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1
2 UNITED STATES DISTRICT COURT
3 NORTHERN DISTRICT OF MISSISSIPPI
4 GREENVILLE DIVISION
5 ------------------------------x
6 TERRI LYNN POSTON,
7 Plaintiff,
Civil Action No.
8 -against- 4:02 CV 26-M-B
9 PURDUE PHARMA, L.P., THE PURDUE
PHARMA INC., THE PURDUE FREDERICK
10 COMPPANY, ABBOTT LABORATORIES
and ABBOTT LABORATORIES, INC.,
11
Defendants.
12
------------------------------x
13
July 25, 2003
14 9:38 a.m.
15
16 Deposition of CURTIS WRIGHT, IV, MD, MPH,
17 taken by Plaintiffs, pursuant to notice, at the
18 offices of Chadbourne & Parke, 30 Rockefeller
19 Plaza, New York, New York, before SUZANNE PASTOR,
20 a Shorthand Reporter and Notary Public within and
21 for the State of New York.
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2 APPEARANCES:
3 COHEN, MILSTEIN, HAUSMAN & TOLL, PLLC
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5 Washington, D.C. 20005-3964
6 BY: DOUGLAS J. McNAMARA, ESQ.
7 -and-
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2 APPEARANCES OF COUNSEL (CONTINUED):
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7 AND: JAY R. HENNEBERRY, ESQ.
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BY: JOEL E. HOFFMAN, ESQ.
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13
ALSO PRESENT:
14
RICHARD SILBERT, ESQ.,
15 Purdue Pharma LP
16 MICHAEL SHANE, ESQ., Food & Drug Administration,
Department of Health & Human Services
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1 CURTIS WRIGHT, IV, MD, MPH
2 CURTIS WRIGHT, IV, MD, MPH,
3 having been first duly sworn by the Notary Public
4 (Suzanne Pastor), was examined and testified as
5 follows:
6 EXAMINATION CONDUCTED BY MR. McNAMARA:
7 Q. Good morning, Dr. Wright. My name is
8 Doug McNamara. I'm representing plaintiffs Terri
9 Lynn Poston today. I'm going to ask you a series
10 of questions. If there's one that you don't
11 understand, just let me know, you can ask me to
12 rephrase it and I'll try to do so.
13 If there's a question I ask you which
14 calls for a yes or no answer, please just give a
15 yes or no answer. If there's something you'd
16 like to add, let your counsel know. And he'll
17 have an opportunity after I'm done questioning to
18 ask you some questions and you could get a record
19 of that matter if you think it's important.
20 If you need any breaks, please let me
21 know. And I think that's the gist of it all.
22 Do you have any medical conditions
23 that affect your memory?
24 A. No.
25 Q. Are you on any medications right now

5

1 CURTIS WRIGHT, IV, MD, MPH
2 that could affect your memory?
3 A. No.
4 Q. Are you feeling generally pretty well
5 physically today?
6 A. Yes.
7 Q. And you feel like you're able to go
8 ahead and answer some questions?
9 A. I will do to the best of my ability.
10 Q. Dr. Wright, can you tell me about
11 your training in medicine.
12 A. Yes, sir. I received my bachelor's
13 degree in chemistry from Haverford College. I
14 took a job at the National Institutes of Mental
15 Health as a research chemist. I attended night
16 school, enrolled in George Washington University,
17 completed a four-year program of medicine.
18 I then joined the navy and did a
19 general surgical internship at Portsmouth Naval
20 Hospital in Portsmouth, Virginia. Served as a
21 general medical officer, received training in
22 undersea medicine and substance abuse treatment.
23 Left the navy, went to John's Hopkins
24 University, did a master's in public health. Did
25 a residency in occupational medicine and general

6

1 CURTIS WRIGHT, IV, MD, MPH
2 preventative medicine, then did a fellowship in
3 behavioral pharmacology and drug dependence.
4 Q. You mentioned the fellowship in
5 behavioral pharmacology. Is that distinguished
6 from pharmacology?
7 A. Yes.
8 Q. How so?
9 A. Behavioral pharmacology is the
10 pharmacology of drugs affecting behavior. The
11 particular program that I went to is a training
12 program funded by the National Institutes on Drug
13 Abuse for scientists doing research in drug
14 abuse.
15 Q. Now, how long were you there?
16 A. Three years.
17 Q. Do you have any training in
18 regulatory affairs?
19 A. Only the courses that I took when I
20 was in the Food and Drug Administration. The job
21 I took after finishing my behavioral pharmacology
22 fellowship was at the Food and Drug
23 Administration, and they run a series of courses
24 for their employees to teach the basics of
25 regulatory affairs. Law, clinical trials

1 CURTIS WRIGHT, IV, MD, MPH
2 analysis, affairs of that kind.
3 Q. Do you have any training in
4 marketing, pharmaceutical marketing?
5 A. No.
6 Q. How long have you been -- are you at
7 Purdue Pharma L.P. now?
8 A. I'm currently at Purdue Pharma.
9 Q. How long have you been at Purdue
10 Pharma?
11 A. Five years.
12 Q. When did you come on board?
13 A. December of 1998.
14 Q. Did you have any other prior
15 pharmaceutical industry job before that?
16 A. Yes, I did.
17 Q. What were those?
18 A. I worked for a small startup firm
19 called Adolor Pharmaceuticals, A-D-O-L-O-R, in
20 Pennsylvania.
21 Q. Is that the only other one?
22 A. Yes.
23 Q. How long did you work for Adolor?
24 A. About a year.
25 Q. And before Adolor you were at the

1 CURTIS WRIGHT, IV, MD, MPH
2 FDA?
3 A. Yes, sir.
4 Q. How long were you at the FDA?
5 A. About nine years.
6 Q. Do you remember about when you
7 started?
8 A. Started in mid 1989. And I left
9 sometime in '97, I don't remember the month.
10 Q. Now, how did you get your current job
11 at Purdue Pharma?
12 A. A recruiter, independent of Purdue to
13 my understanding, had been commissioned to try to
14 find some new doctors for Purdue. And he called
15 my house. My wife spoke to him and she said that
16 I should call him. I did call him. He got in
17 contact with Purdue and asked them if they wanted
18 to interview me.
19 Q. Do you remember who you interviewed
20 with?
21 A. I interviewed -- not everybody. I
22 interviewed with one of the project leaders. I
23 interviewed with Dr. Reder who was head of
24 medical at that time. I don't know who else I
25 interviewed with.

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. What is your current position?
3 A. I am an executive medical director in
4 risk assessment coordination for new products
5 under development.
6 Q. What is risk assessment
7 coordination?
8 A. It's trying to assess the risks posed
9 by potential new products, both during the
10 development process and later on the market or
11 after approval as the first half of the process
12 of risk assessment and management.
13 Q. Do you play a role in the development
14 of clinical trials?
15 A. Yes.
16 Q. With a thought sort of long-term post
17 launch what could happen?
18 A. Several different roles. Are there
19 any risks posed to the participants in the
20 clinical trials. Are there anything that we
21 could learn about risks to the public later in
22 the clinical trials. Are there any specific
23 risks posed by differences between countries and
24 the way they conduct studies. The whole goal --
25 it's in response to a relatively new initiative

1 CURTIS WRIGHT, IV, MD, MPH
2 by the FDA and by the ICAH to it try to build
3 risk assessment into the development process.
4 Q. What did you do at Adolor?
5 A. I was vice president of clinical and
6 regulatory affairs.
7 Q. How did you get that job?
8 A. I was called up by the CEO of the
9 company when I was at Food and Drug
10 Administration. And they described some projects
11 that were very exciting to me, and he made me an
12 offer and I accepted it.
13 Q. Why did you leave Adolor?
14 A. It was a startup company and it was a
15 startup company right about the time the stock
16 market crashed. And after two failed attempts to
17 go public, I was anxious, and my wife's cancer
18 occurred about that time and I felt I needed a
19 job with a stable company. It had gotten to no
20 more than the thinking stage when I got the call
21 from the recruiter.
22 Q. Could you tell me what your current
23 salary is at Purdue Pharma?
24 A. I think it's about $200,000 a year.
25 Q. Has that changed since 1998?

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Oh, yes.
3 Q. What was your salary in 1998?
4 A. I think it was $185,000 a year.
5 Q. In '98 did you have the same position
6 as executive medical director or was it a
7 different position in '98?
8 A. No. I was an executive medical
9 director, but my duties were different. I was at
10 that time associated with general new product
11 development, oversight of clinical studies and
12 development for new products.
13 Q. In your current position who do you
14 report to?
15 A. Lynn Kramer.
16 Q. Who reports to you?
17 A. A medical officer, Doug Kramer, a
18 risk assessment specialist, Mary Ann Zellman, and
19 my secretary Cathy Duffy.
20 Q. Back when you were at the FDA before
21 you left, what was your last position in '97?
22 A. Deputy director of a review
23 division.
24 Q. Of a review division? Which review
25 division?

