibit Number 1 was marked for identification.)
BY MR. ZEBERSKY:
Q. I'm showing you what's been marked as Plaintiff's Exhibit 1 which is the Re-Notice of Taking Deposition Duces Tecum. Have you seen that document before?
A. Not this one. I've seen a copy of it.
Q. Wonderful. Who provided you with a copy of Exhibit 1?
A. The attorneys. I'm not sure which one in particular gave it to me.
Q. The attorneys for the tobacco company, right?
A. Correct.
Q. Now, attached or as part of Exhibit 1, there's a list of documents which we requested to be brought to

this deposition. Are you familiar with that list?
A. Yes.
Q. Have you brought any of those documents to the deposition?
A. Yes, I have.
Q. Can you show us which documents which were requested pursuant to that list you brought with you?

A. Sure. Here is a document which lists the time I spent on this case and the amount that was billed.
Q. May I see it? I'm going to list your time sheet as Exhibit 2.
(Thereupon, Plaintiff's Exhibit Number 2 was marked for identification.)
BY MR. ZEBERSKY:
Q. Did I accurately describe what Exhibit 2 is as your time sheet?
A. Yes. This is a most recent copy of my curriculum vitae.
Q. Your curriculum vitae I am going to attach as Exhibit 3. Fair enough?
A. Yes, sir.
(Thereupon, Plaintiff's Exhibit Number 3 was marked for identification.)
A. This is a case list.
BY MR. ZEBERSKY:

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Q. It's a list -- I'm going to mark this as Exhibit 4, and are you telling us that Exhibit 4 is the list of all the cases in which you've testified?
(Thereupon, Plaintiff's Exhibit Number 4 was marked for identification.)
A. Yes, within the past -- I think four years was the request.
Q. Is there an additional list of cases where you've been retained as an expert but have not testified within the last four years?
A. That list -- can I see it?
Q. Sure.
A. This case includes every case that I've either given testimony at deposition or trial. There have been cases that I've looked at that have not gotten to those stages. They're not included in this list.
Q. Were any of the cases that you looked at but did not get involved with related to tobacco?
A. No.
Q. What would those cases have been related to?
A. Likely standard of care type cases.
Q. Medical malpractice type cases?
A. Yes.
Q. In other words, whether another psychiatrist's actions fell below or above the standard of care?

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A. Correct.
Q. Have you done any work as an expert for the tobacco companies before this case?
A. Yes.
Q. And what other cases have you done work with at tobacco companies other than the Vasko matter?
A. I don't have a list of the particular cases, but I've had conversations with attorneys for the past 12 years. They've come to my office every once in a while and we've discussed my opinions regarding addiction and tobacco.
Q. Do you remember who the first lawyer was you met with 12 years ago?
A. John Still.
Q. Where is Mr. Still located, if you know?
A. I'm not sure. North Carolina, I believe.
Q. Do you know what firm he's with?
A. Womble.
Q. And over the last 12 years how many conversations have you had with Mr. Still?

A. Five or six.
Q. And what were those conversations about?
A. Sometimes very general conversations just regarding addiction issues in general, sometimes conversations regarding my specific opinions regarding

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tobacco smoking behavior.
Q. Anything else?
A. We discussed this case within the last couple of weeks.
Q. Have you been retained in any other cases besides this case to be an expert?
A. I believe so, yes.
Q. And what cases are those?
A. I don't know the names offhand. I remember some of them. There's a Palmeri (sp) case that I've been retained in. Maybe four or five cases that I've looked at over the years.
Q. When did you look at your first case for the tobacco companies?
A. I don't recall.
Q. Now, in those four or five cases, did they all predate the Vasko case?
A. I think so, yes.
Q. And you --
A. When you say "predate," what does that mean exactly?
Q. Meaning that your representation or -- I'm sorry, your involvement with the tobacco companies as an expert in those cases, those four or five cases predated your involvement in the Vasko case?

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A. So is the Vasko case the last case that they sent me, is that what you -- that I looked at?
Q. Sure.
A. I'm not sure. Vasko is a fairly recent case that they sent me, but I'm not sure if I may not have received a case after that.
Q. Now, in those four or five other cases that you worked with tobacco on, did you give a deposition in any of those cases?
A. No.
Q. Do you know why?
A. I have no idea.
Q. Were you ever listed as an expert in any of those cases?
A. Yes.
Q. And which ones were you listed as an expert?
A. I don't know.
Q. Because when I asked you earlier about Exhibit 4 and whether --
A. Which is Exhibit 4?
Q. Exhibit 4 is the list of cases where you've given trial testimony. I asked you if you had worked on any other tobacco cases that were not listed in four, and I believe you said no.
A. I'm not sure. I think we've clarified it, but

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I'm not sure. I thought perhaps you were asking me whether I've given testimony. I did not mean to mislead you.
Q. So to clarify it, you've worked with the tobacco companies on five or six cases other than Vasko in which you were paid as an expert by the tobacco company?

MR. KEEHFUS: Object to the form.
A. Can you repeat the question?
BY MR. ZEBERSKY:
Q. Just so I'm clear, other than Vasko, you've worked on five or six other cases for the tobacco companies where you were a paid expert?
MR. KEEHFUS: Object to form.
A. I think I said four or five other cases, and I was asked to provide opinions and paid for the time that I spent working on the case.
Q. Now, if you were going to total up how much money you were paid for those four or five cases other than Vasko which you worked on for the tobacco companies, how much would you have been paid?
A. To answer that question, I would have to speculate. I would have to guess.
Q. Well, do you have an estimation?
A. No.

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Q. If you were going to guess, what would the guess be?
MR. KEEHFUS: Object to the form. Don't guess, Doctor. You're not going to guess.
MR. ZEBERSKY: You can't instruct him not to answer unless it's privileged.
MR. KEEHFUS: I'm instructing him not to guess or speculate. I think that's entirely fair. If he has an estimate, that's fine, but he's not to guess.
A. In order for me to produce a figure, I'm really pulling it out of my hat. I have no idea as I sit here today.
BY MR. ZEBERSKY:
Q. Do you know how many total hours you would have worked on cases, those four or five other cases for the tobacco companies other than Vasko?
A. No, because if I knew the total hours, then I could tell you how much I was paid.
Q. What's your hourly rate, Doctor?
A. $500 an hour.
Q. And how long has that been your hourly rate?
A. For at least the last seven, eight years.
Q. And do you charge $500 an hour to individuals that come in and take an hour of your time in your

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practice of psychiatry?
A. Close to that, yes.
Q. What do you charge per hour?
A. For a -- well, I don't charge per hour. I charge for certain services that I provide. So, for example, a psychiatric evaluation, that can take me between 40 and 45 minutes, I charge $315.
Q. Now, do you see patients for psychotherapy?
A. Yes, I do.
Q. And are their appointments normally an hour?
A. No. My appointments are typically a half hour.
Q. And how much --
A. Actually, 25 minutes.
Q. How much do you charge for 25 minutes of psychotherapy?
A. 200.
Q. Could you show us what other documents you brought here today?
A. These were just copies of some of the various things that you've already showed me.

Q. I'm going to ask you what this document is?
A. This was a document that was sent to me by one of the Womble attorneys. I guess it's kind of a disclosure that they use to say who I am and what I'm going to be talking about.

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Q. I'd like to list that as Exhibit 5.
(Thereupon, Plaintiff's Exhibit Number 5 was marked for identification.)
BY MR. ZEBERSKY:
Q. Is all of the information on Exhibit 5 true and accurate to the best of your knowledge?
A. Yes.
Q. Thank you. Doctor, when were you retained in this case, if you know?
A. Is there a date on that thing?
Q. It says from March 8th, 2010.
A. So approximately March 2010.
Q. So you were hired in March of 2010 on the Vasko case and from March 8th to October 5th you spent 58 hours, right?
A. Right.
Q. From October 5th to today, how many hours have you spent on the Vasko matter?
A. An hour and a half this morning, four, five, six hours yesterday, so eight hours.
Q. Now, the six hours that you spent yesterday, what did you spend doing?
A. I collated a bunch of material that I knew I would need for today, I went over some facts that I wanted to remember for the deposition, and I had a

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discussion with some representatives from Womble.
Q. And how long did your conversations with the representatives of Womble last?
A. From one until five.
Q. Four hours?
A. Correct.
Q. Do you remember who at Womble you spoke with?
A. I spoke with -- I don't remember everybody's names. I'm sorry. I spoke with you (indicates).
Q. Was John Still one of them?
A. John was on the phone.
Q. You were pointing to someone in this room?
A. Yes. Her.
Q. What's her name?
A. I don't remember. I'm sorry.
Q. I'm sorry to put you on the spot.
MS. DALY: That's a really bad --
A. I apologize.
BY MR. ZEBERSKY:
Q. How many hours do you plan on spending on the Vasko case from today through trial?
A. Well, I imagine that before it goes to trial I will look over everything again. If anything new is presented to me to review, I will be happy to review that, but I think I've done most of the work that I need

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to do.
Q. So would you say it's another six hours or more?
A. Less than that.
Q. Now, Doctor, looking at your CV, it says here that you're a Diplomate, American Board of Psychiatry & Neurology, correct?

A. Correct.
Q. And you have a subspecialty certification in forensic psychiatry?
A. Yes.
Q. Geriatric psychiatry?
A. Yes.
Q. And addiction psychiatry; is that correct?
A. Yes.
Q. Are those three subspecialties the majority of the work that you perform as a psychiatrist?
A. Most of the work that I do is general psychiatry.
Q. And tell us what general psychiatry is.
A. General psychiatry is a medical subspecialty, so I'm a medical doctor who treats human behavior and disorders of brain functioning and as it relates to behavior.
Q. And would that include people with

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schizophrenia, depression, bipolar disorder?
A. Yes.
Q. And you would say that the majority of your practice today as you sit here is treating people with those types of mental disorders?
A. Yes.
Q. And not treating people for geriatric psychiatry, forensic psychiatry, or addiction psychiatry?
MR. KEEHFUS: Object to the form.
A. I mean, I practice in South Florida. There's a huge geriatric population here, and although they may be depressed and schizophrenic and psychotic or whatever, a lot of them are over 65, so I would say close to half of my patients do fall into the geriatric realm.
As well, if you look at comorbidities of substance-related disorders in my population, a great many patients do suffer from substance-related disorders as well. That would probably be about a third of my practice, so it adds up to more than 100 percent because there's a crossover between patients.
BY MR. ZEBERSKY:
Q. Now, what kind of substance abuse do you treat in your professional career?
A. I treat all kinds of substance abuse including

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things like opiates, alcohol, tobacco. I also treat behavioral addictions, things like compulsive overeating or compulsive gambling.
Q. Anything else?
A. Occasionally amphetamine abuse.
Q. What percentage of the people that you treat for substance abuse have opiate problems?
A. I've never thought of figuring that out. Probably a quarter to a third.
Q. Now, currently today do you treat anyone specifically for nicotine addiction?
A. No. Anybody that I'm treating for cigarette behavior disorders have comorbidities that brought them to my office.
Q. What do you mean by comorbidities?
A. Other problems that have brought them to the office, other behavioral problems that have brought them to the office.
Q. So it's true that you don't treat anyone solely for nicotine addiction today?

A. Correct.
Q. Have you ever treated someone for solely nicotine addiction in the past?
A. Yes.
Q. How many times?

A. It's rare.
Q. Is it more than five?
A. Yes.
Q. More than ten?
A. Yes.
Q. More than 15?
A. Yes.
Q. More than 50?
A. Probably not.
Q. So between, let's say, 20 and 40; is that a fair estimate?
A. Uh-huh. Excuse me. Yes.
MR. ZEBERSKY: Can we go off --
(A discussion was held off the record.)
MR. ZEBERSKY: Let's go back on.
BY MR. ZEBERSKY:
Q. Also, in looking at your CV, it doesn't indicate that you have written any articles. Is that true?
A. The CV does not indicate that I've written any articles. I have to look at it.
Q. Sure.
A. Correct. The CV does not indicate I've written any articles.
Q. Have you written any articles?

A. Yes.
Q. What articles have you written?
A. These were papers that were presented related to psychoacoustics and auditory perception.
Q. Psychoacoustics and auditory perception, does that have anything to do with nicotine dependence?
A. No.
Q. Have you ever written anything that has anything to do with nicotine dependence?
A. No, but I did a year of postgraduate studies at the Montreal Neurological Institute before I entered medical school and was involved with research projects that related to behavior -- self-stimulation and behavior in the nucleus accumbens of the brain which is directly appropriate to behavior and reward issues that can apply to nicotine.
Q. Now, in that study that you did, did the study focus on the effects of nicotine on the brain?
A. No. It was on direct electrical stimulation to the nucleus accumbens.
Q. And what's the name of the research project?
A. I don't know because I left, and my thesis supervisor was upset because I left to go into medical school so I don't know what happened to the research.
Q. If I wanted to find that research project, how

would I go about doing that?
A. You would have to get the name of the head researcher and do a MEDLINE search for it.
Q. What was the name of the head researcher?
A. I can't remember. It was a long time ago.
Q. Do you remember what you specifically did for that research?

A. Yes, I do.
Q. Tell us.
A. I implanted electrodes into cat brains and taught the cat brains to self-stimulate electrical stimuli. We were looking at a phenomena called kindling where after a certain amount of time with self-stimulation an electrical pathway becomes established that basically the stimulation occurs on its own.
Q. And are we talking about stimulation, sexual stimulation?
A. No.
Q. Just stimulation on the brain in general?
A. Correct.
Q. And did you utilize stimulation in coming from nicotine as one of your uses in that research project?
A. No. As I explained to you, the cats had a little electrode implanted in their brain connected to a

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switch, a lever that the cat could press that would cause electricity to be sent to that electrode, and they would learn very quickly to self-stimulate.
Q. So, in other words, the pressing of the lever was pleasurable to the cat?
A. We don't know what the cats' experience was.
Q. But you would assume so?
A. That's a big assumption, actually. You're anthropomorphizing.
Q. So why would a cat press a lever if it was not pleasurable to the brain?
A. Well, to say that it was pleasurable assumes that cats experience pleasure the way humans experience pleasure and that's a risk in making that assumption. No one can ask the cat what they were feeling.
What we know is that some type of pathway was established that caused the cats to go back and stimulate over and over again.
Q. In other words, after the cat stimulated its brain long enough, the stimulation stayed in their brain long enough regardless of pressing the lever?
A. No. The stimulation did not stay in the brain. What happened is the cats developed epilepsy.
Q. Interesting. Have you ever worked in a smoking cessation clinic?

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A. No.
Q. You don't work in one now, do you?
A. No.
Q. Have you ever written any articles on smoking cessation?
A. No.
Q. Have you ever worked on any articles dealing with -- well, strike that.
Other than the one research project that we talked about dealing with cat brains, you haven't worked on any other research project, correct?
A. In my entire career?
MR. KEEHFUS: Object to form.
BY MR. ZEBERSKY:
Q. In your entire career.
A. No. That's entirely incorrect.
Q. Well, tell us what other research projects you've worked on.
A. I told you about the psychoacoustic research that I worked on. That was my honors thesis for my

undergraduate studies. I've also been involved in research related to certain -- the use of certain antipsychotics, and my practice was a site for some of those research projects.

Q. So, in other words, abuse of, let's say, Zyprexa, would that be one?

A. No, no. It was monitoring safety and efficacy.

Q. Of what kind of drugs?

A. Of Geodon.

Q. And who did you do that work for?

A. It was a big multi-center study.

Q. Other than the psychoacoustic research and the research on Geodon and the cat brains, have you done any other research projects?

A. Not that I recall.

Q. When did you do the psychoacoustic research, was it in the '80s?

A. Yes.

Q. And when did you do the research project on antipsychotic -- on the antipsychotic?

A. That was in the late '90s or early 2000.

Q. Do you also do work for insurance companies?

A. Yes.

Q. What kind of work do you do for insurance companies?

A. I do medical reviews.

Q. And what do you mean by medical reviews?

A. I look at -- well, first of all, I do a lot of work for insurance companies. One of the things I do is medical reviews where I look at treatment provided to patients and the quality of the care and whether or not the care is appropriate and medically necessary. I also evaluate patients for disability companies. I do independent medical examinations.