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Its name changed multiple times. It
3 was the division of anesthetic analgesic and life
4 support drugs at that time.
5 Q. Who did you report to back when you
6 left in '97?
7 A. Dr. Cynthia McCormick.
8 Q. How long had you worked with
9 Dr. McCormick?
10 A. About six months.
11 Q. Before her who did you report to?
12 A. Bob Bedford. Dr. Robert Bedford.
13 Q. How long was he your superior?
14 A. About three years.
15 Q. What was your salary when you left
16 the FDA?
17 A. I can only guess. It was about
18 $158,000 a year I think. Somewhere between 140
19 and 158. There was a bonus that I don't
20 remember.
21 Q. Do you recall what it was in 1995?
22 A. No.
23 Q. Was it over 100?
24 A. No.
25 Q. Do you remember what your position

13

1 CURTIS WRIGHT, IV, MD, MPH
2 was in 1995? It wasn't deputy director, was it?
3 A. No, no. At that time I was the team
4 leader for the drug abuse staff.
5 Q. Would you agree that FDA sets the
6 minimum requirements of pharmaceutical
7 companies?
8 A. No --
9 MR. STRAUBER: I object to the form
10 of the question.
11 Q. No, you would not agree to that?
12 A. No, I would not agree.
13 Q. Well, if FDA sets certain rules,
14 you'd agree that states are allowed to impose
15 higher rules so long as they don't contradict the
16 FDA rules?
17 A. I don't know the answer to that.
18 Q. Okay, fair enough. Does the FDA when
19 you were there do any actual testing of the
20 products as to efficacy and safety on their own?
21 A. No.
22 Q. They would rely upon the
23 pharmaceutical company to do those tests?
24 A. They would rely upon the
25 pharmaceutical company to do the clinical

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1 CURTIS WRIGHT, IV, MD, MPH
2 testing, although the FDA laboratories would test
3 the purity of the product and conduct additional
4 pharmacology testing when asked and indicated.
5 Q. It wouldn't ever do any clinical
6 studies on its own, correct?
7 A. I don't know how to answer that.
8 Q. Okay.
9 A. There were a number of programs that
10 the agency ran as part of initiatives to improve
11 drug therapy where the agency would provide
12 grants and support for clinical studies in areas
13 where new knowledge was considered important.
14 Q. Back when you were a team leader for
15 the drug abuse staff, do you remember how many
16 drugs you were responsible for?
17 A. At one time?
18 Q. Let's say in '95.
19 MR. STRAUBER: Are you asking him at
20 one time in '95 or cumulative over '95?
21 Q. During '95, how many drugs would you
22 say you were responsible for?
23 A. I never counted it that way. And
24 they varied tremendously by the amount of time
25 they required. I would say that I had three,

15

1 CURTIS WRIGHT, IV, MD, MPH
2 maybe four that required significant amounts of
3 time.
4 Q. You mentioned the drug abuse staff.
5 How many persons were on the drug abuse staff, if
6 you recall?
7 A. It varied from year to year. I'm
8 having to figure it out. Anywhere between four
9 and seven. I'm not counting the consumer safety
10 officers who were not technical staff.
11 Q. What is a consumer safety officer?
12 A. Consumer safety officers are the
13 individual who handle the actual interface with
14 industry. Manage the files, manage the
15 submissions and are the regulatory specialists
16 that guide the scientists in conforming to agency
17 rules.
18 Q. Now, the clinical studies that you
19 had examined for prospective new drug
20 application, the FDA doesn't design clinical
21 studies, does it?
22 A. No.
23 Q. And that's the ultimate
24 responsibility of the sponsor, the pharmaceutical
25 company?

16

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Yes.
3 Q. Besides OxyContin, did you work on
4 any other Purdue Pharma or Purdue Frederick drugs
5 while you were at the FDA?
6 A. Yes.
7 Q. Which ones?
8 A. MS Contin, some strengths of MS
9 Contin.
10 Q. Do you remember who was your contact
11 at Purdue -- I'm going to use Purdue to refer to
12 Purdue Pharma and Purdue Frederick.
13 Do you remember who your contact was
14 at Purdue?
15 MR. STRAUBER: With respect to MS
16 Contin?
17 MR. McNAMARA: Yes.
18 A. I think that would have been Buddy
19 Prettiman.
20 Q. And your contact with regards to
21 OxyContin, was that Dr. Reder?
22 A. The medical contact with respect to
23 OxyContin was Dr. Reder, but I honestly can't
24 remember who the regulatory contact was.
25 Q. Now, when you got the call from the

17

1 CURTIS WRIGHT, IV, MD, MPH
2 recruiter about Purdue Pharma, did you contact
3 anyone at Purdue Pharma?
4 A. He contacted Purdue Pharma and said
5 that I give them a call. And I called
6 Dr. Reder.
7 Q. Had you had any contact with
8 Dr. Reder from I guess '97 until that call?
9 A. No.
10 Q. Did you mention to him that you were
11 looking to leave Adolor?
12 A. Yes. That's why I called.
13 Q. Do you remember the name of the
14 recruiter in the firm?
15 A. No. I could find it out. I've only
16 met him once.
17 Q. Did you interview with any other
18 firms besides Purdue when you were leaving
19 Adolor?
20 A. No. They were the first one to
21 call.
22 Q. When you were at FDA, was part of
23 your role in approving a product's package
24 insert?
25 MR. STRAUBER: I object to the form

18

1 CURTIS WRIGHT, IV, MD, MPH
2 of the question. I'm not sure I understand what
3 you said. But he can answer it.
4 Q. If you understand what I said.
5 A. I was one of the people who looked at
6 the package insert when it came in. But I was
7 not the person who approved it and I was not the
8 only person who looked at the package insert.
9 There were six, seven, sometimes as many as
10 twelve people who reviewed the package insert
11 before it was finally accepted.
12 Q. Who would be the ultimate person who
13 would sign off on it?
14 A. Bob Bedford, the division director.
15 Q. Do you know from your regulatory
16 training generally what the significance of the
17 package insert is?
18 A. Yes.
19 Q. Could you explain.
20 A. Package insert has several
21 functions. Its most important function is to try
22 to communicate to physicians in an orderly
23 readable way what the company knows about the
24 drug at the time they put it on the market and
25 anything they may learn subsequent to that.

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1 CURTIS WRIGHT, IV, MD, MPH
2 It is also a document that's made
3 available to the public through various media
4 that contains the initial summary of the
5 information about the drug when it's first put on
6 the market and other sources of information that
7 have not yet been developed. It's used by the
8 division of drug advertising as a standard
9 against which they evaluate the promotional
10 activities of the company. And it's how a
11 patient, if they were scientifically inclined,
12 would -- it's where they would go to to look it
13 up to know.
14 Q. The division of drug advertising, how
15 would they use the product label with regards to
16 promotion, if you know?
17 A. It is not an area of my expertise. I
18 never worked there. But in general, they would
19 look at the label and try to determine if the
20 promotional material was fair and balanced with
21 respect to the approved labeling.
22 Q. Now, if the promotion material
23 contained claims that were not within the
24 approved labeling, would that be a problem?
25 A. I think that would be a problem.

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1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you know if Purdue Pharma ever
3 made safety or efficacy claims beyond that
4 supporting the OxyContin label?
5 A. I don't know.
6 (Wright Exhibit 1 for identification,
7 Notice of Deposition.)
8 Q. Dr. Wright, you've been handed what
9 is marked Exhibit 1, which is a notice of
10 deposition for you. Have you ever seen this
11 document before?
12 A. No.
13 Q. Turning to page 2, there's a list of
14 items that we had asked your counsel to direct
15 you to bring: current CV or resume, all
16 communications and documents which, as enumerated
17 below, relate to the design and execution of
18 clinical trials for OxyContin, OxyContin's
19 product launch, OxyContin's product labeling, et
20 cetera.
21 Do you have any of those items with
22 you today?
23 A. No. I don't have any of those items
24 at all with respect to the material I had when I
25 was at the FDA.