Q. What percentage of the work that you do, medical reviews, IMEs are done for insurance companies or Defendants versus the individual?

A. Okay. Almost all of it.

Q. And what percent of your practice is working for insurance companies doing these IMEs?

A. A quarter. I'm sorry. Not the IMEs. Everything together would be a quarter.

Q. Fair enough. Now, if a quarter of your practice is working for the insurance companies, there's three quarters left, obviously. What percentage of that is with patients?

A. All of it, but even the work you do for the insurance company, a lot of it involves patients.

Q. But for your treatment of patients, the three quarters of your time is spent treating patients; is that correct?

A. Yeah.

Q. And of that three-quarter percent what percentage of your time is spent with purely addiction-related issues?

MR. KEEHFUS: Object to the form. You can answer.

A. A fifth of the three quarters

BY MR. ZEBERSKY:

Q. So we're talking about maybe 15 percent of your time is treating addiction?

A. No. Purely addiction itself. I've already

explained to you that I deal with addictions as comorbidities all the time.

Q. So purely addictions it's 15 percent of your time, and with comorbidities what percentage of your time if you included that?

A. Probably close to half.

Q. Now, it says that you're a forensic psychiatrist. Is that the work that you do for insurance companies pretty much?

A. Correct, but I also do things like testamentary capacity evaluations. In the last few months, I did a case where a woman was upset at her guardian and wanted her guardianship removed, and I evaluated her and appeared and testified for her.

Q. Now, it says on something that I read that you've worked for I think the Attorney General?

A. Yes.

Q. Tell me what you did for the Attorney General.

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A. There was a big investigation of Medicare/Medicaid fraud in the state of Florida, and they sent me volumes and volumes of hospital records and were interested in trends and whether people were being hospitalized fraudulently.

Q. And what was your analysis?

A. There were problems. There were these companies that were picking up old people from assisted living facilities and placing them into hospitals where they were kept involuntarily under very poor clinical reasoning.

(Thereupon, Plaintiff's Exhibit Number 6 was marked for identification.)

BY MR. ZEBERSKY:

Q. Showing you what's been marked as Exhibit 6, do you recognize that document?

A. Oh, yeah. Sure.

Q. Is that the only document that you've published?

MR. KEEHFUS: Object to the form.

A. I've already said there were other things I published.

Q. You said that there was other research?

A. Correct. Yeah, this was a document that a review organization asked me to do some research and

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present an opinion regarding vagal nerve stimulation, so this was something that I prepared for them.

Q. And that article says that the insurance company shouldn't pay for a certain type of test?

A. Well, it says --

MR. KEEHFUS: Object to the form.

A. That's not exactly what it says. That's kind of a mischaracterization. Insurance companies can decide to do what they want.

My opinion was that safety and efficacy were not established adequately to support this as a reasonable treatment. I thought it was still experimental and required further investigation.

BY MR. ZEBERSKY:

Q. Ultimately was there future research done on this type of test?

A. By?

Q. By anyone.

A. Yeah. There have been lots of opinions that have been published including the Center for Medicare

and Medicaid which basically reached the same determination.
Q. And currently are insurance companies paying for this test?
A. Rarely.

Q. Are you a member of any other organizations that are not listed on your CV specifically relating to addiction?
A. No, I don't think so.
Q. Is there an American Society of Addiction or something along those lines that you know of?
A. Can you be more specific?
Q. American Society of Addiction Medicine?
A. Yes, there is.
Q. Are you a member of that?
A. No, I'm not.
Q. Why not?
A. The American Society of Addiction Medicine is a group that was formed by family physicians to promote treatment of outpatients with addictions.
They are pursuing recognition by the American Board of Medical Specialties, so they want people who become certified by the ASAM, the American Society of Addiction Medicine, to be recognized as board certified in addiction medicine.
In fact, at this time the only organization that is recognized by the American Society -- the American Board of Medical Specialties as addiction specialty is addiction psychiatry, and since I obtained the certification by the American Board of Psychiatry

and Neurology in addiction psychiatry, I felt it was redundant.
Q. So there was just no need to follow and join that organization?
A. Correct. To follow?
Q. Follow what they do.
MR. KEEHFUS: Object to the form.
A. It's not a question of following what they do or what they not do. It's a question of becoming a member. I felt it was redundant to become a member.
BY MR. ZEBERSKY:
Q. Have you ever given any lectures on smoking cessation?
A. No.
Q. Nicotine addiction, any lectures on nicotine addiction?
A. No.
Q. Any CLE -- well, any -- strike that.
Any continuing medical education courses on nicotine addiction?
A. No.
Q. Smoking cessation?
A. No.
Q. The effect of nicotine on the brain?
A. No.

Q. Any lectures on the effect of nicotine on the brain?
A. No.
Q. Let's go through the other documents that you brought here today.
A. This binder includes my notes as I went through all the depositions that I reviewed and all the

documentation that I reviewed, and what I did in most cases was I had a little transcription machine in front of me and as I was going through something I would notate things that I wanted to remember and then my transcriptionist typed them out for me.

As well, it includes a few pages that I've entitled a summary of my opinion because typically in a deposition such as these I'm asked what my opinions are, and I want to remember everything that I want to say.

Q. Did you bring a copy of that book for me?

A. No.

Q. Why not?

A. Because I didn't. I was asked to produce it. I wasn't asked to make you a copy.

Q. Thank you. Now, would it be safe to say that everything that is included in this binder are the items in the depositions that you felt were relevant for your opinion here today?

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MR. KEEHFUS: Object to the form.

A. I've already said as I went through the depositions I wanted to remember things, and this was my way of remembering. The depositions take up two big boxes, and I didn't think that this was a memory quiz.

BY MR. ZEBERSKY:

Q. Well, was there information that is not in this binder from the depositions that you feel are important and relevant in rendering your opinions here today?

A. Yes. Certainly I went through every deposition, every line of every deposition.

Q. I didn't ask you that question. What I asked you was whether or not there was any relevant information in the depositions that you did not put in this notebook?

MR. KEEHFUS: Object to the form.

A. Yes.

MR. ZEBERSKY: Can we make a copy of this? Do you guys have any set-up here for them to make copies?

MR. KEEHFUS: Not that I know of.

(Thereupon, Plaintiff's Exhibit Number 7 was marked for identification.)

BY MR. ZEBERSKY:

Q. Showing you what's been listed as Exhibit 7,

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can you look at that, please? I'm sorry for flinging it at you.

A. That's okay. Yes.

Q. Would you tell us what Exhibit 7 is?

A. As I said previously, this is a paper that I prepared summarizing briefly my opinions so I wouldn't forget any of the salient points that I wanted to make in the deposition.

Q. So does Exhibit 7 have all of the opinions which you expect to give in this case?

MR. KEEHFUS: Object to the form.

A. It does have the salient things that I wanted to remember so I wouldn't leave anything out.

BY MR. ZEBERSKY:

Q. You told us this was your opinion summary.

A. Correct.

Q. I'm just trying to figure out whether or not your opinion summary contains all of the opinions which you intend to give in this case?

MR. KEEHFUS: Object to the form.

A. I think it's a reasonable summary of my opinions. If you ask me a question regarding something that's not on that paper that I feel competent to provide you an opinion, I would be more than happy to do so.

(Thereupon, Plaintiff's Exhibit Number 8 was marked for identification.)

BY MR. ZEBERSKY:

Q. Showing you what's been marked as Exhibit 8, would you tell us what that is, sir?

A. These are my notes on his military records, medical records, and I believe there should be one that also includes employment records. I also went over the interrogatories.

Q. Can I see it for a second? Thank you. At the top of Exhibit 8 it says "Medical Records Non-Contributory." What does that mean?

A. There were no details in there that were speaking to his use of -- his cigarette smoking behavior.

Q. And then there's something that says "Indianapolis Life Insurance Company, Application for Insurance"?

MR. KEEHFUS: Back up. You said "medical records." Are you sure you didn't mean "military records"?

MR. ZEBERSKY: Military records.

MR. KEEHFUS: You said "medical." I wanted to make sure it's clear. Sorry to interrupt.

A. Ask the question.

BY MR. ZEBERSKY:

Q. Did you review the Indianapolis Life Insurance Company application?

A. Yes.

Q. Was there anything relevant in that document --

MR. KEEHFUS: Object to the form.

Q. -- for your opinions?

A. Could I see it?

Q. Sure.

A. As I noted in this paper, he stated that he did not drink alcoholic beverages in that insurance company application, and I thought that was significant.

Q. Was that the only thing of significance that you found in the Indianapolis Life Insurance application?

MR. KEEHFUS: Object to the form.

A. No. He also had indicated in that application he was a nonsmoker.

Q. And why is that important to you?

A. It's important to know that he wasn't -- that he considered himself a nonsmoker on August 31st, 1981.

Q. Do you believe that he was a nonsmoker on August 31st, 1981?

A. According to other fact testimony in the case, he had stopped smoking for a day, so they thought he was a nonsmoker.

Q. Other than the fact that he stopped smoking for a day, is there anything of relevance in the Indianapolis Life application for you in arriving at your opinions here today?

MR. KEEHFUS: Object to the form.

A. I think it's important that he would

characterize himself in a way that was advantageous to him at the moment.
BY MR. ZEBERSKY:
Q. And why is that?
A. Because it leads me to understand his personality function.
Q. And what is your understanding of his personality function based on his response in the Indianapolis Life Insurance Company application?
A. You know, as you've alluded, it's unlikely that he was a nonsmoker at the time he said he was a nonsmoker, and that calls into question other statements that he may make to people.
Q. So, in other words, if he lied on the Indianapolis Life Insurance Company application, he'd lie to anybody?
MR. KEEHFUS: Object to the form.
A. That's not what I said. I said it's just

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another piece of data that a forensic psychiatrist would use to understand a person's personality.
BY MR. ZEBERSKY:
Q. Was there any other forensic data that you reviewed which leads you to believe that Mr. Vasko would be less than honest to someone?
MR. KEEHFUS: Object to the form.
A. You know, I reviewed boxes and boxes of records. To pull out one specific fact or another is really unfair as I'm sitting here right now.
Q. I'm not looking to be unfair to you. Do you have all the medical records here?
A. Yes.
Q. Why don't you look through them all and tell me which ones indicate to you that John Vasko is not telling the truth?
A. Well, you know, there are statements in the medical record regarding his use of cigarettes that from moment to moment the quantity of cigarettes that he's smoking is different.
You know, there are statements in the record about his alcohol use that are different from evaluating doctor to evaluating doctor, so he clearly gave different information to different people.
Q. Now, does his giving different information to

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different people have any bearing at all on your opinion as to whether or not John Vasko was addicted to nicotine?
A. No.
MR. ZEBERSKY: Off the record.
(A discussion was held off the record.)
BY MR. ZEBERSKY:
Q. Doctor, what other documents did you bring here today?
A. I brought -- this binder includes basic bibliography articles that I looked at and my notes from the articles, as well as some independent statistics that I wanted at hand in case I needed them for the deposition. I also have a copy of the appropriate pages of the DSM because I didn't want to schlep the entire DSM.
Q. Fair enough, like I did.
A. Right.
Q. Would it be fair to say that the documents in what I am going to mark as Exhibit 9 are documents which

you relied upon in giving your opinions here today?
(Thereupon, Plaintiff's Exhibit Number 9 was marked for identification.)
A. No. They are documents that I used to inform my opinion, but I relied on my experience, education,

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continuing medical education and the like.
BY MR. ZEBERSKY:
Q. But you also relied on the documents which are in Exhibit Number 9, correct?
A. No.
Q. So you didn't rely --
A. I used them to inform my opinion. In legalese there's a difference between reliance documents and other documents. I just want to be clear.
Q. Would you agree with me that the authors of the articles in Plaintiff's Exhibit 9 are authoritative in the area of nicotine addiction?
A. No.
MR. KEEHFUS: Object to the form.
BY MR. ZEBERSKY:
Q. Why not?
A. They've written specific articles which are part of the knowledge base of the science of medicine. No one article, I think, should be recognized as authoritative in any way, particularly as it applies to a specific patient or a specific person.
Q. So you believe that there are no articles in the literature today which are authoritative on nicotine addiction?
A. Correct.

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Q. Although you have articles which you utilized in assisting you in coming up with your opinions in this case, correct?
A. I utilized them to remind myself of things I've already learned, to refresh my memory, to delve a little deeper into things like statistics and receptor pharmacological type issues, but I didn't rely on them to form my opinions.
Q. Now, Doctor, if you haven't done any research in nicotine addiction, if you haven't written on nicotine addiction and you haven't lectured on nicotine addiction, how would you have learned enough information about nicotine addiction to give any opinions here today?
MR. KEEHFUS: Object to the form.
A. I went to medical school four years, I did a year of basic neurobiological research, I did a general internship where I rotated through various subspecialties of medical practice, I did a three-year residency in psychiatry where I studied human behavior as it applied to general issues and as it applies to compulsive behaviors like addictive behaviors, and I've been in practice now for 20 years.
Q. And other than what you've just described to us, there is no other basis for your understanding of

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nicotine addiction; is that correct?
MR. KEEHFUS: Object to the form.
A. I think that that's a fairly comprehensive basis. It also includes the educational programs I've gone to, my own continuing medical education, my interaction with patients over the years.
BY MR. ZEBERSKY:

Q. Tell us what educational programs you attended for nicotine addiction or anything involving tobacco-related illnesses.
A. I attended a variety of programs related to addiction issues, for example, certain courses having to do with addiction psychiatry, particularly when I initially certified. I took the courses when I recertified. I did a lot of individual education in order to pass the test again for recertification.
Q. Tell us the specific courses that you took which related to nicotine addiction or any tobacco-related illness.
A. I don't know the titles of the courses.
Q. How many courses have you taken that dealt with nicotine addiction or tobacco-related illnesses?
A. Five to ten over the years.
Q. And how many of those five to ten dealt solely with nicotine-related illnesses -- or I'm sorry,

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nicotine addiction or tobacco-related illnesses?
A. Very few. They would relate to many addictions.
Q. Could it have been none, Doctor?
A. Yes, it could have been none.
Q. So you don't feel that Neal Benowitz is authoritative in the field of nicotine addiction?
A. No.
Q. You don't believe that Michael Cummings is authoritative in the field of nicotine addiction?
A. Correct.
Q. Do you believe that anyone that was involved in the 1988 Surgeon General's report is authoritative on the issue of nicotine addiction?
MR. KEEHFUS: Object to the form.
A. Well, I would say that they're knowledgeable but not authoritative.
Q. Well, what's your understanding of being authoritative?
A. Someone whose word is infallible as it relates to a particular subject.
Q. Do you think that the 1988 Surgeon General's report is authoritative on nicotine addiction?
MR. KEEHFUS: Object to the form.
A. No, I do not.

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BY MR. ZEBERSKY:
Q. Do you think the DSM-IV-TR is authoritative on nicotine addiction?
MR. KEEHFUS: Object to the form.
A. No, I do not.
(A discussion was held off the record.)
BY MR. ZEBERSKY:
Q. Now, of the articles that you provided to me in Plaintiff's Exhibit 9, what is the purpose of having those articles in your file?
A. So they're close at hand in case I'm asked questions that pertain to things like statistics that are included in the article, in case I need to refresh my memory here today regarding a particular subject, and since I have a few cases that I'm involved in with the tobacco companies, I feel it's best that I'm well organized as things go forward.
Q. Now, Doctor, if you didn't rely on any of the articles in Plaintiff's Exhibit 9 and you don't find any of the articles in Plaintiff's Exhibit 9 authoritative,

why would you utilize those articles in giving any testimony here today?

MR. KEEHFUS: Object to the form.

A. Well, I think I already answered that. I mean, I'm going to use them if you ask me, for example, a

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specific question about a statistic, I'd like to be able to find that answer for you. It's for reference.

Q. So why would the statistics in Plaintiff's Exhibit 9 be important to you in rendering your opinions here today if none of those statistics are written by someone who is authoritative or written by someone that you would rely upon?

MR. KEEHFUS: Object to the form.

A. I think that something can be very useful without me conceding that it's authoritative.

BY MR. ZEBERSKY:

Q. I understand that you're not conceding that any of the articles in Exhibit 9 are authoritative. I'm just wondering why you would utilize something that wasn't authoritative in rendering your opinions here today?