21

1 CURTIS WRIGHT, IV, MD, MPH
2 MR. STRAUBER: I would just like to
3 note for the record that this listing of
4 documents that's part of the notice of deposition
5 of Dr. Wright was served very late in the game.
6 Our time to respond has not yet expired.
7 We intend to respond to it. And over
8 the past months Purdue has produced tens of
9 thousands of documents to the plaintiffs pursuant
10 to earlier document demands.
11 MR. McNAMARA: Just for the record,
12 this is dated June 30th, right? Looking at the
13 last page.
14 MR. STRAUBER: It has the typewritten
15 date June 30th, that's correct.
16 Q. Dr. Wright, when you were at FDA, did
17 you keep -- well, like I do here, a personal
18 notebook of your notes?
19 A. No.
20 Q. Did you keep a diary or calendar?
21 A. No.
22 Q. Do you have an appointment book?
23 A. No, not personally.
24 Q. If you met with a person from a drug
25 company and had a discussion, would you

22

1 CURTIS WRIGHT, IV, MD, MPH
2 memorialize the conversation in some way?
3 A. The consumer safety officer would.
4 We never met individually with representatives of
5 pharmaceutical firms. One of the requirements is
6 that it a consumer safety officer be present and
7 the consumer safety officer was tasked with
8 maintaining the records of such things.
9 Q. What about telephone conversations?
10 A. Same thing. They would either
11 arrange the call or be present during the call.
12 Q. So if Dr. Reder wanted to call you up
13 and ask you a question about OxyContin, he would
14 have to go through the consumer safety officer?
15 A. He would call a consumer safety
16 officer, and he and the consumer safety office
17 would tell him Reder wanted to call, and we would
18 talk.
19 Q. Do you remember who was the consumer
20 safety officer on OxyContin?
21 A. I think it was Bonnie McNeal.
22 Q. When you left FDA did you take any --
23 well, let me back up.
24 Did you ever see any -- Ms. McNeal
25 was in charge of memorializing the conversations

23

1 CURTIS WRIGHT, IV, MD, MPH
2 as well?
3 A. Yes.
4 Q. And do you know how she would do
5 that?
6 A. No. That was her job.
7 Q. If you had a conversation, say, with
8 Dr. Reder and you wanted to see what was said,
9 would you call Ms. McNeal and ask to look at some
10 notes that she took?
11 A. I'd ask her.
12 Q. Do you recall ever seeing any e-mails
13 or notes or any other communications from her on
14 those conversations?
15 A. No.
16 Q. Was there an instance where you did
17 ask Ms. McNeal if you could see the notes taken
18 from a particular conversation you had, say, with
19 Dr. Reder?
20 A. I would not think so.
21 Q. When you left FDA, did you make any
22 materials with you with regards to OxyContin?
23 A. No. May I amplify on that answer?
24 Q. Please.
25 A. When I left FDA they have a very

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1 CURTIS WRIGHT, IV, MD, MPH
2 strict checkout procedure. And I was instructed
3 that I was not to take any notes, memoranda,
4 paper, documents, files or anything else
5 pertaining to my work when I was at FDA with me.
6 That that belonged to the government, not to me.
7 And I followed those instructions.
8 Q. Very well. While you were at FDA,
9 were you ever disciplined for any reason?
10 A. No.
11 Q. We kind of passed over it because we
12 didn't do -- you have your own personal lawyer
13 here today, correct?
14 A. Yes.
15 Q. Do you know who's paying for that
16 lawyer?
17 A. Purdue.
18 Q. About how long did you take timewise
19 to prepare for the deposition today?
20 A. I don't know exactly. It was about
21 three sessions.
22 Q. Do you remember how long the sessions
23 were?
24 A. They could last up to three or four
25 or five hours.

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1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Without disclosing what was
3 discussed, do you remember who was at those
4 sessions?
5 A. Yes, I remember who was at those
6 sessions.
7 Q. Could you give me their names.
8 A. I can say that they were attorneys
9 for Chadbourne & Parke that are present in the
10 room. Joel Hoffman was present for two of the
11 sessions, and one or two attorneys from Purdue
12 were present at various times.
13 Q. Did you talk to anyone who was
14 previously deposed in this case about their
15 deposition?
16 A. No.
17 Q. Have you reviewed the deposition
18 transcripts of anyone who was previously deposed
19 in this case?
20 A. No.
21 Q. You had mentioned that you had had I
22 guess a couple instances of training in the area
23 of substance abuse, correct?
24 A. Yes, sir.
25 Q. Including a master's in public

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1 CURTIS WRIGHT, IV, MD, MPH
2 health. Was that devoted mostly towards
3 substance abuse or was it general?
4 A. The master's in public health at
5 Hopkins contains both compulsory and optional
6 components. When I was at Hopkins during the MPH
7 years I took elective training in the
8 epidemiology of substance abuse, advanced
9 training in statistics and epidemiology and had a
10 number of other clinical and scientific training
11 experiences relevant to alcohol and drug abuse.
12 Q. Did you ever treat patients who were
13 alcoholics or drug addicts?
14 A. Oh, yes.
15 Q. Did you ever treat pain patients who
16 were also alcoholics and drug addicts?
17 A. Yes.
18 Q. Any idea on the numbers?
19 A. During the time that I was medical
20 officer for the treatment facility I treated
21 about 2,000 patients with alcoholism and drug
22 dependency. During the years that I was at
23 Hopkins I supported the family by moonlighting as
24 the physician in charge, the physician for a
25 number of local area rehabs. And I'd say I

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1 CURTIS WRIGHT, IV, MD, MPH
2 treated an additional 2 or 300.
3 When I was at Bethesda as the senior
4 physician on the alcoholism and drug abuser
5 advice, I was called into consultation on 50, 100
6 cases involving individuals who had pain and
7 chemical dependency.
8 I have never been a practicing pain
9 specialist. Most of my clinical experience was
10 as a general practitioner.
11 Q. Did you in your experience find that
12 there were additional problems -- let me rephrase
13 that. That there was additional complications
14 with treating a pain patient who also had a
15 substance abuse problem?
16 A. Yes.
17 Q. Can you explain some of those
18 problems?
19 A. There were a number of them. The
20 treating physicians were generally quite
21 uncomfortable with administering addictive drugs
22 to someone who had had an addictive problem.
23 They were often uncertain in how to interpret the
24 patient's response to treatment and they were
25 sometimes concerned about any legal liability for

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1 CURTIS WRIGHT, IV, MD, MPH
2 dispensing narcotics to a known addict.
3 Q. In terms of the patients, is there a
4 higher chance of relapse with someone who's got a
5 history of substance abuse?
6 A. Yes.
7 Q. And being treated with opioids for
8 pain.
9 A. Yes.
10 Q. And did you witness that happen, that
11 pain patients go for relapse or by the time they
12 got to you they already relapsed?
13 A. I don't know how to answer that
14 question. I knew -- I had no personal experience
15 with patients who were properly treated whose
16 addiction relapsed, who went out of remission in
17 the course of proper treatment. But it was
18 always of concern.
19 Q. Do you think it's appropriate to tell
20 patients taking opioids that addiction may
21 occur?
22 A. Of course.
23 Q. Do you think addiction is an
24 important concern for patients taking opioids?
25 A. I don't understand the question.

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1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Okay.
3 A. If you're asking is it a patient's
4 concern, I think it's often a patient's concern.
5 If you're asking is it a realistic concern for
6 the physician, addiction to improperly managed
7 patients is uncommon.
8 Q. Sorry, addiction to improperly --
9 A. No, addiction in properly managed
10 pain patients is uncommon.
11 Q. Is it more common in improperly
12 managed pain patients?
13 A. I believe so.
14 Q. Can you explain how that would happen
15 between a properly and improperly -- how that
16 would affect the chances for addiction?
17 A. I'll try.
18 Q. Okay.
19 A. To properly manage a patient with a
20 pain using any drug, but especially opioid drugs,
21 there are elements that are described by the
22 consensus boards, either the state boards of
23 medicine or the DEA or the American Healthcare
24 Practice Guidelines, that say that you should --
25 you need to assess the patient, you need to

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1 CURTIS WRIGHT, IV, MD, MPH
2 examine the reasons for the patient's pain as
3 best you can, you need to take a history and do a
4 physical, you need to formulate a treatment plan,
5 you need to initiate therapy, you need to follow
6 them up and you need to reevaluate how your
7 therapy is doing.
8 For most of the states that I've
9 practiced in, when you're treating an individual
10 very long-term with opiates or you're treating a
11 patient whose case is complicated by chemical
12 dependency, there are suggestions that you may
13 wish to seek appropriate consultation at periodic
14 intervals to make sure your practice is on the
15 beam.
16 Q. If the prescribing physician doesn't
17 take those steps, there's a greater chance that
18 addiction may occur if there's not that
19 professional there to make sure that the
20 appropriate guidelines are followed?
21 A. That's not really known. What is
22 known is that these are the steps that the state
23 boards and the medical community believe to be
24 necessary to keep the risk of that happening to a
25 minimum.