MR. KEEHFUS: Object to the form.

A. Because the articles reflect the literature and they reflect the thinking of the authors at the time that they published the articles and that's important.

Q. Why is that important, Doctor?

A. Because science advances with an exchange of public ideas.

Q. So would you agree with me that there may be statements from other authors that will contradict

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what's in Plaintiff's Exhibit Number 9?

MR. KEEHFUS: Object to the form.

A. There may or may not be.

BY MR. ZEBERSKY:

Q. You just don't know?

A. Well, there may or may not be. It's --

Q. So the answer is you don't know?

MR. KEEHFUS: Object to the form.

A. The question is so broad that it's impossible to answer.

Q. Do you know if there are any authors out there that have information that contradict what's in Plaintiff's Exhibit 9?

MR. KEEHFUS: Object to the form.

A. Once again, your question is so broad that it's impossible to answer. Might there be a statement that contradicts one line in one of the many articles that I produced there? It's very possible. It's likely that there is.

Q. So the answer is yes?

MR. KEEHFUS: Object to the form.

A. It's possible. I don't know one way or another.

Q. You just won't give me a yes or no answer, will you, Doctor?

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MR. KEEHFUS: Object to the form.

BY MR. ZEBERSKY:

Q. Is that true?

MR. KEEHFUS: Object to the form.

A. I think I've answered as best I can.

Q. Who gave you the documents that are in Plaintiff's Exhibit 9?

MR. KEEHFUS: Object to the form.
A. A mixture. Some of the articles I found myself doing literature reviews. Some articles I wanted to get a hold of, but because I don't have access to a medical library I had to ask the researcher to move on but to provide them for me, and some articles they provided to me years ago.
Q. How many years ago did Womble start providing you articles on nicotine addiction?
A. Probably around ten years.
Q. And Womble works for R.J. Reynolds, the Defendant in this case, correct?
A. Correct.
Q. Can you tell us what articles in Exhibit 9 were provided to you by Womble Carlyle?
A. For example, I know the Glynn editorial in JAMA, May 1990, I wanted to get a hold of and I couldn't get a copy. Because I'm a member of the AMA, I have

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access to the -- what's it called, the archives, the JAMA archives, but for some reason it wouldn't give me -- it gave me access to an article but it wouldn't give me access to an editorial that was written about the article, so I asked them if they could get me that and they provided it for me.
Q. Do you have the article on that issue or just the editorial?
A. I have both.
Q. Could you tell us what article it was?
A. It's the Fiore, JAMA May 23rd, 1990, Volume 263, Number 20, Page 2760, Methods Used to Quit Smoking in the United States.
Q. If you can continue looking through and let us know what articles were given to you by R.J.R.'s lawyers in this case.
A. This one I don't remember. The Donny article from Drug and Alcohol Dependence, 2007, they gave to me.
The Hughes article, February 2006, they gave to me. The Wewer article, 2003, they gave to me. This one I don't remember. This was mine. This is mine. I think this was mine. Brody from Biological Psychiatry, 2004, they gave to me. Wonnacott, 1990, they gave me a copy. Bendwell, 1988, they gave me a copy. Pontierri from Nature, 1996, I don't recall. Sorry. Cannon,

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Physiology and Behavior, 2004, they gave to me. Dejiara (sp). No. They didn't give me that one. The rest are all mine.
Q. Now, all those articles that you just described to the court reporter are the articles that were given to you by Womble Carlyle, the lawyers for R.J.R. in this case?
A. They were provided to me by them.
Q. Did you charge R.J.R. to read those articles?
A. Yes.
Q. Now, you've spent 58 hours at least through October 5th on the Vasko case and you told us you spent another six hours in the last two days. That would bring us up to 64 hours, right, on the Vasko to today?
A. I'm not keeping track of the math, but I'll assume you're correct. 58 plus six --
Q. Is 54, isn't two?
A. 64.
Q. So I'm right that you spent 54 hours on the Vasko case, right, for today?

A. I think you mixed up the numbers.
Q. Am I right that you spent 64 hours on the Vasko case for today?
A. Correct.
Q. All right. On the four or five other cases

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that you've worked on, did you spend more or less time on those cases than you did in Vasko?
A. Less. I wasn't preparing for a deposition.
Q. How much time on average did you spend on each one of those cases, the four or five that you looked at before?
A. Less than ten hours.
Q. What journals do you subscribe to now with regards to addiction?
A. I get the Journal of American Psychiatric Association.
Q. Do you find that journal authoritative in the area of psychiatry?
A. No.
MR. KEEHFUS: Object to the form.
A. No, I don't.
BY MR. ZEBERSKY:
Q. Have you ever found an article in that journal that is authoritative on any of the issues that are being written about?
MR. KEEHFUS: Object to the form.
A. No. Archives of General Psychiatry.
Q. Any other journals?
A. The journal of -- the American Journal of the -- American Academy of Psychiatry and the Law.

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Q. Do you find any one -- either one of those two journals authoritative in those specific areas?
MR. KEEHFUS: Object to the form.
A. No.
BY MR. ZEBERSKY:
Q. And again, none of the articles that were written in any of those journals would be authoritative with respect to what they were written about?
MR. KEEHFUS: Object to the form.
A. Correct.
Q. Okay.
A. And there's a few others. The titles of the journals are escaping me as I'm sitting here right now.
Q. If none of those journals or their writers are authoritative on what they're writing about, why do you read those journals?
MR. KEEHFUS: Object to the form.
A. I want to keep abreast in the current research, current thinking in the field.
Q. But what's the point with keeping current with research in the field that's not authoritative?
MR. KEEHFUS: Object to the form.
A. The science of medicine is an ever evolving field, and it's very important to keep abreast of how the exchange of knowledge that's occurring if one wants

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to be current.
Q. But if you don't believe that any of that exchange of knowledge is authoritative, why would you rely on that in your treatment of human beings?
MR. KEEHFUS: Object to the form.
A. It helps to inform in my treatment. It's not the only thing I rely on.

Q. I didn't ask whether it was the only thing you relied on. I asked why you rely on it at all if it's not authoritative?
MR. KEEHFUS: Object to the form.
A. It's one of the sources of knowledge that I use in formulating how I treat my patients.
Q. Now, you mentioned earlier that there may be some statistics in some of the articles written in Plaintiff's Exhibit 9, right?
A. Yes, I did.
Q. Why would those statistics be important to you in giving any of your opinions here today if those statistics are not authoritative?
MR. KEEHFUS: Object to the form.
A. If certain information is generally accepted and relevant, I don't want to be guessing. You know, I gave statistics as an example.
Q. Well, if the statistics are generally accepted,

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wouldn't you agree with me that they're at least authoritative with respect to what the statistic is?
MR. KEEHFUS: Object to the form.
A. No.
BY MR. ZEBERSKY:
Q. Why not?
A. Because I think the legal definition of authoritative is very different than how doctors use statistics in their practice.
Q. You know, Doctor, I'm not really asking you for legal definitions. I'm asking you for just general everyday understanding in how you practice psychiatry. Fair enough?
A. Fair enough.
Q. Now, why would you be so concerned about what a legal definition is as you sit here today giving us opinions about whether John Vasko is addicted to smoking cigarettes?
MR. KEEHFUS: Object to the form.
A. Because there's often a discordance between the way doctors think and the way the legal system thinks.
Q. What is the discordance?
A. A difference.
Q. Why would you be concerned here today whether or not you and I have a difference of opinion with

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regards to what words mean?
A. Oh, I'm not concerned. I just want to be clear. I'm operating right now in your sphere so I'm adapting myself to your sphere as part of my training.
Q. So if I was a doctor, you would give me different answers to some of these questions?
MR. KEEHFUS: Object to the form.
A. Not at all. Not at all. The fact is no one is an authority on how to treat my patients other than me. I'm the only authority that matters when it comes to treating my specific patient.
Q. Well, do you feel that there are people that are authoritative in a field such as psychiatry?
MR. KEEHFUS: Object to the form.
A. No. There are people who are knowledgeable and who impart their knowledge to other practitioners, but I don't think any of those people would say that my opinion is the only valid opinion.
Q. Do you think that Dr. Benowitz is knowledgeable in the area of nicotine addiction?

A. I don't know him.
Q. You don't know him personally or you don't know him at all, you've never heard the name before?
A. I've heard the name before.
Q. Where have you heard the name?

A. I've heard the name. I've seen him referenced in articles and books.
Q. Some of the articles that you've read?
A. Yes.
Q. Some of the articles that you actually find informative?
A. Yes.
Q. What about Dr. Cummings, do you find any of the information that he's written about informative?
A. Yes.
Q. Informative in the way where you would utilize it in your treatment of patients?
A. Not necessarily. Informative in helping me keep abreast with what people are thinking about the field and formulate my own opinions in treatment decisions that I make.
Q. We talked about you don't find the DSM-IV-TR authoritative in the area of psychiatry, right?
MR. KEEHFUS: Object to the form.
A. Correct.
Q. So would it be safe to say that you don't find the DSM-IV-TR authoritative with regard to diagnosing people with nicotine addiction?
MR. KEEHFUS: Object to the form.
A. Correct.

BY MR. ZEBERSKY:
Q. Why would a psychiatrist use DSM-IV-TR in the diagnosis of nicotine addiction?
A. I don't think a psychiatrist would use the DSM in making a diagnosis. We use the DSM when we have to pick a diagnosis for a bill that we send to an insurance company. For example, we use the DSM if we're in an academic center and we're doing research and we want to make sure that when we are talking about schizophrenia that everybody else knows what we're talking about and we're speaking the same language, but I think if you read the DSM carefully including the cautions at the beginning of the DSM, you see that they in fact caution against using the DSM in making diagnoses. They specifically say diagnosis is based upon clinical expertise and not by any menu in a book.
Q. So you don't feel that utilizing the DSM -- scratch that.
You don't feel that the DSM should be utilized in formulating opinions about whether or not people are addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. Correct. You also need to recognize, and it's important for the jury to understand, that the DSM is only one classification system. There are other

classification systems that exist that are used in other parts of the world.
BY MR. ZEBERSKY:
Q. What other classification systems are there with respect to nicotine dependence or nicotine addiction?
A. The ICD criteria.

Q. Do you rely on the ICD criteria in diagnosing someone with nicotine addiction?
A. No.
Q. Do you rely on the Fagerstrom test in diagnosing someone with nicotine addiction?
A. Absolutely not.
Q. Do you rely on the smoking heaviness test to arrive at your opinion with respect to someone being nicotine addicted?
MR. KEEHFUS: Object to the form.
A. No, I do not.
Q. So what you rely upon in arriving at whether someone is nicotine addicted are your own skills as a clinician in diagnosing people with that type of disorder; is that fair to say?
A. I rely on a careful clinical history, examination, and my years of expertise in treating patients.

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MR. ZEBERSKY: Could you read those back to me, please.
(The portion referred to was read by the reporter as above recorded.)
THE WITNESS: Could I take a break to use the bathroom?
MR. ZEBERSKY: Sure.
(A recess was taken, after which the following proceedings were had:)
BY MR. ZEBERSKY:
Q. So, Doctor, would it be safe to say that your careful medical -- strike that.
Is it safe to say or fair to say that you rely upon your careful clinical history, your exam, and your years of experience in treating patients in determining whether someone has nicotine addiction?
A. Well, those are generic things that I rely on in treating all my patients. In coming to a diagnosis, formulating a treatment plan, it would include patients who I'm treating for addictions. It's not exclusive by any means.
Q. Well, what else would you utilize in addition to the careful clinical history, examination, years of experience and treating patients with nicotine addiction to diagnose someone with nicotine addiction?

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A. Well, for example, I mean, oftentimes patients are referred to me by other clinicians and I would get clinical information from the other clinicians when they refer patients.
Q. So you would rely, in addition to those three elements, on information that you would receive from other clinicians, correct?
A. Correct.
Q. And that would be through conversations with the other clinician?
A. Or records that may be sent to me.
Q. Is there anything that you rely upon in arriving at your determination as to whether or not someone was nicotine addicted?
A. Well, you're speaking specifically about nicotine addiction. I'm speaking about all patients in general. I don't think I could say there's certain things I use for addictions and certain things I use for other things.
I also get collateral information oftentimes

speaking to friends, family, other interested people involved with patients that I treat.
Q. And those would be conversations with family members or other interested persons?
A. Correct.

Q. Is there anything else?
A. It's not uncommon that I'll order diagnostic studies.
Q. So that would be testing?
A. Correct.
Q. Anything else?
A. No. I don't think so.
Q. Were you able to do a careful clinical history with respect to John Vasko?
A. I was able to do a forensic history. Forensic psychiatrists often don't have the luxury of having a patient in front of them so we rely on things like medical records that are available to us, like sworn testimony from people who are involved in the case, and that's generally accepted within the standard of forensic psychiatry.
Q. My question is, did you do a careful clinical history of Mr. Vasko?
A. No.
Q. Did you do an exam of Mr. Vasko?
A. No.
Q. You couldn't because he's dead, right?
A. Correct.
Q. Obviously, you utilized your years of expertise in treating patients in arriving at your opinion as to

Mr. Vasko's addiction, right?
A. Correct.
Q. Did you do any diagnostic testing with regards to Mr. Vasko?
A. No, but there was diagnostic testing in the record.
Q. What diagnostic testing was there with respect to nicotine addiction?
A. There's no specific diagnostic testing that one would do for nicotine.
Q. Was there any diagnostic testing that you utilized with respect to John Vasko in arriving at your opinion as to whether Mr. Vasko was nicotine addicted?
A. No.
Q. Now, you talked about collateral information, right?
A. Correct.
Q. Was there any collateral information that you utilized in determining whether or not Mr. Vasko was nicotine addicted?
A. Yes.
Q. And what collateral information did you utilize?
A. There was a great deal of sworn testimony, fact witnesses.

Q. Sworn testimony by way of depositions?
A. Correct.
Q. Was there any other collateral information other than the testimony and the depositions that you relied upon as collateral information in arriving at your opinion as to whether John Vasko was addicted to nicotine?

A. There were his medical records.
Q. Other than the medical records?
A. I reviewed the employment records. I reviewed his military records.
Q. Could you point to any medical record which was important to you in arriving at your determination as to whether or not Mr. Vasko was nicotine addicted or addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. There's a great many references to his smoking behavior in the medical record including estimates of his use which I utilized in formulating my opinions.
BY MR. ZEBERSKY:
Q. Now, what is your opinion as to how much John Vasko smoked daily?
A. The data in the medical record is all over the place regarding how much he smoked, anywhere from a pack a day to a pack and a half a day to two packs a day at

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one point. I think it's reasonable to conclude that for most of his smoking career, if you want to put it that way, he smoked about a pack and a half a day.
Q. When did John Vasko start smoking cigarettes?
A. Approximately 12 years old.
Q. And you agree with that in arriving at your determination as to whether or not John Vasko was addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. I have no reason to not accept that.
BY MR. ZEBERSKY:
Q. And since the age of -- what did we say? 12? -- when did John Vasko become a daily smoker?
Let me ask this question first: Do you know what a daily smoker is?
A. I think it's self-explanatory. A person who smokes every day.
Q. Fair enough. Do you know when John Vasko became a daily smoker?
A. No.
Q. Wouldn't that be something that would be important to you in arriving at your determination as to whether or not Mr. Vasko was addicted to nicotine?
A. Well, we know that at some point in time he was a daily smoker. It really is not important to his

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status, for example, in 1990 whether he was a daily smoker in 1960.
Q. Would you agree with me that --
MR. KEEHFUS: Were you done with your answer?
THE WITNESS: Yeah.
MR. KEEHFUS: Okay.
BY MR. ZEBERSKY:
Q. Would you agree with me that it's more likely than not that John Vasko was a daily smoker as of 1960?
MR. KEEHFUS: Object to the form.
A. Yes.
Q. Would you agree with me that it's more likely than not that John Vasko was a daily smoker by the time he was 18 years old?
A. Yeah. I'm not sure when he entered the military though. I would say at that point.
Q. Would you agree with me that it's more likely than not that John Vasko was smoking a pack to a pack and a half of cigarettes a day in 1960?
MR. KEEHFUS: Object to the form.

A. I don't know. I don't know the exact quantity he was smoking in 1960.
BY MR. ZEBERSKY:
Q. So you have no opinion as to how much he was smoking -- John Vasko was smoking back in 1960?

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A. I'm saying as I sit here this moment at this second I don't remember the testimony about how much he was smoking in 1960.
Q. Is there anything that would help you refresh your recollection?
A. If I could have a look at my notes for a few minutes.
Q. Go right ahead.
(Interruption.)
(A discussion was held off the record.)
A. I'm forgetting the question.
(The portion referred to was read by the reporter as above recorded.)
BY MR. ZEBERSKY:
Q. Is it more likely than not that John Vasko was smoking more than a pack of cigarettes a day in 1960?
A. There are references in medical records, the Gulf Family Practice medical records, indicating that when the doctor took a history there he said that he had been smoking a pack and a half since a young age, since age ten as a matter of fact.
His wife reported that he was smoking a lot when she met him, although she did not provide precise information about how much he was smoking, so there's information to suggest that kind of use at that point in

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time.
Q. Now, Doctor, before the Vasko case how many times have you utilized forensic psychiatry to determine whether or not someone was addicted to nicotine?
A. Four or five times.
Q. And those were all -- those four or five times other than Mr. Vasko were all for the Womble Carlyle law firm, correct?
A. Yes.
Q. The folks who represent R.J.R.?
A. Correct.
Q. And those four or five times that you reviewed records other than Mr. Vasko, how many times did you find that the individual was addicted to nicotine?
A. Probably about half of the time.
Q. So two of those four times, if it was four, you would have found that the person was addicted to nicotine, right?
A. Correct.
Q. Would you agree with me, Doctor, that it's more difficult to determine whether someone was addicted to nicotine based on forensic psychiatry as opposed to actually treating a patient?
A. Not necessarily.
Q. Why not?

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A. If one has adequate information, adequate medical records, adequate witness reports, one can in fairly good comfort make a determination.
Q. What would adequate witness statements be for you, as a forensic psychiatrist, in determining whether someone was addicted to nicotine?
A. I mean, I think a good clear description of a

person's smoking behavior over time from a reliable source.

Q. And do you feel that you have that in the John Vasko case?

A. I think adequate to come up with an opinion, yes.

Q. Would it be adequate to treat someone with nicotine addiction?

A. I generally don't treat people that I've not evaluated.

Q. When you treat someone for nicotine addiction, could you tell us what you do? I mean, obviously the person comes in and says, "I'm addicted to smoking and I want to stop," right?

A. Uh-huh.

Q. What do you do as a clinician?

A. Excuse me. Yes. The first thing I do is take a history from the person, find out about their medical

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status, their underlying psychiatric status, try to get an understanding of their personality, their motivations, why they've shown up now as opposed to some other time in their life, and then try to reach a diagnostic formulation.

Once a diagnosis is made, you then have to have a talk with the patient regarding their status and motivation to really effect change in their life to reach the goal that they come in stating they want help with.

Assuming that patients are presenting for good reason with a good clear motivation, there are a variety of treatment interventions that can be accomplished to help them with smoking behavior. The first thing would be --

Q. Let me stop you and let's go over some of that because you've given us a lot of information. Is that fair to stop you right now, Doctor?

A. Okay. You do need to understand I'll probably forget everything I wanted to say.

Q. Go ahead and say everything you wanted to say.

A. The first intervention that a physician can use in dealing with a patient with addictive behavior is psychoeducation, a frank discussion of the risks involved and continuing to engage in a behavior of what

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would be involved in bringing that behavior under control and the fact that although certain behaviors may seem insurmountable, the facts show that such behaviors are in fact not insurmountable at all and with appropriate motivation and support patients typically do well in stopping smoking behavior.

Research seems to suggest that just the act of a doctor sitting down with a patient and intervening in smoking behavior is a very useful intervention in helping patients make the decision to quit smoking. Then, as with all addictions, it's very important to elicit support from the patient's support system in order to optimize the chances of success. This is things like involving friends, family, loved ones, spouse in supporting a person's decision and in effecting change in the psychosocial environment to promote success in quitting.

The patient can then be referred to community-based resources which are available such as community-based smoking cessation programs oftentimes

modeled on 12-step programs. Patients can also be given somatic interventions.
Q. What is that?
A. Things like nicotine replacement therapy, for example, things like certain pharmacological agents that

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have been suggested to be useful in helping people stop smoking, things like Wellbutrin, Zyban, Chantix, all of which are useful in treating cigarette smoking.
Q. Would you ever treat a somatic with just a psychological -- or pharmaceutical drug who wasn't addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. Can you clear up the question a little bit?
BY MR. ZEBERSKY:
Q. Sure. Would you ever, as a psychiatrist, ever prescribe Wellbutrin or Zyban to an individual if they were not addicted to nicotine?
A. Yes.
Q. Why?
A. Because it's useful and it's worked.
Q. Okay.
A. And then finally there are behavioral interventions, things like cognitive behavioral psychotherapy and other behavioral techniques that you can give people to help them over the hurdles involved in quitting smoking.
Q. Would you agree with me that when someone comes in to quit smoking that it's important to figure out whether or not they're addicted first?
A. Not necessarily.

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Q. Why not?
A. Because you're dealing with the behavior, and there are people who have a hard time stopping who aren't addicted.
Q. So you would agree with me that it's not always important to determine whether someone is addicted to nicotine in you attempting to help them quit smoking?
MR. KEEHFUS: Object to the form.
A. Say it again. There's a lot of negatives in that statement.
BY MR. ZEBERSKY:
Q. Okay. You would agree with me that it is not necessarily important for you as a clinician to determine whether someone is addicted to nicotine in your treatment of an individual?
A. Correct. It's not always important.
Q. Do you currently treat any individuals that are addicted to nicotine?
A. Yes.
Q. How many?
A. Probably between 20 and 50.
Q. What makes those 20 to 50 people addicted to nicotine?
A. These are people who have compulsive smoking use behavior, who have tried unsuccessfully on a variety

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of occasions to stop smoking, who, when they stop smoking, experience the classic withdrawal symptoms associated with smoking cessation, people who, for example, chain smoke from the time they wake up in the morning until basically the time they go to sleep at night, and people who are experiencing significant psychosocial distress related to their tobacco use.

Q. Tell me what you mean by psychosocial distress with regards to the tobacco use.
A. Things like impairment in psychosocial functioning, conflicts with those around them, difficulty achieving their life role, estrangement from loved ones.
Q. Would you agree with me that -- well, let's back up for a second. So it's your testimony that there needs to be some type of psychosocial distress in order for someone to be considered addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. No. You asked me how do I reach the conclusion that they're addicted. These are all the factors that I look at in determining whether a person is addicted.
Q. So, in other words, someone doesn't have to have psychosocial distress in order to be addicted to nicotine, right?
A. I think that as someone who treats addiction

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that you do need to see that type of impairment in order for the behavior to become a pathology.
Q. So, in other words, someone needs to show some psychosocial distress in order to have a determination that they are addicted to nicotine?
A. Yes.
Q. Would you agree with me that someone needs to chain smoke in order for you to diagnose someone as addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. No.
BY MR. ZEBERSKY:
Q. What about withdrawal symptoms, do you need to see withdrawal symptoms in order for you to diagnose someone as addicted to nicotine?
A. Yeah.
Q. What do you mean by compulsive smoking behavior?
A. I think it's fairly self-explanatory. Seeking out cigarettes to the detriment of other activities in life, spending more and more time around the activity, becoming very distressed when one is not able to engage in that activity.
Q. Well, becoming distressed when someone doesn't engage in smoking are withdrawal symptoms, aren't they?

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A. No, not necessarily. Typically something is defined as a compulsion in psychiatry when a person experiences anxiety and distress if kept from performing that act.
So a hand washer, for example, is able to not wash their hands for a time, but if kept from washing their hands they become more and more anxious until it reaches a point where they can't resist it anymore and they go back to it.
Q. Would you agree with me that it's more likely than not that John Vasko was a compulsive smoker?
MR. KEEHFUS: Object to the form.
Q. According to your definition.
A. No, I don't think I would agree with that statement. I think he was a smoker.
I think his wife, for example, reports that at times he felt compelled for the next cigarette, but I see evidence that Mr. Vasko throughout his life was able to modify his smoking behavior without too much difficulty.

Q. What evidence did you see that Mr. Vasko was able to modify his smoking behavior without any difficulty?
A. For example, when his wife banned smoking in the house, he was able to modify his behavior and not

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smoke in the house and smoked outside on the patio. When his workplace instituted a smoking ban, he didn't have to quit working and get another job. He was able to modify his behavior to accommodate to that situation. He was able to sit through a church service without smoking, another modification of his behavior.
Q. So would you agree with me that unless someone has a compulsive smoking use behavior, they are not addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. Once again, I don't use a menu in order to reach a diagnosis so none of these things would be a litmus test for me to reach a diagnosis of a nicotine addiction.
Q. Now, Doctor, when you take the history of someone that comes into your office to quit smoking, what are the important aspects of that person's life that you want to glean in order to assist you in arriving at your determination whether or not that person's addicted to nicotine?
A. I want to know when they started smoking. I want to know how their smoking behavior has changed through the course of their life. I want to know how they have responded to life changes in terms of their behavior. I am acutely interested in -- well, I'm

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interested in their current functioning, their current level of stress, their current medical status and behavioral status, whether or not there are comorbidities present that require treatment, what kind of psychosocial supports they have that can be elicited in targeting the behaviors that they come for. I want to know if there are any other addictions present that need to be addressed as you're dealing with the smoking behavior.
Q. Do you believe that Mr. Vasko had any other addictions?
A. I think that the record is suggestive of a problem with alcohol.
Q. Do you think he was addicted to alcohol?
A. I don't have enough data to make a decision one way or the other. There are, however, things that lend to suspicion. You know, there are reports of him drinking a pint of vodka daily for 30 years. There's a prescription for Naltrexone that's not explained, and Naltrexone is a medication that's generally used for treating cravings associated with alcohol.
Q. Now, Doctor, you're not going to render an opinion as to whether or not John Vasko was addicted to alcohol, are you?
A. You know, I think I've just rendered an opinion

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that there are suspicions of alcohol abuse on history, but there is not enough data for me to render an opinion that he was addicted to alcohol.
Q. So you're telling us that within a reasonable degree of medical certainty you cannot give a diagnosis that Mr. Vasko was addicted to alcohol --
MR. KEEHFUS: Object to the form.

BY MR. ZEBERSKY:
Q. -- based on the information that you have before you?
A. Yes.
Q. Now, Doctor, would it also be important for you to know when you take someone's history in determining whether or not they're nicotine addicted as to when they smoke their first cigarette in a day?
A. It's part of the information that generally is obtained in a history. I don't think it's a highly relevant issue because I'm focusing my history on what I can do to help the patient, and I don't think that smoking a cigarette first thing in the day means anything in terms of the patient's ability to quit smoking.
Q. I didn't ask you that question. I asked you, do you think that smoking first thing in the day is relevant to whether or not an individual is addicted to

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nicotine?
MR. KEEHFUS: Object to the form.
A. It may or it may not be depending on a specific case.
BY MR. ZEBERSKY:
Q. Do you think that when John Vasko smoked his first cigarette in the day is important to whether or not he was addicted to nicotine?
A. Well, in this case it's questionable whether that is relevant to reaching a diagnosis of addiction. He had his first cigarette of the day, according to witnesses, with his first cup of coffee of the day, and that is a behavior association and may say nothing about nicotine whatsoever.
Q. Wasn't there testimony in the record that showed that John Vasko smoked his first cigarette of the day even before his coffee?
A. Well, in that case, the testimony is conflicting because there's also testimony that he had the first cigarette of the day with his cup of coffee.
Q. And who gave that testimony?
A. I have to have a quick look and check.
Q. Go ahead.
MR. ZEBERSKY: Off the record.
(A discussion was held off the record.)

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A. Your question was who said that?
Q. Yeah.
A. On Page 160 of her deposition, Mrs. Vasko's deposition, she said he put on the coffee, went on the porch and smoked one after the other in the morning.
Q. So you would agree with me that the testimony is he just turned on the coffee pot and then walked outside and smoked one after the other, right?
MR. KEEHFUS: Object to the form.
A. I don't think that is exact. I mean, I think it says he put up the coffee and had a cigarette.
BY MR. ZEBERSKY:
Q. So it's your opinion that Mrs. Vasko's testimony is that he smoked his first cigarette of the day with his morning coffee?
A. I believe so, yes.
Q. And why do you believe that --
A. That's my understanding.
Q. -- based on that one statement?
A. Well, that's my understanding of her testimony.

Q. Would it be important to you to know what Mrs. Vasko meant by that statement in arriving at your opinion as to whether or not Mr. Vasko was addicted to nicotine?
MR. KEEHFUS: Object to the form.

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A. It may or it may not be relevant. If I mischaracterized her testimony, I'm happy to be corrected.
BY MR. ZEBERSKY:
Q. Now, would you agree that it's more likely than not that Mr. Vasko had his first cigarette of the day during the majority of his life within five minutes of waking up?
MR. KEEHFUS: Object to the form.
A. I don't know that for sure one way or the other. I know that there is testimony he had his first cigarette quickly upon wakening.
Q. So you would agree with me that it's more likely than not that Mr. Vasko had his first cigarette within five minutes of waking up?
MR. KEEHFUS: Same objection.
A. I don't know if it was five minutes or not.
Q. You just have no opinion one way or the other?
A. Correct.
Q. Do you know when Mr. Vasko had his last cigarette before he went to sleep?
A. I think I recall testimony saying just before he went to sleep, but I can't remember the exact reference.
Q. Is that important to you in arriving at your

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diagnosis as to whether or not an individual is addicted to nicotine when they smoked last before they went to bed?
A. Not necessarily. There are lots of people who smoke a lot all day who don't meet the accepted criteria for nicotine addiction.
(A discussion was held off the record.)
(The portion referred to was read by the reporter as above recorded.)
BY MR. ZEBERSKY:
Q. Doctor, what are the accepted criteria for addiction or did we already go over that with the compulsive smoking, tried unsuccessfully to quit, etcetera?
A. Well, I mean, I think we went over it. There are lots of different criteria. Some are in the DSM. There's ICD criteria that are used so people think they're talking about the same thing when they're talking about addiction.
In terms of actual clinical practice, however, I know of no clinician who sits with the DSM and ticks off the items and says, "Ah-ha, I have four so it's an addiction." You know, I think we use our clinical judgment in reaching a determination.
Q. Do you utilize the DSM-IV in determining

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whether or not someone is addicted to smoking?
A. Not really.
Q. And you don't use the ICD criteria in determining whether someone is addicted to smoking either, right?
MR. KEEHFUS: Object to the form.
A. Correct.

BY MR. ZEBERSKY:
Q. Would someone waking up in the middle of the night to have a cigarette be significant to you in determining whether or not someone is addicted to nicotine?
A. People wake up in the middle of the night for a variety of reasons. If they then go on to have a cigarette, it's a notable event. It doesn't, one way or the other, affect whether or not I would call them addicted to nicotine.
Q. If someone wouldn't fly on an airplane because they weren't able to smoke, would that be significant for you in determining whether or not that person is addicted to nicotine?
A. No, not necessarily.
Q. Why not?
A. Because people might not fly for a variety of psychological reasons, only one of which may be the fear

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that they couldn't cope being without cigarettes for the time the flight takes.
Q. I would like you to assume that John Vasko wasn't afraid of flying but he wouldn't step foot on an airplane that wouldn't let him smoke. Okay? Will you assume that for me?
A. Sure.
MR. KEEHFUS: Object to the form.
BY MR. ZEBERSKY:
Q. Would you agree with me that whether or not the fact that John Vasko couldn't smoke on an airplane would be an important factor in determining whether or not he was addicted to smoking?
MR. KEEHFUS: Object to the form.
A. I think it's relevant in terms of understanding his smoking behavior. I don't think it necessarily says one thing or another regarding whether or not he was addicted to nicotine.
Q. Well, doesn't that show that he has changed his life-style as a result of his addiction to nicotine?
A. It may or it may not. Who knows if Mr. Vasko had to fly.
Q. You just don't know, right?
A. I don't know whether he had or had not to fly, correct.