31

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Can you give me an example of how an
3 improperly managed pain patient could become
4 addicted as opposed to a properly managed pain
5 patient?
6 MR. STRAUBER: I object to the form
7 of the question. He can answer it.
8 A. I'd have to go back into history. Is
9 that okay? Is that acceptable?
10 Q. Sure.
11 A. Prior to the existence of the
12 Controlled Substances Act and the beginning of
13 the evolution of both legal and regulatory
14 controls on narcotics prescribing, it was
15 possible for patients to obtain drugs directly
16 from a drugstore, and it was relatively common
17 for physicians to provide a large bottle of
18 narcotic, a hypodermic syringe and instructions
19 to take this medication when you needed it.
20 That practice was associated with a
21 high rate of dependence in patients who probably
22 would not have developed dependence in modern
23 practice.
24 In addition, drugs leaked out of that
25 kind of distribution system and became traded as

32

1 CURTIS WRIGHT, IV, MD, MPH
2 drugs of abuse to get high by people who weren't
3 sick.
4 I've studied the evolution of these
5 controls and each step of the way it's perceived
6 that a new level of control has been added and
7 has addressed what are perceived problems as
8 society changes and grows.
9 Q. If I can sort of try to take some of
10 the parts of your answer and I guess get somewhat
11 of a paradigm, part of the distinction between
12 the properly and the improperly managed pain
13 patient which could affect the likelihood of
14 addiction would include things like careful
15 monitoring of the patient by the prescribing
16 physician in terms of how much drug they're
17 taking. Would that be one thing --
18 A. And how they're doing with it.
19 Q. Well, how do you mean by that?
20 A. If you start a patient on drug
21 therapy, and it doesn't matter which drug, some
22 will respond, some won't. Some will do well,
23 some will not. Critical to keeping a patient out
24 of trouble with a medicine is to look for adverse
25 events, look for the response to therapy and

33

1 CURTIS WRIGHT, IV, MD, MPH
2 making a judgment for that patient in that
3 individual patient whether the benefits that
4 you're observing for the patient and the patient
5 tells you about are worth the risks posed by the
6 drug.
7 Q. We've got assessment of the patient,
8 both how much they're taking and how they're
9 doing on it --
10 A. History, physical, diagnostic work as
11 appropriate, development of a treatment plan,
12 trial of -- initiation of therapy, periodic
13 assessment, modification of therapy as required
14 and consultation when appropriate.
15 Q. And these are the kind of guidelines
16 that are out there for prescribers of controlled
17 substances that include some of the things you
18 just mentioned?
19 A. I think those elements are available
20 to practitioners in the Healthcare Practice
21 Guidelines published by the federal government,
22 the pain treatment guidelines from the American
23 Pain Society, and in many states, the states that
24 I've been licensed in, are also periodically
25 provided to providers in the form of

34

1 CURTIS WRIGHT, IV, MD, MPH
2 communications from their state board of
3 medicine. It's certainly part of the training;
4 these principles were part of my basic training
5 in pharmacology in medical school and they
6 pertain to all drugs, but they are perceived as
7 being particularly useful in opioids.
8 Q. We talked a little bit about drug
9 abuse. Can you define for me what abuse
10 liability means?
11 A. No.
12 Q. Have you ever heard the phrase "abuse
13 liability"?
14 A. Yes. My difficulty is that it's used
15 by many different people in many different
16 contexts to mean many different things.
17 Q. Okay.
18 A. In the medical context abuse
19 liability could mean the liability that a patient
20 who is being treated with a drug would begin to
21 abuse the drug.
22 In a legal context it could easily
23 mean the propensity of people with drug abuse
24 problems to seek out the drug and abuse it. Both
25 occur.

35

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. This would help explain I guess
3 somewhat of a dichotomy between what might be
4 called the Schedule II abuse liability of a drug
5 and a drug's natural abuse liability, correct?
6 A. Yes, sir.
7 Q. The Schedule II abuse liability would
8 probably -- you're familiar with that term from
9 the scheduling of controlled substances?
10 A. Yes.
11 Q. That would refer to the legal side of
12 it, the propensity of addicts or abusers to seek
13 out the drug, as opposed to the medical?
14 A. More. It would be more the need for
15 control by law as determined by the eight factors
16 that govern what schedule you should put a drug
17 in.
18 Q. In terms of -- and I've called it the
19 medical liability. I guess you have, too. In
20 terms of the medical abuse liability of a drug,
21 what factors go into that, do you know?
22 A. A great many. The nature of the
23 drug, the class itself, what therapeutic class it
24 belongs in. The pharmacokinetics of the drug; is
25 it absorbed, does it get into the circulation,

36

1 CURTIS WRIGHT, IV, MD, MPH
2 does it get into the brain. The nature of the
3 dosage form.
4 We would anticipate a different abuse
5 liability for patients for drugs that were
6 formulated as nasal sprays or inhaled
7 particulates or oral solid dosage forms or
8 transmucosal dosage forms or transdermal patches,
9 each of which you might anticipate posed a
10 different degree of risk to the patient. What
11 the consequences -- what the pharmacologic
12 actions of the drug are and what the consequences
13 of exposure to the drug are. Whether the drug
14 is -- who the drug's being used in, what their
15 intrinsic vulnerability is, what the social
16 context of use is.
17 All of these things interact to
18 result in a level of risk that someone will
19 receive a drug medicinally and will -- and the
20 degree to which they're at risk that they're
21 going to begin to abuse the drug.
22 Q. What about -- you mentioned a little
23 bit about dosage form. What about the amount of
24 dose, would that factor into a medical abuse
25 liability? Or I should say the amount of the

37

1 CURTIS WRIGHT, IV, MD, MPH
2 dose you could ingest at one time.
3 MR. STRAUBER: I object to the form
4 of that question. I don't understand it. If the
5 witness understands it, you can respond.
6 A. I don't understand the question.
7 Could you help me understand it?
8 Q. Sure. How I often used to hear some
9 alcoholics describe it, it's speed in volume.
10 How fast you ingest it and how much you ingest
11 it. Would that also factor into the abuse
12 liability of a drug?
13 A. I thought I just said that. But
14 you're blurring it to me because you're talking
15 about alcoholics and we're talking about patients
16 previously.
17 For a patient, I would anticipate
18 that the amount of drug prescribed was adjusted
19 by the practitioner to the appropriate amount of
20 drug for the patient's weight, size, general
21 state of health, all of the other things that
22 would make you pick a dose for somebody. You
23 might give since you're a thinner man than I am,
24 you might give you less drug than you might give
25 me to achieve the same effect.

38

1 CURTIS WRIGHT, IV, MD, MPH
2 That's very different when you're
3 talking about diversion and abuse by someone who
4 is intentionally diverting the drug. For
5 intentional drug diverters, the bigger the pill,
6 the better.
7 Q. Do oxycodone and morphine have the
8 same abuse potential medically?
9 A. Probably not.
10 Q. Which one would have a higher -- or
11 which one would have a higher medical abuse
12 potential?
13 A. Parenterally, they're probably about
14 the same. If you inject them, they're probably
15 about the same. Orally, you could argue that
16 oxycodone because of its higher bioavailability
17 will get you a higher blood level and may have
18 higher abuse liability. But no one's ever shown
19 a difference in drugs that are so close.
20 Q. You mentioned a higher blood level.
21 I've never actually seen a pharmacokinetic blood
22 level -- blood plasma versus time for morphine.
23 Let's talk orally, does oxycodone have a higher
24 level than, say, morphine sulfate?
25 A. I don't know. It's hard to assess --

39

1 CURTIS WRIGHT, IV, MD, MPH
2 well, for morphine -- I don't know.
3 Q. In terms of time to peak level, do
4 you know if oxycodone orally reaches a peak blood
5 plasma level faster than morphine sulfate?
6 A. Are these immediate release dosage
7 forms?
8 Q. Let's say they're both immediate
9 release.
10 A. I would anticipate their time to peak
11 to be about the same.
12 Q. What about for controlled release?
13 A. Depends on the controlled release
14 formulation. They come in -- morphine comes in
15 many different controlled release formulations.
16 Q. Let's talk about OxyContin and MS
17 Contin. Do you know if there's a difference
18 between the time to peak plasma between MS Contin
19 and OxyContin?
20 A. I know they're about roughly the same
21 magnitude. I don't know precisely to the minute
22 how they vary.
23 Q. I asked you about oxycodone and
24 morphine. What about oxycodone and Tramadol, do
25 they have the same medical abuse liability?

40

1 CURTIS WRIGHT, IV, MD, MPH
2 A. No.
3 Q. Oxycodone's higher?
4 A. Yes.
5 Q. What about oxycodone and codeine,
6 which one has the higher medical abuse
7 liability?
8 A. For patients or in terms of the
9 society as a social problem?
10 Q. I'm trying to focus on medical abuse
11 liability as opposed to, say, I guess the legal
12 abuse liability -- I know what they're scheduled
13 as, but I meant for a patient getting the drug.
14 Presumably legitimately for pain.
15 A. For equivalent doses, therapeutically
16 equivalent doses, I think -- I truly don't know
17 on that one. Codeine is a complex drug that has
18 significantly different effects due to the
19 pharmacogenetics of the individual involved
20 because it's actually in some people a pro drug.
21 So that would be a toughy. That one would depend
22 on the individual.
23 Q. Do you know of any opioids that have
24 a higher abuse potential, let's say on a
25 milligram per milligram basis, than oxycodone?