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Q. And you don't know that because you never met Mr. Vasko?
A. Correct.
Q. Because he's dead?
A. Correct.
Q. Do you know why John Vasko died?
A. I know that he entered the hospital and he became septic, I believe, and that led to his death.
Q. Do you have an opinion one way or another as to whether or not Mr. Vasko died as a result of smoking?
A. No, I don't.
Q. Do you have an opinion as to whether or not nicotine is addictive?
A. Yes, I do.
Q. And what is your opinion?
A. Nicotine is a mildly to moderate reinforcing substance in human beings. As such, people do develop behavorial problems associated with it.
Q. Is nicotine addictive?
A. For some people it may be addictive, yes.

Q. What type of people would nicotine be addictive to?
A. People who are at risk, for example, because of their psychology for certain behavioral problems.
Q. Do you believe that John Vasko was one of those

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people at risk for certain behavioral problems that would lead to his dependence on nicotine?
A. I mean, I think Mr. Vasko is characterized by the people who knew him as a strong-willed person who did what he wanted to do in life including smoking when doctors told him not to smoke, so I think he had a very strong will and I think had he wanted to stop smoking he could have stopped smoking.
Q. So would it be fair to say that someone who is strong-willed is not addicted to nicotine?
MR. KEEHFUS: Object to the form.
Q. In your opinion, Doctor?
A. Well, I'm being specific to Mr. Vasko.
Q. So you believe that the fact that Mr. Vasko is described as strong-willed is a reason why he is not addicted to nicotine?
A. Firstly, that was one example of Mr. Vasko being strong-willed. If one looks at the records, Mr. Vasko was able to successfully stop drinking which really takes the same skills that are involved in stopping smoking. Mr. Vasko was in fact successful in discontinuing his cigarette smoking for a few months according to the medical records, so he in fact demonstrated the ability to stop smoking.
Q. What is relapse?

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A. Relapse is when one stops doing a certain behavior and then after a time starts doing it again.
Q. And why would someone start doing that behavior again?
A. There can be a multitude of reasons.
Q. Give us the reasons.
A. There can be psychological factors, for example, just the fact that someone likes doing what they're doing. People engage in self-defeating behaviors all the time. They make the choice to engage in self-defeating behaviors. It's something we deal with in psychiatry all the time.
Q. Isn't that one of the criteria, showing that someone's addicted to nicotine in DSM-IV that they smoke even though they know that smoking is going to cause them health problems or continue their health problems?
A. Well, it's a little different than that. It's continued use despite negative consequences.
Q. You would agree with me that hurting your health is a negative consequence, wouldn't you?
A. Yes.
Q. So you would agree with me that one of the criteria at least used in the DSM-IV which you don't utilize in determining whether someone is addicted to nicotine is that they smoke notwithstanding the fact

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that they know it's harmful to them?
MR. KEEHFUS: Object to the form.
A. Well, first of all, you know, I might have answered your question that I don't utilize, and I think I need to modify that and say I don't exclusively utilize the DSM in reaching diagnoses. I'm clearly aware of the DSM. It's part of the knowledge base.

It's part of the understanding of addictions and addiction psychiatry. I had to learn it to pass the test. I have to choose a diagnosis when I'm dealing with insurance companies so it is involved in my practice, but I'm not sitting there with a pen ticking off criteria and come to an ah-ha moment where I'm able to say, okay, yes or no based upon the number of criteria that are met.

Q. Do you anticipate describing or utilizing the DSM in your testimony at the Vasko trial?

MR. KEEHFUS: Object to form.

A. I think if other people bring up the DSM, I am more than happy to engage in that discussion.

Q. Do you utilize the Fagerstrom test in determining whether or not someone is addicted to nicotine?

A. No.

Q. Why not?

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A. I don't know any practitioner who uses it in clinical practice.

Q. I didn't ask you that question.

A. It's not a relevant issue. It's not a relevant test to use in clinical practice.

Q. What is irrelevant about that test?

A. It doesn't speak to options available for patients. I don't use a test that doesn't help me treat a patient. Fagerstrom doesn't. There's nothing in the Fagerstrom that predicts a person's ability to be helped and to stop smoking.

Q. Well, I'm not asking you whether it predicts whether or not someone can be helped. I'm asking you whether or not the test can be utilized in determining whether someone is addicted to nicotine in the first place?

A. No. You asked me why I don't use it. I explained to you why I don't use it.

Q. Would you agree with me then that it can be used to determine whether or not someone is addicted to nicotine in the first place?

A. No.

Q. Why not?

A. Because I don't think that there's anything in there that would be useful for me to make that

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diagnosis.

Q. So when someone smokes first thing in the morning isn't useful to you in arriving at your diagnosis as to whether someone is nicotine addicted?

MR. KEEHFUS: Object to the form.

A. That alone is not useful, no.

BY MR. ZEBERSKY:

Q. Whether or not someone refrains from smoking in places where it's forbidden isn't useful to you in determining whether or not someone's addicted to nicotine?

A. Correct.

Q. Whether someone would hate to give up their first cigarette in the morning is not important to you in arriving at your opinion as to whether or not someone is addicted to nicotine?

A. Yes.

Q. How much someone smokes in a day is not important to you as far as your determination as to whether or not a human being is addicted to nicotine?

A. Correct. There are many people who smoke a lot of cigarettes a day who are not addicted. There are many people who smoke very few cigarettes who are addicted.
Q. Again, we already talked about whether someone

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who smokes knowing that the smoking is causing their illness, that's not important to you in determining whether or not someone is addicted to nicotine, right?
A. Correct. People who -- sorry.
MR. KEEHFUS: Object to the form. Go ahead.
A. Correct. People who blow their mortgage money gambling still engage in negative behavior despite consequences that are negative.
Q. Where's the list of your opinions? Great.
MR. ZEBERSKY: Why don't we go off the record.
(A discussion was held off the record.)
MR. ZEBERSKY: Let's go back on.
BY MR. ZEBERSKY:
Q. In your opinion, was Mr. Vasko suffering from any type of depression?
A. I think he was depressed at times. I don't see any evidence of what would be called a major depressive episode which is what we typically call depression.
Q. Would you agree with me that his physicians at least from the medical records that you were provided and the pharmacy records you were provided were prescribing him medication for use for depression?
A. Yes. I would agree.
Q. Do you have an opinion one way or another whether or not the those physicians would prescribe

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medication for depression if he wasn't in fact depressed?
MR. KEEHFUS: Object to the form.
A. I think that primary care doctors often prescribe antidepressant medications for patients who don't have severe depressive illness and who really should not be on antidepressive medication.
In Mr. Vasko's case, I see no evidence from the record of a severe depressive disorder. There are no, for example, mental status examinations documenting his state. There's no evidence of pervasive functional impairment related to depressive disorders. There's no evidence of suicidal ideation, homicidal ideation, somatic delusions that one expects to see in severe depressive disorders, so I don't see any evidence that he was being treated for a major depression.
Q. But you don't know as you sit here today whether or not he had any of those symptoms that you described because you never met Mr. Vasko, right?
A. Well, I'm relying on the medical records.
Q. And you don't have the medical records from Dr. Koplewitz who prescribed him Zoloft and some of the other psychotropic drugs during his lifetime, correct?
A. Correct.
Q. Do you know what kind of doctor Dr. Koplewitz

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is?
A. No. It's mentioned, but I can't recall.
Q. So it's your opinion here today that the psychotropic drugs, the Zoloft, etcetera was diagnosed to Mr. Vasko by his family physician?
MR. KEEHFUS: Object to the form.
BY MR. ZEBERSKY:

Q. Is that correct?
A. No. I think that the patient was referred to Dr. Koplewitz. I don't think he was the family doctor.
Q. So who prescribed the Zoloft?
A. I have to go over the prescription records again. I don't recall.
Q. Now, Doctor, what are the opinions that you intend to give in this case?
A. I think the primary question is related to my opinion that I do not think that Mr. Vasko's -- I don't think that addiction caused the diseases that led to Mr. Vasko's death, and I base this upon the fact that he did not display any clear motivation to stop smoking. His attempts to stop smoking were minimal in the 1990s.
Over the course of his life he showed the ability to modify his smoking behaviors. I see no evidence of a severe mood disturbance that would have impacted his ability to stop smoking. He showed ability

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at points in his life to quit using alcohol. He showed ability to quit smoking at times in his life.
When people spoke to him about his smoking behavior, he would put them off. When his doctor spoke to him about his smoking behavior, he didn't modify his behavior, and he in fact showed no irresistible compulsion or loss of personal control in regard to his smoking behavior.
Q. Are you telling us that someone needs to have a desire to quit smoking cigarettes in order to be addicted to nicotine?
A. No. I'm saying without a desire to quit, a person is not going to stop smoking whether or not they are addicted or not addicted.
Q. Well, my --
A. It's irrelevant.
Q. My question is not whether Mr. Vasko wanted to quit smoking. Okay. Are we fine with that? Can we assume that?
A. If you ask me the question. We can assume that.
Q. I just want you to assume that for me --
A. That's fine.
Q. -- because you talked a lot about quitting. I don't want to know whether or not Mr. Vasko wanted to

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quit smoking.
I want to know whether or not Mr. Vasko was addicted to smoking at any point in his life, and what is your opinion with respect to whether Mr. Vasko was addicted to cigarettes at any point in his life?
A. Mr. Vasko may have been addicted to cigarettes after 1990.
Q. He may have been addicted to cigarettes after 1990?
A. Yes.
Q. Is that your testimony?
A. Yes.
Q. And what do you base that on?
A. I base that on his pattern of use, the fact that his wife reported moderate withdrawal symptoms when he tried to stop using, the fact that he kept using despite negative health consequences.
If he would have showed up in my practice with that constellation, I would have said that he was a person who was hooked on cigarettes.

Q. So you would agree with me that Mr. Vasko was addicted to cigarettes sometime after 1990?
A. Yes.
Q. Was he addicted to cigarettes before 1995?
A. I feel comfortable with 1990 as a time period

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because after that there's discussion of his attempts to stop smoking and there really is no discussion anywhere of him ever having made any attempts to modify his behavior before then. 1995 I really don't have an opinion.
Q. Would you agree with me that Mr. Vasko first attempted to quit smoking in 1990 when Dr. Dhanani told him that he had emphysema caused by smoking?
MR. KEEHFUS: Object to form.
A. I don't know when exactly Dr. Dhanani told him he had emphysema or not, and frankly I don't have an opinion on that, but when Dr. Dhanani told him to stop smoking, he didn't stop smoking. He actually increased his smoking.
BY MR. ZEBERSKY:
Q. But would you agree with me that he was addicted right after Dr. Dhanani told him that he had emphysema as a result of smoking cigarettes and that he should stop?
MR. KEEHFUS: Object to the form.
A. Yes.
Q. So if Dr. Dhanani told him to stop smoking in 1990 because his emphysema was caused by smoking cigarettes, you would agree with me that Mr. Vasko was addicted to smoking in 1990, correct?

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A. Yes.
Q. Is that correct?
A. Yes.
Q. And it's your testimony that Mr. Vasko was not addicted to smoking cigarettes in 1970; is that correct?
A. No. It's my testimony that I don't have enough data with which to make a determination.
Q. So you have no opinion as you sit here today as to whether or not Mr. Vasko was addicted to smoking cigarettes in 1970?
MR. KEEHFUS: Object to the form.
A. My opinion is that there is inadequate data in the records that I've been provided with to come to a determination within a reasonable degree of medical certainty.
Q. So I just want to make sure you have no opinion one way or another within a reasonable degree of medical certainty whether John Vasko was addicted to cigarettes in the 1970s?
MR. KEEHFUS: Object to the form.
A. I think I've answered that question. I have inadequate data with which to reach a determination.
Q. So the answer is you don't have an opinion within a reasonable degree of medical certainty, correct, Doctor?

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MR. KEEHFUS: Object to the form.
A. Yes.
BY MR. ZEBERSKY:
Q. What about in the 1980s, do you have an opinion within a reasonable degree of medical probability whether or not Mr. Vasko was addicted to nicotine in the 1980s?

MR. KEEHFUS: Object to the form.
A. No.
Q. What about the 1960s?
A. No.
Q. But you would agree with me -- well, strike that.
Glad we got your opinions down.
Doctor, why do people smoke?
A. People smoke for a lot of reasons.
Q. Do you think people smoke to get nicotine?
A. I think people smoke because they like it. I think that to say that people smoke only because cigarettes are a nicotine delivery device is a dramatic oversimplification.
Q. Would you agree with me, Doctor, that one of the reasons people smoke cigarettes is to obtain nicotine?
A. I think that some people may smoke and that for

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that group of people nicotine may be involved. As I said before, I think that nicotine is a mild to moderate reinforcer. However, my opinion is that people smoke because they want to smoke whether or not they're getting nicotine from the cigarettes.
Q. So it's your opinion that if the cigarette companies took nicotine out of the cigarettes, people would still smoke?
A. I think that people would engage in behaviors that are reinforcing to them. I have no opinion as to how a person would use a sanitized cigarette, a cigarette without nicotine.
Q. And, Doctor, why would you give an opinion that one of the reasons that people smoke is not to get nicotine?
MR. KEEHFUS: Object to the form.
BY MR. ZEBERSKY:
Q. It's a bad question. I'll ask it again. Doctor, why would you be able to give us an opinion then that obtaining nicotine is not one of the reasons why people smoke?
MR. KEEHFUS: Object to the form.
A. Almost exclusively in my practice when I discuss with patients why they smoke they tell me that they smoke because they like smoking, and that has

0099

nothing to do with nicotine.
Q. So your response to the question that you don't feel -- or you don't have the opinion that people smoke in order to obtain nicotine is based on your own clinical experience with about 50 people that you treat for nicotine dependence, correct?
MR. KEEHFUS: Object to the form.
A. No. That's a gross mischaracterization of what I said.
Q. Please make it clear for the record.
A. Firstly, I treat hundreds of patients and over my career I've treated thousands of patients who smoke, and as a physician I feel it's my responsibility to discuss smoking behavior with everyone who comes in my office who is smoking and discuss their readiness to stop smoking, so to suggest to the jury that I only have experience with 50 patients is you attempting to mislead the jury.
Secondly, I think that your questioning, your line of questioning was confining a person's smoking

behavior to their desire to obtain nicotine, and I think that that is a highly simplistic view of why people smoke.

People smoke because of the biological issues, but they also smoke because of the social issues and the

behavioral issues around the act of taking a cigarette, and that's why whether or not a person may be said to be addicted to cigarettes, they don't stop smoking until they've made up their mind that they're ready to stop smoking and want to stop smoking.

Q. You keep talking about stopping smoking, and I'm not really asking those questions yet. I'm just trying to get a simple answer. Do people --

A. I think I've been very responsive.

Q. I'm not saying you're not. Do people smoke in order to obtain nicotine?

MR. KEEHFUS: Object to the form.

A. I think that the way that question is posed I can't answer it. There are some people who may smoke to get nicotine. There are some people who smoke and it has nothing to do with nicotine.

BY MR. ZEBERSKY:

Q. And in your practice you told me that you've treated thousands of people that have been smokers, right?

A. Correct.

Q. And you had told me earlier that in your opinion that the majority of people smoke not to get nicotine but because they like it?

A. No. I said when I ask patients why they smoke

and why they continue to smoke they don't say, "It's because I need a fix of nicotine." They say it's because they enjoy smoking.

Q. Do you have an opinion within a reasonable degree of medical probability as to why people smoke cigarettes?

MR. KEEHFUS: Object to the form.

A. Yes.

Q. And what is that opinion?

A. I think that people smoke for a variety of multifactorial reasons including the biological, the social, and the psychological.

Q. And when you say the biological, you mean addiction to nicotine, right?

A. I mean the effect of the ingested substances on the person.

Q. So would you agree with me that in the majority of the people that you treat there is a biological component to smoking that is important to the people that you treat?

A. As I said before, it is my opinion that nicotine is a mild to moderately reinforcing substance. As such, it does have psychoactive activity.

Q. Would you agree with me that the use of nicotine changes brain function?

MR. KEEHFUS: Object to the form.

A. That's a very broad statement. Nicotine does act on nicotinic receptors in the brain and causes opening of certain channels within those receptors resulting in the flow of molecules in and out of neurons in the brain.

Nicotine is associated in in vitro studies, in

vitro means in laboratory studies, with some increase in Dopamine in certain parts of the brain. So yes, I would agree that nicotine does cause certain molecular actions in the brain, and I don't think anybody really understands what those changes ultimately do in terms of a person's behavior.

Q. Doctor, do you believe that when someone starts smoking cigarettes with nicotine at the age of 14 that their brain functioning starts to change?

MR. KEEHFUS: Object to the form.

A. I think that there are certain changes that occur as I just discussed.

Q. Now, John Vasko started, I think you said, at 12?

A. Yes.

Q. Do you think there were changes in John Vasko's brain when he started smoking at the age of 12?

MR. KEEHFUS: Object to the form.

0103

A. Well, I think that there were changes at the receptor level in his brain, yes.

Q. Tell us again what you mean by the receptor level. Are we talking about how the brain receives the nicotine?

A. Yeah.

Q. Would you agree with me that a cigarette is a nicotine delivery device?

MR. KEEHFUS: Object to the form.

A. I think that a cigarette is much more than just a nicotine delivery device. I think it is a ritual, a behavior. It has social consequences. It has status consequences in terms of a person's behavior. One of the other things that it does is contain nicotine that gets ingested when a person inhales cigarette smoke.

Q. Would you agree with me that at least back in the 1950s the reason why people started smoking was based on peer pressure and environmental issues?

MR. KEEHFUS: Object to the form.

A. Can you repeat the question?

Q. Sure. Would you agree with me that in the 1950s when people started smoking it was not to get nicotine, it was based on those behavioral social status issues that you were discussing previously?

MR. KEEHFUS: Object to the form.

0104

A. I think that people start smoking for a lot of different reasons, and I can't generalize that everybody starts for that reason.

BY MR. ZEBERSKY:

Q. I'm asking you back in the 1950s?

MR. KEEHFUS: Object to the form.

A. Correct.

Q. You just don't have an opinion one way or the other?

A. I think that individuals start smoking for a lot of different reasons.

Q. Do you know what an informed smoker is?

MR. KEEHFUS: Object to the form.

A. I would assume that -- I mean, I'm making an assumption that informed means one is aware of the risks of smoking.

Q. Let's assume that that's the definition. Do you have an opinion one way or another whether John Vasko was an informed smoker in the 1950s?

MR. KEEHFUS: Object to the form.

A. Likely not.
Q. Would you agree with me that it's more likely than not that John Vasko was not an informed smoker in the 1960s?
MR. KEEHFUS: Object to the form.

A. Well, I think the first Surgeon General's report came out speaking about cigarettes being a habit. Mr. Vasko was a literate man who read, watched the news. You know, I think he would have been informed as the rest of society was informed.
Q. So it's your opinion that John Vasko was informed of the health risks of smoking in the 1960s?
MR. KEEHFUS: Object to the form.
A. I think he was aware of the media reports just like everybody else in society was.
Q. Do you have an opinion one way or another whether Mr. Vasko was an informed smoker in the 1970s?
MR. KEEHFUS: Object to the form.
A. In the '70s?
Q. Yes.
A. I don't know, but I know in the mid '80s when his wife didn't want him smoking in front of his pregnant -- in front of the grandchild because she knew that cigarettes were not good for you and she told him about it I think he was informed.
Q. So it's your testimony that in the 1980s when Loretta Vasko asked John Vasko to smoke outside and not in front of their grandchild he was an informed smoker?
MR. KEEHFUS: Object to the form.
A. Yes.

Q. And that happened in the 1980s?
A. Yes.
Q. Now, let me ask you this question: Was there anything in the record which would indicate that John Vasko did not believe that emphysema was caused by smoking cigarettes?
A. I'm just stuck on the last question for a minute. I want to make sure I got my dates correct. Can you repeat the question?
MR. ZEBERSKY: Could you read it back?
(The portion referred to was read by the reporter as above recorded.)
BY MR. ZEBERSKY:
Q. I don't want to trick you. If you want to take a look at Loretta Vasko's deposition, go ahead. I would suggest you take a look at Page 92.
A. Could I see, if you have a copy of Page 92?
MR. ZEBERSKY: Is it okay if I show him my copy? It's highlighted.
MR. KEEHFUS: Sure.
BY MR. ZEBERSKY:
Q. I'm showing you what's part of Loretta Vasko's deposition. I'd like you to read it and ask if that refreshes your recollection as to whether or not John Vasko thought that the emphysema was caused by smoking?

MR. KEEHFUS: Object to the form.
A. Mrs. Vasko testified that John told her that cigarettes weren't the cause of the pulmonary problems that Dr. Dhanani was concerned about.
Q. So that would be the emphysema, correct?
A. Correct.
Q. Do you have an opinion one way or another

whether John Vasko thought that emphysema was caused by smoking cigarettes in 1990?
MR. KEEHFUS: Object to the form.
A. Other than his wife's testimony to the contrary, no.
Q. You don't dispute that testimony, do you?
A. No.
Q. So before 1990 it would be your opinion that Mr. Vasko did not know that smoking would cause emphysema, right?
MR. KEEHFUS: Object to the form.
A. Yes.
BY MR. ZEBERSKY:
Q. Would you agree with me that obtaining nicotine is one of the substantial reasons why people smoke cigarettes?
A. No, I would not agree.
Q. Would you agree with me for people who are

0108

addicted to nicotine that smoking -- I'm sorry. Strike that.
Would you agree with me that for people who are addicted to nicotine the nicotine in cigarettes is a substantial reason to smoke?
A. No, I would not agree. I think that you're mixing up the effect of the substance once it gets into the body and the steps that the person takes to get the substance in the body. You know, I think the behavior of smoking a cigarette is very different than what happens when someone ingests nicotine.
Q. So is it my understanding that you believe that nicotine in cigarettes has a very minimal effect on the reason why people smoke?
A. Like I said, cigarette smoking is multifactorial. Nicotine does play a role, but people smoke -- people choose to smoke. They are not slaves to nicotine.
Q. So do you believe that when someone is addicted to nicotine they are a slave to nicotine?
MR. KEEHFUS: Object to the form.
A. Absolutely not.
Q. And why not?
A. Because people who are addicted quit all the time.

0109

Q. Do you believe that 100 percent of people can quit smoking?
A. I think that would be appropriate motivation and support that people can quit smoking, yes.
Q. What percentage of people today are addicted to cigarettes, or addicted to nicotine, I should ask you?
A. That's one of those statistics that I wanted to be able to look at. Give me second.
Well, the study suggests that about 40 percent of daily smokers never reach nicotine dependence, and if the prevalence of smoking is around 20 percent now and 40 percent of them never reach nicotine dependence, that means 60 percent of them do reach nicotine dependence. We're talking about 12 percent.
Q. 60 percent of people who smoke cigarettes are nicotine dependent, correct?
A. Correct.
MR. KEEHFUS: Object to form.
BY MR. ZEBERSKY:
Q. And what study are you relying on for that

statistic?
A. That was the -- I was not relying. I was quoting the Donny study.
Q. So you don't rely on the Donny study, you're just quoting the Donny study?

A. Yeah. I mean, it's epidemiological data.
Q. Could I see the Donny study, please? The Donny study was one of those articles that were provided to you by the Womble Carlyle firm?
A. I don't recall when I went over them. I told you which ones were and which ones weren't.
Q. And the Womble -- I'm sorry. And the Donny study was done in 2006?
A. You have it there.
Q. It says 2006. Do you disagree with that?
A. No.
Q. Do you find Mr. Donny authoritative in the field of determining the percentage of people who are addicted to nicotine?
MR. KEEHFUS: Object to the form.
A. No.
BY MR. ZEBERSKY:
Q. What about his cohort Lisa Dierker, do you find her authoritative?
A. No.
Q. Then why would you quote their statistic if you don't find either one of those individuals reliable or authoritative in determining the statistical number of people who smoke cigarettes?
MR. KEEHFUS: Object to the form.

A. But now you've changed the question from authoritative to reliable.
BY MR. ZEBERSKY:
Q. You find him reliable?
A. No. Just a reliable statistic.
Q. You just don't think it's authoritative?
A. Correct.
Q. Why do you find the information in the Donny study reliable?
A. I think that's a reasonable statistic. That's something I'm willing to accept.
Q. Why do you find that number reasonable?
A. I've seen it referred to many times in the literature.
Q. What literature have you seen it referred to?
A. For example, in addiction psychiatry textbooks.
Q. What textbooks?
A. I have two textbooks in my office that I use. One is the APA Textbook of Addiction Psychiatry and the other I forget the title to.
Q. The APA?
A. American Psychiatric Association Textbook of Addiction Psychiatry.
Q. When was it written?
A. There was a new edition within the past few

years.
Q. And what's the other textbook?
A. I can't recall the name. I know I have two addiction textbooks sitting next to each other. I just can't recall the name.
Q. Just for consistency, you don't find either one of those textbooks authoritative in the field of

psychiatry?
MR. KEEHFUS: Object to the form.
A. Correct.
(Thereupon, Plaintiff's Exhibit Number 10 was marked for identification.)
BY MR. ZEBERSKY:
Q. Showing you Exhibit 10 which I will let you know is a copy of certain pages from the DSM-IV-TR with respect to nicotine addiction and substance addiction, which I should say dependence -- okay?
A. Okay.
Q. I'd like you to open up to Page 268.
A. They're not numbered.
Q. You've got to be kidding?
A. No.
Q. Let me see.
MR. KEEHFUS: Keep going. Second to last page.
MR. ZEBERSKY: Thank you.

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BY MR. ZEBERSKY:
Q. I'm going to ask you to take a look at the second full paragraph where it says, "An estimated 80 to 90 people who are regular smokers have nicotine dependence." Do you agree with that statement?
A. No. I think that's -- obviously there's a disagreement in the literature regarding those numbers.
Q. But that was what the guidebook that the American Psychiatric Association put out to all of the psychiatrists in the United States, correct?
MR. KEEHFUS: Object to the form.
A. No. It's not a book that they put out to all the psychiatrists in the United States and it's not a guidebook. It's a diagnostic and statistical manual, and it was put together by a committee who came up with this reference.
Q. And the committee through the American Psychiatric Association of which you are a member --
A. I am.
Q. -- determined that between 80 and 90 percent of regular smokers are nicotine dependent, correct?
A. Right. Correct.
Q. You just disagree with that?
A. Correct, with all due respect.
Q. Do you also disagree that 80 percent of smokers

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report attempting to quit but during the first attempt less than 25 percent of those who do abstain remain successful for extended periods of time?
A. Hold on one second. I'm sorry. I'm just checking something.
Q. Do you disagree with that statement?
A. Can you repeat the statement?
Q. More than 80 percent of smokers report attempting to quit but during the first attempt less than 25 percent of those who do abstain remain successful for extended periods of time?
A. I would not disagree with that.
Q. Would you agree with the comment on Page 269 which is the next page, "Because regular nicotine use does not appear to impair mental functioning, nicotine dependence is not readily confused with other substance-related disorders and mental disorders"?
A. Yes.
Q. What do they mean by mental functioning?
A. A person's cognitive reasoning, whether or not

they're in touch with reality, presence, absence of delusions, higher level functioning like orientation, sensorium.

Q. Are we also talking about psychological distress?

A. No, I don't think that's what they're talking about at all.

Q. Are they talking about psychosocial distress?

A. No. They're talking about higher order mental functioning like reasoning and cognition and being in touch with reality.

Q. Do you agree with the statement "once an addict always an addict."

A. No.

Q. Why not?

A. I think that's simplistic. I have a lot of patients in my practice who are addicted to a variety of substances, were able to successfully stop, and who I followed for 20-30 years and have never gone back to using substances.

Q. Do you have patients that stopped smoking for a period of time and then went back to smoking?

A. Yes.

Q. What percentage of the people that you have treated have stopped smoking and eventually have gone back?

A. It's difficult to know because people are lost to follow-up so I don't know the long-term outcomes of every patient I look at, but in terms of the patients that I follow, I have some patients who stop completely

and never go back. I have some patients who go back to minimal use of cigarettes, a couple cigarettes a day, and I don't think that they would meet the criteria for a dependence disorder, and I have some patients who go back to smoking a lot the way they were before.

Q. What percentage of your patients that actually quit smoking actually go back and start smoking again?

A. About a third.

Q. And you already told us that there were a bunch of people that quit smoking through your methods and you just don't track them, correct?

A. Correct.

Q. So you wouldn't know how many of those people actually went back to smoking, correct?

A. Correct.

Q. And would you agree with me that a lot of times when a psychiatrist helps someone to do something, change a behavior, and they revert back to that behavior, it's less likely that they would come back to that psychiatrist?

MR. KEEHFUS: Object to the form.

A. Not necessarily. If the person has ongoing problems, they might in fact be more likely to come back.

BY MR. ZEBERSKY:

Q. You just don't know whether or not any of those other people that you haven't tracked went back to smoking?

A. Correct.

Q. Do you have any statistical data on what percentage of people who actually quit smoking relapse?

A. Yeah. There's a bunch of statistics in the

binder on that.
Q. So you'll just rely on whatever is in the binder for that statistic?
A. I mean I'll --
MR. KEEHFUS: Object to the form.
A. I won't rely on it, but if you want me to quote statistics, I'm happy to look and quote you statistics.
Q. I don't want you to quote me anything. I want to know what your opinion is on what percentage of people relapse after quitting smoking?
A. Well, I prefer to tell you that in clinical practice it is not unusual for someone to relapse after quitting smoking, and it's not unusual for someone to have to go through multiple quit attempts before they're finally successful and don't go back.
Q. Do you have an opinion one way or another whether John Vasko was motivated to quit smoking?
A. Yes. I don't think he was motivated.

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Q. And what's the basis for that opinion?
A. He said he wasn't going to stop smoking when people asked him about it. He said "not now" when family members approached him regarding cigarette smoking.
Q. Who did he say he wasn't going to stop smoking cigarettes to?
A. In the deposition with Glen Wilson, Glen remembers telling Mr. Vasko he should try to quit smoking. Mr. Vasko reacted with silence, didn't want to answer.
Q. So that's your justification for having the opinion that --
A. Glen Wilson further said that he expressed concern to Vasko that he was addicted and that he should stop, and Mr. Vasko said, and I quote, "Soon, soon." Dr. Dhanani told Mr. Vasko to stop smoking and he didn't.
Q. But Mr. Vasko never said he wasn't going to stop smoking, correct?
A. Correct. And when he decided to stop smoking, he did for two or three months.
Q. You would agree with me that Mr. Vasko relapsed his smoking, right, relapsed and started smoking again?
A. After those three months, yes.

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Q. And that's not unusual, is it?
A. It's not unusual, but the nicotine by that time was way out of his body. That wasn't the issue.
Q. Is it unusual for someone who is addicted to smoking to relapse?
A. No.
Q. Even if they wanted to quit smoking, correct?
A. Correct. It's also not unusual at all for people who want to quit smoking to quit and be successful at it.
Q. Now, Doctor, does smoking cause COPD?
MR. KEEHFUS: Object to the form.
Q. Or do you just not have an opinion?
A. You know, I'm not a pulmonologist and I would really defer to them.
Q. Do you have an opinion whether or not smoking causes emphysema?
MR. KEEHFUS: Same objection.
A. Same answer.
Q. What about smoking causing lung cancer?

MR. KEEHFUS: Same objection. Object to the form.
A. Same answer.
(A recess was taken, after which the following proceedings were had:)

(The portion referred to was read by the reporter as above recorded.)
BY MR. ZEBERSKY:
Q. Do you have an opinion whether smoking causes lung cancer?
A. No.
Q. Would you agree with the proposition that the more highly addicted someone is to smoking the harder it is for them to stop?
MR. KEEHFUS: Object to the form.
A. No. In fact, I think that that's not a predictor of how hard it is for a person to stop smoking. The number one predictive factor is their educational level as opposed to anything else.
Q. And could you describe what you mean?
A. People who are greater than high school educated have better success than people who are less than college educated.
Q. And what about people who didn't graduate from high school?
A. The cutoff that I've read is in college as opposed to not in college, high school versus non-high school. Mr. Vasko had a GED. He didn't graduate high school, but I think he would fall in the less educated group.