41

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Oh, yes.
3 Q. Which ones?
4 A. Fentanyl, etorphine, hydromorphone,
5 levorphanol, and a whole list of others that
6 aren't common in medical practice anymore.
7 Q. Now, do you know how abuse potential
8 for a drug is scientifically demonstrated? Are
9 there studies specific to abuse potential?
10 A. There are studies very specific to
11 abuse potential, both animal and human.
12 Q. In terms of the human ones, have you
13 ever participated in any of those kinds of
14 studies?
15 A. As the investigator, never as the
16 subject.
17 Q. Fair enough.
18 MR. STRAUBER: When you reach a
19 convenient point, can we take a morning break?
20 MR. McNAMARA: Why don't we do it
21 right now.
22 (Recess taken.)
23 BY MR. McNAMARA:
24 Q. Dr. Wright, we talked a little bit
25 about abuse potential studies. You had mentioned

42

1 CURTIS WRIGHT, IV, MD, MPH
2 that you had worked as an investigator on some.
3 Do you know how many?
4 A. Personally as an investigator? Four
5 or five.
6 Q. Could you describe generally how
7 these studies are done?
8 A. The human studies.
9 Q. The human studies.
10 A. There's about four or five different
11 actual scientific methods that are used, and they
12 are technical and I don't think I need to go into
13 those.
14 Q. Okay.
15 A. The general strategy for these
16 studies is to find someone who either knows what
17 the subjective effects of an abusable drug are,
18 they're a former drug abuser, or to take someone
19 and train them into what the subjective effects
20 of an abusable drug are. That technology was
21 done in the investigations of caffeine, for
22 example. Or drugs that are not recognized as
23 having high abuse potential.
24 Then using a variety of
25 methodologies, you test several doses of the drug

43

1 CURTIS WRIGHT, IV, MD, MPH
2 of interest. Placebo and usually several doses
3 of a comparative drug, measuring subjective
4 effect and often trying to measure physiologic
5 effect and unpleasant or dysphoric effects as
6 well. Trying to find out where on a continuum
7 this compound lies relative to others.
8 Q. Did you do some of that work at
9 John's Hopkins?
10 A. Yes.
11 Q. Did you ever do work with a Donald
12 Jasinski?
13 A. No. I say no. He was never my
14 principal investigator.
15 Q. Okay.
16 A. But during my time at Hopkins I met
17 with Don, I knew Don. Subsequent to my time at
18 the FDA when I was in private industry, I worked
19 with Don on a number of questions pertaining to
20 abuse liability.
21 Q. Now, you mentioned subsequent to your
22 leaving, would that be work that you did at
23 Purdue with Dr. Jasinski?
24 A. Some was work at Purdue with
25 Dr. Jasinski and some was discussions at Adolor

44

1 CURTIS WRIGHT, IV, MD, MPH
2 with Dr. Jasinski.
3 Q. With regards to Purdue, would this
4 involve a hydrocodone with Naltrexone product?
5 A. Yes.
6 Q. Are you working with Dr. Kramer on
7 that product? Dr. Lynn Kramer.
8 A. Working for Dr. Lynn Kramer. I'm not
9 actively currently assigned to that product. I
10 was assigned to that product and to drugs of that
11 type in general during my first four years with
12 Purdue.
13 Q. Since you've been at Purdue, have you
14 been involved either as investigator or
15 supervising any abuse potential studies?
16 A. Oh, yes.
17 Q. Do you have an idea how many?
18 A. Ten.
19 Q. Would one of those drugs be the
20 hydrocodone with Naltrexone product?
21 A. Yes.
22 Q. Do you recall some of the others?
23 A. Many of the others weren't specific
24 to -- many of them used hydrocodone but not with
25 respect to a specific product. We used

45

1 CURTIS WRIGHT, IV, MD, MPH
2 hydrocodone as a prototype opioid because it has
3 the highest abuse rate -- rate is not the right
4 word. It's such a problem drug of abuse in
5 America today. And we -- most of the studies
6 were basic science studies trying to determine
7 proof of principle to see if it was technically
8 possible to preserve analgesia while providing
9 some deterrence for abuse.
10 Q. So then these would be -- well, you
11 mentioned a known comparator. Did you use
12 hydrocodone as the known comparator in your
13 studies?
14 A. Yes. Hydrocodone was the standard
15 opioid.
16 Q. And I guess that's an example of --
17 it's a Schedule III drug, correct?
18 A. Yes.
19 Q. Even though it's a Schedule III drug
20 it still has from a medical abuse liability
21 standpoint a pretty high degree of liability.
22 A. Hydrocodone is an anomaly.
23 Hydrocodone I believe, I would have to check the
24 law, there is no single entity hydrocodone
25 product other than cough syrups, to the best of

46

1 CURTIS WRIGHT, IV, MD, MPH
2 my knowledge, available in the American market.
3 I think bulk hydrocodone is a Schedule II. But
4 hydrocodone in combination with aspirin or
5 Tylenol is a Schedule III, or hydrocodone in a
6 cough syrup formulation is a Schedule III.
7 There's considerable dispute in the
8 addiction sciences community as to whether
9 hydrocodone needs to be a II or it needs to be a
10 III. So that's why I'm having trouble answering
11 that precisely.
12 Q. That's fine. Oftentimes is morphine
13 used as a comparator drug in abuse potential
14 studies?
15 A. Relatively infrequently. But it
16 depends on the period of history. In the 1940s,
17 '50s and '60s morphine was the gold standard as
18 a comparator drug. As technologies changed and
19 as interests in abuse liability, not just by
20 injecting a drug but by taking pills as well,
21 began to emerge, people began to use drugs with a
22 higher oral bioavailability as their comparator
23 drugs. So they began to use hydromorphone,
24 hydrocodone, oxycodone because it had a more
25 predictable oral bioavailability than morphine.

47

1 CURTIS WRIGHT, IV, MD, MPH
2 Morphine's a somewhat variable.
3 Q. In the ten or so studies -- well, is
4 it ten drugs or ten studies?
5 A. Ten studies.
6 Q. In the ten or so studies, have you
7 used hydrocodone as the only comparator drug?
8 A. I have to think. In the studies that
9 have actually been completed to date, hydrocodone
10 is the only comparator drug. I believe that some
11 of the other studies that are sort of half done
12 are using oxycodone as a comparator drug.
13 Q. In any of those studies was oxycodone
14 used in comparison with hydrocodone to determine
15 abuse potential?
16 A. No. The studies were not focused on
17 trying to determine the relative abuse potential
18 of the two drugs but to try to determine the
19 extent to which altering the formulation or
20 including an opioid antagonist could either
21 improve the safety or decrease the toxicity or
22 reduce the abuse liability or increase the tamper
23 resistance of these kinds of drugs.
24 Q. Was an oxycodone with Naloxone
25 product compared to hydrocodone?

48

1 CURTIS WRIGHT, IV, MD, MPH
2 A. No.
3 Q. What about oxycodone with Naltrexone
4 product?
5 A. No. I don't think we've run any
6 oxycodone/hydrocodone head-to-head comparisons.
7 Q. What about oxycodone/Naltrexone or
8 Naloxone against oxycodone?
9 A. I think that one's on the books.
10 Q. When you say on the books, it's been
11 completed or it's being worked on?
12 A. Yes.
13 Q. You're not working on that?
14 A. No. What happened was when -- and
15 this is my perception. The company may feel
16 differently, I don't know. But when I started at
17 Purdue, the science of tamper resistant dosage
18 forms was not well developed. At that point in
19 time it was new science for the company. They
20 were interested in it, they wanted to work on it
21 and I had every one of these products.
22 As the products matured and we began
23 to get technology that worked and we began to get
24 technology that might work -- worked on the bench
25 and we began to get technology that might work in

49

1 CURTIS WRIGHT, IV, MD, MPH
2 the clinic, other senior clinicians in the
3 company saw these as potentially exciting
4 products and began to ask if I would let them
5 have some.
6 And at the same time when this risk
7 assessment initiative came up with the FDA, they
8 said who do we got who could handle that, and so
9 that was me. They became normal products and
10 they are now in what I would call normal
11 development.
12 Q. You mentioned that the technology had
13 not been developed, or was it the department you
14 were referring to hadn't had a lot of experience
15 with antagonist/agonist products?
16 A. The company did not have much
17 experience with agonist/antagonist products. And
18 there are huge gaps in the science pertaining to
19 agonist/antagonist products. The products that
20 have been developed are pretty primitive and have
21 very limited application.
22 I think there's potential in this
23 area. It has turned out to be trickier science
24 than I imagined, certainly.
25 Q. Generally speaking, the abuse

50

1 CURTIS WRIGHT, IV, MD, MPH
2 potential studies that you've been working on at
3 Purdue, you mentioned there's four or five
4 different technical ways that they could be
5 done. What is the general way that they're being
6 done at Purdue?
7 A. Maybe it would be -- I don't know how
8 to answer that because each one is different.
9 All of them are using subjective effects
10 measurement. Asking people who should know what
11 drug effects are like. So they're selected as
12 people who say yes, I know what drug effects are
13 like, yes, I have abused drugs in the past, yes,
14 I can tell what high is. And then giving them a
15 series of doses of opioid in a controlled and
16 blinded fashion to see if that's true, to see if
17 they can tell the difference between opioid and
18 placebo and if they can tell the difference
19 between different doses of opioid.
20 Then beginning the experimental part
21 of the study, looking to see if you can modify
22 that abuse liability in any way, if you can make
23 the drug less attractive or if you -- if somebody
24 will develop withdrawal symptoms if they're
25 physically dependent, or see if the ratio of good

51

1 CURTIS WRIGHT, IV, MD, MPH
2 effects to bad effects can be modified. In some
3 cases it's basic safety studies to see if the
4 risk of overdose for somebody who took the
5 drug -- you know, a kid who took the drug, see if
6 you can lower their risk of overdose.
7 Q. You mentioned subjective effects. Is
8 there a questionnaire that they'd be asked about
9 certain effects?
10 A. There's several different kinds of
11 questionnaires. There are what are -- the most
12 common portfolio, which is used by most of the
13 NIDA investigators but which is unfortunately not
14 perfectly standard from laboratory to laboratory,
15 is what are called visual analog scales where you
16 give somebody essentially a thermometer and you
17 say how high are you, or how much do you like the
18 drug, or how much would you pay for this drug.
19 And then there are adjective
20 checklists that say how much do you feel any of
21 the following. And those adjective checklists
22 are woozy, dizzy, fuzzy, muzzy. There's a whole
23 list of things that people can feel when they're
24 taking drugs and check them and check how much
25 you feel.