Q. And that's the highest predictor on whether someone is going to be able to quit smoking?
A. Correct.
Q. And what is the second predictor on whether or not someone is going to be able to quit smoking?
A. There are things like whether they're -- their line of work, whether they're blue collar or white collar work. Things like whether or not they've had military service is also a negative predicting factor.
Q. Let me stop you for a second. If someone is in blue collar work, it makes it less likely that they're going to be able to quit smoking?
A. Correct.
Q. And if someone is in the military for a portion of their life, it makes it less likely that they're going to be able to quit smoking?
MR. KEEHFUS: Object to the form.
A. Correct.
BY MR. ZEBERSKY:
Q. What are the other criteria?
A. Certain personality factors.
Q. What personality factors?
A. Things like risk-taking behavior.
Q. What else?
A. Sex.

Q. Men or women are less likely to quit?
A. Women are more likely.
Q. So men are less likely to quit smoking?
A. Correct.
Q. Why is that?
A. I don't know.
And in terms of your question regarding heavy

smokers, about a third of both people who succeed and people who relapse were heavy smokers.
Q. And what do you rely on for that information?
A. These are just statistics that I've come across in doing my preparation and education.
Q. Why is education a determinant factor on whether someone is going to be able to quit?
MR. KEEHFUS: Object to form.
A. It's unclear. I don't think anybody knows why specifically. It's just an epidemiological issue.
Q. And why is whether someone is blue collar make it less likely that they're going to be able to quit?
MR. KEEHFUS: Object to the form.
A. I think it's -- my opinion on that is it's probably more likely that people who are white collar are higher educated.
BY MR. ZEBERSKY:
Q. What is it about people's personality that

0123

makes it less likely that they will quit?
MR. KEEHFUS: Object to the form.
A. You know, there are certain people who are more apt to engage in risk-taking behavior and to not pay attention to society restrictions on behavior.
Q. There were no society restrictions on smoking cigarettes at any point in time, are there?
MR. KEEHFUS: Object to the form.
A. I mean, I think that there have been a great deal of public health propaganda targeted at cigarette smoking behavior making it appear a less attractive thing.
Q. What do you mean by public health propaganda?
A. I mean steps that public health people in this country and other countries have taken to make cigarette smoking appear as an unattractive alternative to people. I'm not using propaganda in a pejorative manner. I'm just saying it's a way to influence public behavior.
Q. Do you believe that smoking is unattractive?
A. Personally?
MR. KEEHFUS: Object to the form.
BY MR. ZEBERSKY:
Q. Yes.
A. Personally, yes, I do believe it's unattractive.

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Q. Why is that?
MR. KEEHFUS: Object to the form.
A. I mean, this has nothing to do with my expert opinion. It's just my personal opinion. It's not attractive. It's smelly. It's not something I like to be around.
BY MR. ZEBERSKY
Q. What is it about being in the military that makes people more or less likely to quit?
A. I don't know.
MR. KEEHFUS: Object to the form.
Q. Do you feel that John Vasko's personality contributed to his inability to quit cigarettes after you determined him to be addicted?
MR. KEEHFUS: Object to form.
A. You know, I think that Mr. Vasko had a very strong will. His will was so strong that despite the advice of physicians, he made the choice to continue smoking. A person's will is part of their personality.
Q. So you believe that Mr. Vasko's personality,

more specifically the fact that he had a strong will, is an indicator that he wanted to smoke as opposed to quit smoking?
A. I think it's an indicator that he continued to smoke when people in authority told him that it wasn't a

0125

good thing for him to do, and that to me is evidence of a person with a lot of will.
Q. Do you feel that Mr. Vasko enjoyed smoking?
A. I think there's some testimony that he enjoyed smoking.
Q. But do you feel as you sit here today that Mr. Vasko enjoyed putting toxins from smoke into his body?
MR. KEEHFUS: Object to the form.
A. You're again confusing the behavior, which almost any cigarette smoker will tell you is an enjoyable behavior, with the result of the behavior.
You know, I think the jury understands the act of cigarette smoking and we all know people who enjoy the act of cigarette smoking. I think we understand that people don't want to put toxins in their lungs, but that doesn't mitigate the fact that they enjoy the smoking behavior.
Q. Do you feel that Mr. Vasko enjoyed putting the toxins in his lungs?
MR. KEEHFUS: Object to the form.
A. I don't know whether he enjoyed putting the toxins in his lungs or not.
Q. Would you agree with me that most of the factors that you described which indicate a poor

0126

likelihood that someone would quit smoking cigarettes, John Vasko meets them all?
MR. KEEHFUS: Object to the form.
A. He meets some of them, yes.
BY MR. ZEBERSKY:
Q. He meets low education, right?
A. Correct.
Q. He meets that he's blue collar, right?
A. Correct.
Q. He meets that he has a strong personality, he's a risk taker, right?
A. Well, we don't know he's a risk taker. We know he's a strong personality.
Q. So you would agree with me that Mr. Vasko is not a risk taker or you just don't have an opinion?
A. I said I don't know.
Q. You would agree with me that the fact that he has a strong personality makes it more likely that he wouldn't quit, correct?
MR. KEEHFUS: Object to the form.
A. I think that that can go in both ways. If a person has made a personal decision to stop smoking, their strong will can help them.
Mr. Vasko, at the time that he was presented with a strong warning by Dr. Dhanani to stop smoking,

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chose not to.
BY MR. ZEBERSKY:
Q. Is there any evidence in the literature that people with strong wills are more likely to quit smoking than people without strong wills?
A. No.
Q. Mr. Vasko was in the military, right?

A. Yes.
Q. Mr. Vasko is a male, right?
A. Yes.
Q. Would you agree with me that Mr. Vasko is heavily addicted to smoking?
MR. KEEHFUS: Object to the form.
A. No. I think he was addicted to smoking, as I said before.
Q. But just not heavily addicted, in your opinion?
A. Correct.
Q. If Mr. Vasko came in to be treated by you, is it your opinion that you would have been able to get him to quit smoking?
MR. KEEHFUS: Object to the form.
Q. Within a reasonable degree of probability?
A. I don't know.
Q. Based on the fact that Mr. Vasko had all of these characteristics which indicate that a person

0128

wouldn't quit smoking, would you agree with me that it would be more difficult for him to quit than someone else?
MR. KEEHFUS: Object to the form.
A. No, I wouldn't agree. If Mr. Vasko came at a stage where he was ready to take action, I think that he would have had a good chance of stopping smoking. In fact, he did.
Q. Isn't there evidence in the record that Mr. Vasko actually went to a doctor to quit smoking?
A. There is a brief mention that he went to a doctor. There's no details about what type of treatment was provided, his compliance with the treatment, what the recommendations were made or not made.
Q. You just don't know one way or another whether Mr. Vasko complied with that doctor's treatment to quit smoking?
A. Correct.
Q. Aren't there just some people that can't quit smoking?
MR. KEEHFUS: Object to the form.
A. I think that that's not the case. I think that people, with appropriate motivation and care, can stop smoking.
BY MR. ZEBERSKY:

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Q. What is the most important predictor on someone deciding to quit smoking?
MR. KEEHFUS: Object to the form.
A. I don't know how to --
Q. Would you agree with me it's motivation?
MR. KEEHFUS: Let's get an answer to the first question before we have a follow-up.
A. I don't know how to answer that question.
Q. Would you agree that motivation is one of the most important factors that drives someone to quit smoking?
A. Yes.
Q. Would you also agree with me that part of being motivated to quit smoking is because you think that smoking might harm your health?
MR. KEEHFUS: Object to the form.
A. That may be part of it for a particular individual. Other people that may not be playing a role at all.
Q. But you would agree with me that in a portion

of the population the motivation to quit smoking is so you're not going to die, right?
MR. KEEHFUS: Object to the form.
A. I don't know. I know of no data that shows that to be true.

BY MR. ZEBERSKY:
Q. I'm asking you as a clinician, someone who treats people as a psychiatrist on a daily basis?
A. Then I would say absolutely not. I think people tend to think of themselves as infallible and don't want to think that the worst consequences can happen to them, so I would disagree.
Q. And would you agree with me that people's infallibility is only propped up or supported when people are given information that they want to hear?
MR. KEEHFUS: Object to the form.
A. May or may not. I need to know more about the specific circumstances.
Q. Would you agree with me that for the average smoker if they're being told that cigarettes aren't bad for their health, that would be an indicator on whether or not they would be motivated to quit smoking?
MR. KEEHFUS: Object to the form.
A. I think it's impossible to extrapolate to an average smoker. One would have to take a particular case on its merits.
Q. Do you think if John Vasko knew that smoking was bad for his health he would have stopped smoking?
MR. KEEHFUS: Object to the form.
A. I don't know. Well, in fact, I can say yes.

Mr. Vasko did stop smoking at a point in time when he knew that cigarette smoking was bad for him.
Q. You would agree with me that had John Vasko known that smoking was bad for his health, he would have been motivated to quit smoking?
MR. KEEHFUS: Object to the form.
A. No. All I can say is at that specific point in time when he was motivated to stop, he did stop.
BY MR. ZEBERSKY:
Q. Do you believe that Mr. Vasko craved nicotine?
A. I'm sorry?
Q. Do you believe that Mr. Vasko craved nicotine?
A. I believe there's testimony that at some points in time when he was without a cigarette that he craved the cigarettes.
Q. And at what point in time was that?
A. His wife reported that when he would stop for a few days he would just want that next cigarette, I think were her words.
Q. Do you have an opinion with regards to whether Mr. Vasko craved cigarettes before 1990 or you just have no opinion?
A. We don't know.
Q. Do you believe that Mr. Vasko was tolerant to nicotine, that he had tolerance?

A. Yes.
Q. When did he have tolerance, in your opinion?
A. Well, I think over the course of his lifetime he developed tolerance.
Q. When would you say, in your opinion, that he first developed tolerance, if you have an opinion?
A. You know, it's a very difficult question to

answer because his use went from zero cigarettes to a pack and a half a day, and I don't think he could have tolerated a pack and a half a day when he started smoking. When exactly that developed, I don't know.
Q. So is it safe to say you just don't have an opinion one way or another?
A. Correct.
Q. I'd like you to open up the DSM-IV again. I'm going to ask you to take a look at Page 264. I'm hopeful that page --
A. I have the numbers in my book. I'm on 264. I have it.
Q. I'm referring down midway through the paragraph on nicotine dependence where it says, "Many individuals who use nicotine take nicotine to relieve or to avoid withdrawal symptoms when they wake up in the morning or after being in a situation where use is restricted."
Do you agree with that statement?

A. Yes.
Q. Do you believe that that statement applies to John Vasko?
A. You know, I know he used nicotine in the morning when he woke up. I don't know if he was experiencing withdrawal symptoms at that time. I know that there is testimony that when he was in a situation where his use was restricted that he would then go out and smoke, but again the testimony doesn't indicate that when he went out he was experiencing withdrawal, so the behaviors were there.
Q. You would agree with me that many individuals who use nicotine take nicotine to avoid withdrawal symptoms, right, not just to relieve but to avoid withdrawal symptoms?
A. Yeah.
Q. Would you agree that that was the case with John Vasko?
A. I don't know.
Q. I'm going to ask you to take a look at Page 266, the third to the last page, I believe.
A. I'm not using yours. I have numbers.
Q. Where it says "Additional Information on Nicotine-Related Disorders."
A. Okay.

Q. Five lines down it says, "Several features associated with nicotine dependence appear to predict a greater level of difficulty in stopping nicotine use." You with me so far?
A. Yes.
Q. Smoking soon after waking, do you agree with that?
A. No.
Q. Why not?
A. I don't have -- based on my experience, that's not true.
Q. Smoking when ill, do you agree with that?
A. No.
Q. Why not?
A. Again, based upon my experience, that's not a predictive factor in a person's ability to stop.
Q. And it's your experience with just the people that you treated for nicotine dependence, correct?
MR. KEEHFUS: Object to the form.
A. No. As I said before, it's based upon my

entire medical training and career.
Q. All right. You would agree with me that dependence is the same thing as addiction at least?
A. I think we've been through that already.
Q. No, we really haven't. I didn't ask you that question.
A. Oh. I'm sorry. I thought we did. Yes. Yeah.
Q. So addiction is the same thing as dependence?
A. I think that I'm -- yeah. I mean, you know, there's a lay understanding, but it's interchangeable. As a matter of fact, in the DSM-V they're working on that distinction.
Q. "The number of cigarettes smoked per day, the nicotine yield in the cigarette, and the number of pack years are also related to the likelihood of an individual stopping smoking," do you agree with that?
A. Yes.
Q. And would you agree with me that all of those criteria with respect to John Vasko would tend to lead that it would be more difficult for him to stop smoking?
MR. KEEHFUS: Object to form.
A. No. It says that they're related to the likelihood of an individual stopping to smoke, not whether they would be successful if they tried to stop smoking, so it's an important distinction.
Q. What is the distinction? Explain it to us.
A. You know, a person who's smoking a lot may be really into it and like it and just not want to stop smoking.
Q. But they also might be heavily addicted to nicotine, correct?
A. Correct. However, you know, some of the studies that we discussed earlier show that in fact people who are heavy cigarette smokers don't meet these same criteria that you're quoting from.
Q. Would you tell me what study you're talking about?
A. Donny 2007, sir.
Q. So the statement that "The number of cigarettes smoked per day, the nicotine yield of the cigarette, and the number of pack years" also are related to the likelihood of an individual stopping smoking?
A. You're the one who went from the likelihood of them stopping smoking and extrapolated beyond that. I'm willing to accept the likelihood of them stopping smoking because that's a behavioral issue. That has nothing to do with addiction. One's likelihood of stopping smoking has to do with one making the choice to stop smoking.
Q. And wouldn't you agree with me that it's more likely than not that people who smoke heavily every day are less likely to choose to stop smoking?
A. It's possible. I think that, you know, a lot of heavy smokers do choose to stop smoking. A lot of light smokers choose not to stop smoking.
Q. I'm just asking you if it's more likely than not the heavier the smoker --
A. I don't think so.
Q. You don't think so?
A. No.
Q. You don't think it's more likely than not that the more nicotine that an individual needs makes it more

likely that they won't quit smoking?
MR. KEEHFUS: Object to the form.
A. I think that the -- again, you're trying to mix the behavior with the fact that when you smoke, nicotine gets in your body. I think that the behavior depends on behavioral control and that every cigarette smoker has behavioral control over what they're doing. They have a choice. Whether they're a heavy smoker or a light smoker, they have a choice.
Q. Do you believe that drugs prevent people from utilizing their free will?
A. No.
Q. Do you think that addiction to drugs prevent people from utilizing their free will?
A. No. I'm not of the opinion that people are robots whose free will can be taken from them by nicotine. I think that's ridiculous.
Q. Do you think that drugs, any drug can prevent a

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person from being able to function properly in their daily routine?
A. That's an extremely broad question. I mean, I could --
Q. What's the answer?
A. -- hypothesize a situation where, you know, a crystal methamphetamine user has a decline in function because of their crystal methamphetamine use, so the answer to that question would be "I guess."
Q. What do you think caused Mr. Vasko's diseases? Let's start first with emphysema.
MR. KEEHFUS: Object to the form.
A. I don't know what caused his emphysema.
BY MR. ZEBERSKY:
Q. Did smoking cause his emphysema?
MR. KEEHFUS: Object to the form.
A. I don't --
Q. You don't have an opinion one way or another what caused his emphysema; is that correct, Doctor?
A. Excuse me. You know, I have an opinion that his addiction absolutely did not cause his emphysema.
You know, if you have pulmonary people who say it is the ingestion of the cigarette smoke that caused his emphysema, I think that's a reasonable opinion if they so express it. However, I don't believe that the