52

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. About how long do these studies
3 take?
4 A. They are very variable. One of the
5 studies in which we were actually trying to look
6 at the effect of dosage form, would the drug in
7 this dosage form be different from the drug
8 injected, took over two years to enroll the study
9 and about three-quarters of a year to analyze the
10 results and write them up.
11 Q. When you're saying these dosage
12 forms, were those ones with an
13 antagonist/agonist?
14 A. That was not. May I stop for a
15 second here? I want to ask the Purdue attorneys
16 something. What do I do?
17 MR. STRAUBER: Can we go off the
18 record?
19 MR. McNAMARA: Yes.
20 (Recess taken.)
21 BY MR. McNAMARA:
22 Q. Were these drugs with
23 antagonist/agonist?
24 A. No, that was a comparison of a
25 controlled release dosage form with an immediate

53

1 CURTIS WRIGHT, IV, MD, MPH
2 release dosage form.
3 Q. Is this related to a hydromorphone
4 product?
5 A. No.
6 Q. Do you know what the results were
7 comparing that controlled release dosage form
8 with immediate release dosage form?
9 A. Yes.
10 Q. What were those results?
11 A. The perceived ratings of liking,
12 drug-liking, were substantially lower with the
13 controlled release dosage form relative to the
14 immediate release dosage form.
15 Q. Can you tell me the drug that was
16 used for the controlled release dosage form?
17 A. Buprenorphine.
18 Q. Buprenorphine is a mixed
19 agonist/antagonist, correct?
20 A. Yes.
21 Q. So it has within it its own
22 somewhat -- well, why don't you explain what a
23 mixed agonist/antagonist is.
24 A. Some opioids as you give larger and
25 larger doses begin to act as their own antidote.

54

1 CURTIS WRIGHT, IV, MD, MPH
2 So that the drug effects from the drug, instead
3 of going up and up and up and up with increasing
4 dose begin to level off.
5 Buprenorphine is such a drug. That
6 leveling off for Buprenorphine takes place at
7 fairly high levels of the drug. In the low dose
8 range it acts more like a pure agonist. In the
9 mid dose range it acts like an
10 agonist/antagonist, and in the high dose range it
11 can actually have antagonist effects to other
12 opioids. Is that clear?
13 Q. Okay. And the antagonist effects
14 would mean they would precipitate withdrawal?
15 A. Yes.
16 Q. Would it also not be as effective as
17 an analgesic?
18 A. Yes.
19 Q. Do you have any idea how much abuse
20 potential study comparing Buprenorphine to the
21 immediate release opioid was? How much it cost?
22 A. No.
23 Q. Do you know who was in charge of that
24 study?
25 A. Yes.

55

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Would that be Dr. Kramer?
3 A. No.
4 Q. Dr. Reder?
5 A. No.
6 Q. Why don't you tell me the name. I've
7 exhausted my supply of medical directors.
8 A. During that period of time, for most
9 of that study, that study was being run by a
10 scientist named Dr. Christopher Breder.
11 Q. Is he still with Purdue Pharma?
12 A. No.
13 Q. Do you know when he left?
14 A. Last year.
15 Q. Do you know who is in charge of that
16 product now?
17 A. As the clinical leader?
18 Q. Yes.
19 A. I would say Steve Ripa.
20 Q. We've been talking a little bit about
21 abuse liability. We've used the phrase
22 "addiction liability." Have you ever heard that
23 phrase?
24 A. I don't remember it. It's not a
25 common phrase.

56

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Addiction is distinct from abuse,
3 correct?
4 A. Yes.
5 Q. Is it a subset or just a completely
6 different phenomenon?
7 A. It is a difficult question to
8 answer. Almost all addiction, perhaps all
9 addiction, starts out as abuse. Self
10 administration for nonmedical purposes. Some
11 individuals, for the reasons that we discussed
12 earlier this morning, once they begin a drug
13 abuse go on to develop the brain changes
14 characteristic of addiction.
15 Q. Do you know what some of those brain
16 changes are?
17 A. I know how they manifest themselves.
18 You'd have to get someone from the National
19 Institutes on Drug Abuse to talk about their
20 current research in that area.
21 Q. Well, let's focus on the
22 manifestation as opposed to the neurobiological
23 aspects. What are some of the manifestations?
24 A. The premiere manifestation of
25 addiction distinct from abuse is the loss of

57

1 CURTIS WRIGHT, IV, MD, MPH
2 control over drug use. The individual takes drug
3 under circumstances where a reasonable individual
4 would choose not to.
5 Q. Now, physical dependence would be
6 distinct also from addiction, correct?
7 A. They're sometimes related. There are
8 different concepts. Any patient's physical
9 dependence to opioids begins in anyone who
10 receives them. The clock starts winding as you
11 give someone opioids, and some investigators
12 believe that they can demonstrate alterations in
13 tolerance and dependence within ten minutes of a
14 dose of opioids. Not great, but they can detect
15 them.
16 However, certain forms of dependence
17 are much more characteristic of individuals that
18 have addiction. Literally people on the street
19 will manifest florid opioid withdrawal while
20 waiting to make contact with the pusher.
21 So physical dependence, addiction,
22 separate concepts. But people with addiction can
23 and do often have physical dependence.
24 Q. Is it sometimes a symptom of
25 addiction if somebody's physically dependent?

58

1 CURTIS WRIGHT, IV, MD, MPH
2 A. For everyone but a pain patient.
3 Q. For a pain patient it's not a symptom
4 at all?
5 A. It becomes tricky. If someone -- and
6 this is a scientific dilemma and I don't think
7 anyone's answered it yet. There are certain --
8 when the DSM 3 R was developed, this is a manual
9 for how to diagnose and classify disorders for
10 research, it placed a great stress on being able
11 to operationalize definitions of disease. Make a
12 list, make a scoring system, create a checklist.
13 So instead of a concept, addiction is this, they
14 began to develop multidimensional scoring systems
15 for many disorders, for character disorders,
16 thought disorders, addictive disorders, in an
17 attempt to improve the specificity of diagnosis.
18 Those checklists work well when
19 someone has one disorder, and they work well when
20 an individual's behavior is not complicated by
21 treatment. But in many of the behavioral
22 disorders, when you have two things going on it
23 becomes very difficult. Some drugs that affect
24 your mood will also cloud your thinking. You
25 asked me that question when we started the

59

1 CURTIS WRIGHT, IV, MD, MPH
2 deposition today. So if you could easily -- if
3 you didn't know someone was taking the drug, you
4 could easily decide they have a thinking problem
5 when they didn't; it was the drug they were
6 taking.
7 With chronic pain patients, some of
8 the behaviors that you think you'd find in an
9 addict, someone who has no good reason to take
10 the drug, begin to lose their diagnostic value.
11 So if someone's on a high dose of opioid at their
12 physician's prescription and they need it for
13 management of their pain, they're going to be
14 tolerant. They're going to demonstrate
15 withdrawal if you abruptly discontinue the drug.
16 These are givens.
17 In addition, patients, when they have
18 bad pain, when they have pain that is beginning
19 to dominate their lives, can become very anxious
20 about making sure they get good treatment for
21 their pain. Some writers and investigators and
22 pain specialists have come up with the concept of
23 something called pseudoaddiction. That's a term
24 of art, but I think the principle behind it is
25 real.

60

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. You mentioned it's a term of art. Do
3 you know if it's ever been studied clinically,
4 the prevalence of pseudoaddiction in chronic pain
5 patients?
6 A. No, I don't know.
7 Q. Do you know how frequently it might
8 occur?
9 A. What I -- no. What I know about it
10 is that it's been reported. I've heard lectures
11 and presentations on it. I'm not a pain
12 specialist, and it's a bit -- it's a very
13 specific topic in pain management.
14 Q. We were talking about some things
15 that might be in the DSM would lose some of its
16 diagnostic value when you're talking about
17 chronic pain patients taking opioids. I think
18 you mentioned tolerance and withdrawal and
19 physical dependence being three. Are they
20 without any diagnostic value at all?
21 A. No. Let me try to answer that.
22 Q. Okay.
23 A. These findings can be of diagnostic
24 value, but they must be interpreted in the
25 context of what kind of pain the patient has,

61

1 CURTIS WRIGHT, IV, MD, MPH
2 what their diagnosis is, what kind of treatment
3 they've been on, what kind of concomitant
4 medications they're on. That's a reasoned
5 judgment. Does this individual have what you
6 would anticipate someone with that diagnosis on
7 that dose would demonstrate.
8 Q. Generally speaking, is OxyContin
9 addictive?
10 A. Yes.
11 Q. Does OxyContin cause euphoria?
12 A. Yes.
13 Q. Is that a common side effect? Well,
14 let me -- I've seen this, and I don't know if I'm
15 right on this, but my understanding is if
16 something's called a common side effect in the
17 parlance of the industry, that's usually about a
18 1 to 5 percent occurrence.
19 A. Common --
20 MR. STRAUBER: Can I hear that
21 question again.
22 (The pending question was read.)
23 MR. STRAUBER: I object to the form
24 of that question.
25 A. You asked -- what I heard of your

62

1 CURTIS WRIGHT, IV, MD, MPH
2 question is are you right on that. I don't think
3 so. There's tremendous variability from label to
4 label, from review division to review division
5 from my experience on what words like "common"
6 "rare," "very common," "uncommon," "very rare"
7 mean. And there have been multiple efforts to
8 try to sort that out. But I'm not sure they're
9 helpful.
10 Q. So there's no table that says common
11 equals 1 to 5, very rare equals less than 1, rare
12 equals 1 percent, there's no breakdown like that,
13 correct?
14 A. There are publications of individuals
15 or organizations who say we think common is this
16 to this, we think rare is this to this. The
17 terms are not without meaning, but it's much
18 better to try to talk about for a given treatment
19 population what the actual rates are when you're
20 trying to talk about those rates.
21 Q. Do you know if euphoria occurs with
22 OxyContin between 1 to 5 percent of the time in
23 patients who were tested?
24 A. Not off the top of my head. I would
25 have to look at the package insert.

63

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you know if OxyContin causes less
3 euphoria than immediate release opioids?
4 A. No. I don't know.
5 Q. Do you know any studies on that
6 topic, whether or not OxyContin causes less
7 euphoria than immediate release opioids?
8 MR. STRAUBER: Are you talking about
9 patients or generally?
10 Q. Let's start with any studies and then
11 we'll break it down to patients, if there are
12 any.
13 A. I know of no abuse liability or
14 clinical studies that were powered and designed
15 specifically to address that question.
16 Q. Do you know any studies that happen
17 to address that question, even if they weren't
18 designed to?
19 A. Not directly.
20 Q. Have you ever heard of the RADARS
21 program at Purdue?
22 A. Yes.
23 Q. Are you a participant in that
24 somehow?
25 A. No.

64

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you have any contact or relation
3 to the RADARS program?
4 A. Not directly with RADARS. Because
5 that's housed in the risk management group,
6 because risk assessment hands off to risk
7 management, I have contact with the people who
8 work in the group. But I routinely do not attend
9 RADARS meetings. I do not write RADARS
10 documents, I'm not supervising RADARS.
11 Q. We addressed this a little about MS
12 Contin and OxyContin. From a pharmacologic
13 standpoint, is there much of a difference?
14 A. There are differences between MS
15 Contin and OxyContin pharmacologically and
16 pharmacokinetically. Whether those differences
17 mean anything is unclear.
18 For example, OxyContin is more
19 bioavailable and more predictively bioavailable
20 in the dosage forms that are available. But the
21 doses of MS Contin are bigger. So I've never
22 thought of the question what are the relative
23 abuse liability, pharmacokinetics, clinical
24 pharmacokinetic questions between the two drugs.
25 Q. Oxycodone I've seen is a 1.8 to a 1

65

1 CURTIS WRIGHT, IV, MD, MPH
2 to 2 ratio of oxycodone potency to morphine.
3 A. Parenteral or oral?
4 Q. Oral.
5 A. Oxycodone is slightly more potent
6 than morphine.
7 Q. What role did you have with respect
8 to OxyContin's approval?
9 A. I was team leader in charge of
10 oversight of the primary medical officer reviews
11 for some of the studies or that were reviewed by
12 other individuals. I was primary reviewer on
13 some studies under the IND and in the NDA. I was
14 part of the drug abuse team working on the abuse
15 liability discussions. I was part of the team
16 that worked on the label.
17 Q. Part of the team that worked on the
18 labeling, was that team -- did y'all have
19 separate parts of the label that you worked on?
20 A. We worked on it both separately and
21 together. Different parts of the label
22 corresponded more precisely to somebody's
23 expertise than somebody else's. So the chemist
24 would spend most of the time on the how
25 prescribed and how supplied sections. The

66

1 CURTIS WRIGHT, IV, MD, MPH
2 kineticist would spend most of the time on the
3 kinetics section and so on and so forth. Both
4 the drug abuse staff and the clinical reviewers
5 worked on the clinical sections.
6 Q. Who worked on the section for drug
7 abuse and dependence?
8 A. Several people. Myself, Mike Klein,
9 I can't remember if -- we had two very good
10 pharmacologists who were working on drug abuse,
11 but I can't remember whether they worked on it as
12 well.
13 Q. Was one of them Ms. Hayes?
14 A. Yes, Belinda. And of course all of
15 the clinical sections of the label were subject
16 to a multidisciplinary review and reviewed by the
17 division director.
18 Q. Dr. Bedford?
19 A. Yes.
20 Q. Do you recall meeting with Purdue in
21 November of 1992 to discuss the process for
22 approval of OxyContin?
23 A. I know we had a meeting. I don't
24 remember it.
25 (Wright Exhibit 2 for identification,

67

1 CURTIS WRIGHT, IV, MD, MPH
2 document bearing Bates production number
3 8002065027 through 8002065089.)
4 Q. I'm just going to ask you to look
5 over that quickly. We're only going to focus on
6 a couple of sections of it. I think specifically
7 we're going to look at Appendix 1 and Appendix
8 4.
9 MR. STRAUBER: I note that Exhibit 2
10 is stamped confidential, subject to protective
11 order. There is of course a protective order in
12 this case and we will at the appropriate time
13 designate exhibits and information in the course
14 of the deposition that are deemed confidential.
15 Q. Dr. Wright, could I direct you to --
16 well, first, generally speaking, this is a letter
17 from James Conover at Purdue Pharma to John
18 Harter, correct?
19 A. Yes.
20 Q. Do you know who John Harter is?
21 A. John Harter was director of the pilot
22 drug evaluation staff. He was not a division
23 director but he had the functional authority of
24 one.
25 Q. Turning to page, I'm going to use the

68

1 CURTIS WRIGHT, IV, MD, MPH
2 last three numbers of the Bates stamp, which are
3 033, this appears to be a portion of some minutes
4 from a September 8th, 1992 meeting.
5 A. Uh-huh.
6 Q. Looking at number 4 -- well,
7 apparently this is some of your suggestions to
8 Purdue Pharma about what they should do for
9 purposes of approval as part of their NDA.
10 MR. STRAUBER: I object to the form
11 of that question. Go ahead.
12 A. No. Your question says some things
13 that are wrong.
14 Q. Okay, please.
15 A. There are limits on what an
16 individual reviewer or indeed an individual --
17 even a division director can require of a
18 company. There were appropriate and applicable
19 guidance documents in place that were not -- and
20 I'm not an expert in the litigation involving
21 this, but the guidance documents say if a company
22 performs studies in accordance with these
23 guidance documents in good faith, the agency and
24 the review staff have to explain why that's not
25 enough.

69

1 CURTIS WRIGHT, IV, MD, MPH
2 And I have to review -- yes, this
3 is -- do you know whether this is an early IND
4 meeting, a pre-IND meeting, into Phase 1
5 meeting?
6 Q. Well, sir, I'm looking at page 031
7 where it actually talks -- looking at this,
8 apparently it's a meeting that was held on June
9 3, 1992, and these were the minutes that were
10 typed up in September of '92. Looking at page
11 032, I'm focusing on the last sentence of the
12 fourth paragraph where it says he had the
13 following.
14 A. Yes.
15 Q. "He," being it looks like you,
16 Dr. Wright, "had the following specific comments
17 on our clinical program to be incorporated into
18 our NDA submission."
19 A. Yes.
20 Q. That's what I meant by my question,
21 these were comments or recommendations that you
22 had --
23 A. Recommendations.
24 Q. That's the problem? That's the
25 word --

70

1 CURTIS WRIGHT, IV, MD, MPH
2 A. That's the word that gives me
3 trouble. There are limits on the ability of an
4 individual and individual reviewer to make
5 statements that are binding on the government or
6 binding on the division or binding on the future
7 review of an application.
8 A reviewer will often make statements
9 about what he thinks is wise. But those comments
10 can be right, they can be wrong, they can be
11 revised in light of later findings, and they can
12 be overruled at the time of review of the NDA.
13 So they're recommendations, they're not
14 requirements for approval.
15 Q. Gotcha. I understand now.
16 Going back to page 033, looking at
17 number 4.
18 A. Number 4.
19 Q. It says "perform an IND ceding
20 study. This would be a labeling validation study
21 involving about a thousand patients. Such a
22 study need not be completed by initial NDA
23 submission but would need to be completed for the
24 NDA date."
25 This is the suggestion about a

71

1 CURTIS WRIGHT, IV, MD, MPH
2 labeling validation study. Do you recall why you
3 made it?
4 A. Yes. There was a considerable
5 controversy at the time within the Food and Drug
6 Administration as to how to handle what I'm going
7 to call IR/CR switches. The controversy might be
8 the wrong word, but there was robust scientific
9 debate.
10 The agency was not interested in
11 providing -- in imposing upon industry greater
12 regulatory burdens than were necessary by the
13 scientific perspective. But they were also very
14 committed to a role to protect the public -- a
15 role at the time -- sometimes I speak as if I'm
16 still an agency employee. It was very deeply
17 ingrained. The agency's role to protect the
18 public from unsafe medications.
19 Certain -- there were significant
20 differences between review divisions on how much
21 science and how much clinical study the sponsors
22 were asked to perform for an IR to CR switch of
23 the same drug where you were just changing the
24 dosage form from four hours to eight hours or six
25 hours to twelve hours.