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addiction is really an issue. I don't think that it caused his emphysema.
Q. So what do you think did cause his emphysema?
MR. KEEHFUS: Object to the form. Asked and answered at least four or five times. You can answer again.
A. You know, once again, I'm not a pulmonologist. I'm not an expert in the pathophysiological changes in the lungs, how does that happen from cigarette smoke.
Q. So you're just saying that it's your opinion and your only opinion that it wasn't addiction that caused his emphysema, correct?
A. Well, I think I said a lot of other opinions here today.
Q. I understand, but that's the opinion that you're stating with regard to the cause of emphysema, your only opinion with respect to the cause of emphysema is that it was not a result of addiction to nicotine?
MR. KEEHFUS: Object to the form.
A. I don't feel comfortable as a psychiatrist

asked to provide opinions regarding the addiction issues in Mr. Vasko's presentation to offer an opinion regarding pulmonary pathology.
BY MR. ZEBERSKY:
Q. I'm not asking you to do that. You gave us the opinion earlier that addiction did not cause disease?
A. Correct.
Q. And I'm asking you, do you have an opinion, if addiction did not cause the disease, what else caused the disease?
MR. KEEHFUS: Object to the form.
A. Well, you know, I think that as a physician it's reasonable to say that cigarette smoking caused his pulmonary disease, but that is separate, the behavior of cigarette smoking is separate from the addiction.
Q. I'm just asking you whether you're going to give an opinion at trial whether anything but addiction did not cause his disease?
MR. KEEHFUS: Object to the form.
A. I don't think that I'm being asked to render any other opinion.
Q. So the only opinion that you're going to give with regards to the causation of his disease is that addiction didn't cause it, right?
MR. KEEHFUS: Object to the form.
A. Yes.
Q. And you're not going to tell us what caused his disease, right?
MR. KEEHFUS: Object to the form.
A. Correct. I'm a little confused with the -- you told me not to answer questions that I didn't understand, and I'm a little confused --
BY MR. ZEBERSKY:
Q. I'm just trying to figure out --
A. -- of what you're asking me.
Q. I'm just trying to figure out if there's something other than addiction that you're going to testify to?
I mean, it's tough because I mean, look, your testimony is that addiction did not cause his disease?
A. Yeah.
Q. Right? And I accept that. Now, is there anything besides addiction that you are going to testify to that caused Mr. Vasko's disease?
A. I don't think so.
MR. KEEHFUS: Object to the form.
A. I don't think so.
MR. KEEHFUS: Just for clarification, for the record, when you say "anything," are we talking -- I think we probably could get on the same page. We're talking medical factors or exposures to environmental toxins? Anything is --
MR. ZEBERSKY: I'm just asking him what he's going to testify to as a psychiatrist. If you want to get into medical discussions as to what caused his diseases, that's fine. I just want to know what this gentleman is going to testify to.
MR. KEEHFUS: Okay. Fair enough.
MR. ZEBERSKY: I may be done, Doctor. Give me a couple of minutes.

BY MR. ZEBERSKY:
Q. Do you believe that John Vasko smoked cigarettes to get nicotine?
MR. KEEHFUS: Object to the form.
A. I think that Mr. Vasko smoked cigarettes for many reasons.
Q. Do you think one of those reasons was to put nicotine into his body?
A. Yes.
Q. Do you believe or have an opinion within a reasonable degree of medical probability whether John Vasko would have smoked cigarettes had the cigarettes not contained nicotine?
MR. KEEHFUS: Object to the form.
A. No, I don't.
Q. Are there any other addictive qualities of cigarettes other than nicotine?
A. Yes. There's a whole behavioral paradigm

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associated with cigarette use.
Q. So there are behavioral qualities with cigarette use that cause addiction?
MR. KEEHFUS: Object to the form.
A. No. That's a different question. I mean, the issue is that the behaviors associated with smoking take on a life of their own. You know, how else hence the fact that someone who has quit for months at a time goes back to the behavior? They're not going back to the nicotine. They're over the nicotine withdrawal, both the acute and subacute nicotine withdrawal. They're going back to the behavior, the memory, the pleasurable feeling.
BY MR. ZEBERSKY:
Q. The release of Dopamine?
A. Well, that's only a theory. You know, Dopamine now is -- the theory now is maybe Dopamine is really not the reward molecule. Maybe Dopamine has to do with the tension and it's the brain saying this is an important thing in the environment.
Q. So is it your testimony here today that the release of Dopamine is not one of the reasons why people smoke?
MR. KEEHFUS: Object to the form.
A. People may smoke because of the rewarding

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properties associated with dopamine release, but it's by far not the only reason that people are smoking, and surely the fact that Dopamine is being released does not rob the person of free will to make a choice regarding their smoking behavior.
BY MR. ZEBERSKY:
Q. Do you think that the release of Dopamine makes it harder for someone to exercise their free will in deciding whether or not to quit smoking?
A. No. I think free will is free will. One just needs to make a choice.
Q. It's as simple as just making a choice to quit smoking and people are just able to quit?
A. I'm not saying that it's an easy choice to make, but it's still a choice that one has to make in order to be successful in stopping.
Q. Would you agree with me that some of the behavioral issues that you talk about that encourage people to smoke are things like cigarette smoking is fun?

MR. KEEHFUS: Object to form.
A. Yes.
BY MR. ZEBERSKY:
Q. Cigarette smoking is cool?
MR. KEEHFUS: Object to the form.

A. For some people, yes.
Q. Cigarette smoking is manly, for men?
MR. KEEHFUS: Form.
A. Yes.
Q. Cigarette smoking is something you do after eating a meal, right?
A. What's the question attached to it again?
Q. That would be something that would be a behavioral issue with respect to smoking?
A. For a particular individual, yes, that may play a role.
Q. And would you agree with me that advertising affects behavior?
MR. KEEHFUS: Object to the form.
A. I'm really not an expert in advertising.
Q. Do you believe that when people see advertisements that show something as being cool it makes it more likely that if they want to be cool they're going to go ahead and do that activity?
MR. KEEHFUS: Object to the form.
A. Once again, I'm not an expert on how advertising affects behavior.
BY MR. ZEBERSKY:
Q. So you just --
A. So I don't know.

Q. Do you have an opinion one way or another whether cigarette advertising affected John Vasko's behavioral aspects to smoking cigarettes?
A. No.
MR. KEEHFUS: Object to the form.
Q. Do you believe -- what is your opinion with regards to what behavioral motivations John Vasko had to smoke?
A. I believe he wanted to smoke and he made the choice at various points in his life to continue to smoke.
Q. But we talked about some of the behavioral elements of people smoking, being cool, being manly.
What types of behavioral issues or behavioral activities do you believe encouraged and kept John Vasko smoking cigarettes?
MR. KEEHFUS: Object to the form.
A. It's difficult to know with the database that I have available to me.
Q. I'm asking you to base it upon the testimony that you see.
A. I'm saying it's difficult for me to know with the testimony I've been able to review. You know, it's clear that he wanted to smoke. He would go out on the patio and smoke. He had rituals around his smoking

behavior. All these things are reinforcing.
Q. Do you believe that John Vasko -- okay. I'm not going to ask that question. Give me a minute. I may be done.
What is the National Institute of Drug Abuse?
A. Probably part of the National Institute of Health.

Q. Do you find anything that they do authoritative with respect to nicotine addiction?
A. No.
MR. KEEHFUS: Object to the form.
A. Their job is to inform clinicians, public health official.
BY MR. ZEBERSKY:
Q. I'm going to ask you to open up your DSM-IV, if you will, to the introduction.
A. Which page? I have some of them copied. Maybe I have copies.
Q. I think it's XXIII. You may not have it.
A. No.
Q. Second full paragraph, would you agree with me that individuals other than psychiatrists can utilize the DSM-IV-TR in evaluating patients?
A. You know --
MR. KEEHFUS: Object to the form.

BY MR. ZEBERSKY:
Q. Do you just not have an opinion?
A. No, no. I think that in fact many other fields other than physicians do use the DSM. You know, if you look at a little further on in the introduction, it says that anybody who does use the DSM needs to rely on appropriate clinical training and experience in diagnostic making. That's on Page XXXII.
Q. So you would agree with me though that non-physicians can utilize the DSM-IV-TR in diagnosing illnesses?
MR. KEEHFUS: Object to the form.
A. What I said is the DSM is meant to be used by individuals with appropriate clinical training in making diagnoses and in evaluating.
Q. So included in that would be non-physicians, right?
A. Correct.
MR. KEEHFUS: Object to the form.
A. You know, I also think that since you're talking about the introduction, you should move on to XXXIII where the DSM introduction states that the fact that someone has a DSM mental diagnosis doesn't, for legal purposes, imply a mental defect, mental disease, mental disability, or mental disorder.

Q. I'm aware of that. Would you also agree with me, Doctor --
MR. ZEBERSKY: By the way, I move to strike that as being nonresponsive.
BY MR. ZEBERSKY:
Q. Would you also agree with me, Doctor, that in order to utilize DSM-IV, that you need to take -- or you need to perform an interview of the person that's being diagnosed?
MR. KEEHFUS: Object to the form.
A. No, I disagree.
Q. Why do you disagree with that?
A. Because there's nothing in the DSM that says you have to do an interview of a person.
You know, if I may, while you're looking, since we're talking about the DSM, you know, in the introduction as well, you know, the DSM notes that having a diagnosis does not and should not be construed as implying that one's behavior is uncontrollable. Having diagnosis does not in-and-of itself demonstrate

that a particular individual is unable to control his or her behavior at a particular time.

Excuse me. My office is calling.

(A discussion was held off the record.)

MR. ZEBERSKY: I don't have anything further.

I appreciate your time, Doctor.

THE WITNESS: Thank you.

MR. ZEBERSKY: Do me a favor. Send me a bill for your time. I'll make sure I pay it.

MR. KEEHFUS: I've got a couple of questions.

CROSS-EXAMINATION

BY MR. KEEHFUS:

Q. Since we are talking about the DSM, let's talk about this portion of the introduction, Dr. Abramson, and the portion specifically we're talking about is Page XXXIII, and there were two portions I wanted to ask you about. The first is at the top of the page which I think you referenced just a few minutes ago, but I'd like you to point me to the section that you were talking about and then I'd like to ask you a few questions about that.

A. I think I referenced the first paragraph.

Q. This is the first paragraph on --

A. On Page 33 in the introduction.

MR. ZEBERSKY: Are you going to read it into the record? I don't know.

MR. KEEHFUS: I don't think I -- I don't want him to read the whole thing into the record, but it's at the top of Page XXXIII.

MR. ZEBERSKY: Here?

THE WITNESS: Yeah.

A. And then I also referenced the issue of control that was in the next paragraph.

BY MR. KEEHFUS:

Q. In the first -- what's the significance of that first paragraph to you?

A. There's a few significant issues. Number one, the fit between the law and psychiatry is not great, and when mental health practitioners talk about mental disorders and mental problems, that's different than what the law considers a mental defect in that we look at personal functioning and personal ability to modulate behavior even in the context of people with certain mental diseases or mental deficits.

It becomes dangerous to assume that the presence of a mental disorder causes behavioral dyscontrol to the point that a person is not responsible for their actions, and that's not really supported by clinical data.

In fact, most people who are laboring under mental disease have relatively good control of their behavior.

Q. The first full paragraph on Page XXXIII in the introduction is the other issue that you highlighted in

the introduction. I'll just read this sentence. It says, "Non-clinical decision-makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or associated impairments." And then the next sentence -- I'm sorry, the third sentence says, "Moreover, the fact that an individual's presentation

meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder," and I'd like to ask you just a question about that.

Today you've talked about the difference between behavior and addiction. Do you recall that?

A. Yes.

Q. Is there anything in this paragraph in the introduction that is significant to your opinions regarding the distinction between addiction and behavior?

A. Well, I think that the paragraph sets it out quite clearly that the presence of a diagnosis of a substance dependence disorder does not speak to the person's ability to control their behavior.

Q. You were asked about what Mr. Vasko believed or what he thought about the risks of smoking. Do you

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recall that?

A. Yes.

Q. To be clear, do you really know what Mr. Vasko thought or believed at any point in time?

A. No.

Q. Okay. We know what the record records, right?

A. Correct.

Q. Now, the record is what the record is?

A. Yes.

Q. But you don't actually know what Mr. Vasko himself thought or believed at any point in time?

A. Correct.

Q. You're not a mind reader?

A. Especially a person who is not alive, correct.

Q. You do recall Dr. Dhanani's testimony -- I'm sorry, Mrs. Vasko's testimony that Dr. Dhanani told Mr. Vasko that smoking caused his COPD, do you recall that?

A. Yes.

Q. And you recall that that was during a doctor's visit in sometime -- well, whenever it happened --

A. Correct.

Q. -- during his diagnosis?

A. Correct.

Q. Finally, I want to talk to you about this very

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book, the DSM, just to make sure we clearly have your opinions on its utility in the clinical setting.

A. Okay.

Q. Does the DSM itself speak to whether it should be used as a cookbook or a take-out menu from which criteria can be selected out and mathematically used to derive a clinical conclusion, does it speak to that?

A. Yes, it does.

Q. And what does the DSM say about that?

A. There are cautions given to clinicians that experience and skill needs to be applied to the issues in the DSM and that one should not use it as a cookbook.

In fact, they speak to the issue of if a patient appears to be a certain diagnosis but doesn't meet every specific requirement of the categorization that one should not exclude them from having a diagnosis.

Q. And notwithstanding the fact that it shouldn't be used as a cookbook or it shouldn't be used mechanically, does it still inform your clinical

judgment and opinions as you treat patients and make psychiatric evaluations?
A. Yes.
Q. So the DSM does have utility in your clinical practice?

A. Correct.
(A discussion was held off the record.)
(A recess was taken, after which the following proceedings were had:)
BY MR. KEEHFUS:
Q. Doctor, you were asked about predictive factors and the likelihood of the success of quitting smoking. Do you recall that?
A. Yes.
Q. You talked about education level?
A. Yeah.
Q. Those factors don't have anything to do with the ability to quit smoking; is that right?
A. No. They're just correlations.
Q. In other words, all those people are able and capable of quitting smoking?
A. Correct. Just when you look at quitters, more of them are higher educated than not.
Q. Okay. That's all I have.

REDIRECT EXAMINATION

BY MR. ZEBERSKY:
Q. Here's my one question. Then I'd like to give the court reporter a couple minutes to look for something.
Would you agree with me that what the law would

consider an addiction is different than what psychiatry is going to consider addiction?
MR. KEEHFUS: Object to the form.
A. I don't know what the law is going to consider an addiction, so you need to help me on that.
Q. So you're not taking an opinion one way or another whether legally Mr. Vasko is addicted to smoking cigarettes; is that correct?
MR. KEEHFUS: Object to the form.
A. I'm speaking as a clinician.
Q. So you're saying from a psychological standpoint Mr. Vasko was addicted to cigarettes after 1990, correct?
MR. KEEHFUS: Object to the form.
A. Yes.
(A discussion was held off the record.)
MR. ZEBERSKY: I'm done.
THE WITNESS: I would like to read.
MR. ZEBERSKY: Can you get it to me Friday?
MR. KEEHFUS: Can I get mine at the same time?
(The taking of the deposition was concluded at 5:14 p.m.)

ERRATA SHEET

DO NOT WRITE ON TRANSCRIPT. ENTER ANY CHANGES HERE.

RE: ENGLE PROGENY CASES, TOBACCO LITIGATION
DEPO OF: I. JACK ABRAMSON, M.D.
TAKEN: OCTOBER 13, 2010

Page No.	Line No.	Change	Reason

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

_____ _____

Date Signature

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CERTIFICATE OF OATH

STATE OF FLORIDA)
) ss.
COUNTY OF BROWARD)

I, Lynda Royer, Registered Professional Reporter, Notary Public, State of Florida, certify that I. JACK ABRAMSON, M.D. personally appeared before me on October 13, 2010 and was duly sworn.

Signed this 15th day of October 2010.

Lynda Royer, R.P.R.
Registered Professional Reporter
Notary Public - State of Florida
Commission # DD 907038
Expires: August 27, 2013

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
) ss.
COUNTY OF BROWARD)

I, Lynda Royer, Registered Professional Reporter, certify that I was authorized to and did stenographically report the deposition of I. JACK ABRAMSON, M.D.; Pages 1 through 159; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel for any of the parties, parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 15th day of October 2010.

Lynda Royer, R.P.R.
Registered Professional Reporter