72

1 CURTIS WRIGHT, IV, MD, MPH
2 Some divisions treated that as if it
3 were an entirely new drug product. Some
4 divisions treated that, and the generics
5 divisions in particular, treated that as if it
6 was a pharmacokinetic problem. Just do a peak
7 case study, you're done, it's the same, go. And
8 that was troubling because having different
9 divisions with different approaches to the same
10 scientific problem is not good policy. It may
11 not even be good science.
12 So at the time when we were wrestling
13 with the issue of how much is enough, my
14 thinking, which is not binding on the agency but
15 represents one person's opinion, was that we
16 needed to see pharmaco -- good stable
17 pharmacokinetic performance, head to head
18 comparisons, and some indication from some
19 direction that the proposed labeling was adequate
20 for selling -- for safe use of the product.
21 That last was probably inappropriate
22 for the time, but I made it anyway.
23 Q. Why was it inappropriate for the
24 time?
25 A. It's only been relatively recently

73

1 CURTIS WRIGHT, IV, MD, MPH
2 that the agency has given serious consideration
3 to the approval requirements being prospective --
4 the approved labeling being prospectively
5 tested. Very few drugs had that and I'm not even
6 sure if I know if any drugs had that at that
7 period of time.
8 Since that time one of the issues
9 pertaining to risk management and risk assessment
10 is to say okay, let's test the labels prior to
11 approval, let's see if physicians comprehend
12 them, let's see if they are safe. So this was a
13 novel request at the time.
14 Q. And the goal was basically to see if
15 in following the instructions of the product
16 labeling, if --
17 A. The product was of acceptable risk.
18 Q. If the instructions were adequate and
19 clear and people could follow them and use them
20 appropriately, and then if they were not, amend
21 the label if need be?
22 A. Yes. That is correct.
23 Q. Looking at the bottom of the page,
24 under general it says here "Dr. Wright
25 recommended we consider developing a Naloxone

74

1 CURTIS WRIGHT, IV, MD, MPH
2 combination product." And it doesn't continue on
3 to the next page.
4 Do you remember making that
5 recommendation back in June of '92?
6 A. No, but I have no reason to
7 disbelieve the minutes.
8 Q. Do you remember in '93 or '94 ever
9 mentioning this again to Purdue about developing
10 a Naloxone combination product with oxycodone?
11 A. I very well -- seeing this, I very
12 well could have. I don't remember. I remember
13 discussing -- other discussions about
14 agonist/antagonist products, but this was a topic
15 that was very common in '94-'95.
16 Q. The topic of combination products
17 with an antagonist?
18 A. Yes. The National Institutes on Drug
19 Abuse was during that period developing a
20 Buprenorphine/Naloxone product that has since
21 come on to the market. And they were very
22 enthusiastic about the potential for this, making
23 the product less abusable and hence more
24 appropriate to prescriptive use.
25 There had been some preliminary data

75

1 CURTIS WRIGHT, IV, MD, MPH
2 suggesting that this might work that was more
3 exciting than the data that had been done with
4 Talwin Nx which was using technology that wasn't
5 as good as today's technology and left
6 significant safety questions.
7 So any product of this nature I think
8 I would have been talking to them about, well,
9 can you put Naloxone in, can you put Naltrexone
10 in, can you make the caplet purple.
11 Q. Understood.
12 Do you recall if Purdue ever said we
13 looked at it and we can't do it, Dr. Wright?
14 A. What I remember, they certainly could
15 have, but I don't remember.
16 Q. Stating the obvious, though, Purdue
17 never did add a Naloxone product to oxycodone for
18 an OxyContin/Naloxone product, or has not yet,
19 correct?
20 A. Correct.
21 Q. Or a Naltrexone product?
22 A. Correct. There's a considerable
23 amount of research on how to make such a product
24 and trial formulations of this kind have been
25 made and are under test.

76

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Right.
3 A. But there is no current NDA approved
4 for such a product.
5 Q. I think we discussed, did you have
6 any work on that product at Purdue?
7 A. Yes.
8 Q. And do you remember when that work
9 began? Do you know when it began at Purdue?
10 A. No, I don't know exactly when that
11 work began at Purdue. I know that clinical
12 studies began somewhere in '97, '98.
13 Q. Can you turn to page ending 079.
14 This appendix says "marketing position and
15 proposed launch advertising claims as of
16 11/2/92." Do you remember asking them to give
17 you some idea of what their potential marketing
18 claims were going to be in their launch
19 advertising?
20 A. I don't remember asking them to do
21 that. Given the early nature of the meeting, I'm
22 not sure we would have much cared what their
23 proposed claims were.
24 Q. Looking at page 080, and looking at
25 the last claim listed, the bullet point that says

77

1 CURTIS WRIGHT, IV, MD, MPH
2 "less subject to potential abuse by addicts."
3 Do you recall asking Purdue about that potential
4 claim back in '92?
5 A. No, I don't remember that. It would
6 have -- I don't remember that.
7 Q. Do you remember seeing this proposed
8 claim back in '92?
9 A. It's in the minutes. I must assume
10 that it was in the submission. I don't remember
11 being particularly interested in this claim.
12 Q. Would that have been an out of the
13 ordinary claim in '92, that a controlled release
14 drug would be less subject to abuse?
15 A. No. There was a general perception
16 that the controlled release dosage forms were
17 less desirable. They were certainly not lighting
18 up on the surveillance systems that we had at the
19 time. I'm not sure -- the person -- the people
20 that would have been more concerned with this
21 would have been the chemists and the drug
22 scheduling people. And they would only have been
23 concerned with it had this been an attempt to
24 move the drug out of Schedule II into
25 Schedule III.

78

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. I believe in '97 you might have
3 worked with Purdue while you were still at FDA on
4 a proposed hydrocodone/Naltrexone product,
5 correct?
6 A. I met with them.
7 Q. And part of the goal was to move that
8 drug down to a Schedule IV, correct?
9 A. That is correct. Or keep it in
10 Schedule III. Even at that time there was
11 concerned about hydrocodone.
12 Q. And do you recall instructing them on
13 some of the -- well, making suggestion to them on
14 some of the studies they would have to do to
15 support changing in the scheduling?
16 A. As I remember that meeting, I have
17 not reviewed the minutes of that meeting for -- I
18 don't think I ever reviewed the minutes of that
19 meeting, but I might have, what I told them they
20 had to do and what the DEA representative told
21 them what the DEA felt that they had to do was to
22 robustly show for oral use, because that's the
23 pattern of abuse for hydrocodone products, that
24 there was reduced abuse potential, either by
25 reducing the risk of abuse, the consequences of

79

1 CURTIS WRIGHT, IV, MD, MPH
2 abuse or the probability of abuse.
3 And as I remember the meeting, there
4 was considerable discussion as to whether
5 Naloxone or Naltrexone or Nalmefene or some other
6 antagonist product would be appropriate.
7 Q. Do you recall ever discussing with
8 Purdue with regards to OxyContin anything like
9 that in order to make a claim about reduced abuse
10 potential?
11 A. I don't remember that.
12 Q. Let me show you the next exhibit. I
13 think it's kind of unfair to ask you if you
14 remember discussion back on October 6, 1992, so
15 why don't I just show you the letter.
16 A. Thank you.
17 (Wright Exhibit 3 for identification,
18 document bearing Bates production number
19 8113900032 through 8113900043.)
20 A. Okay, it looks like a letter that
21 Dr. Reder sent me, a series of Kenzie's and Don's
22 article on Tramadol.
23 Q. I apologize, but I hadn't given you
24 the September 29th letter that I think he's
25 talking about.

80

1 CURTIS WRIGHT, IV, MD, MPH
2 (Wright Exhibit 4 for identification,
3 document bearing Bates production number
4 8113900019 through 8113900024.)
5 A. Yes, this looks like presentations
6 that were done by -- studies that were done by
7 Don.
8 Q. Looking at the letter on
9 September 28th, 1992 that Dr. Reder sent you, I
10 guess it starts on the second page after the
11 abstract.
12 A. Yes.
13 Q. He discusses an adjective checklist
14 which is then attached. Are these some of the
15 adjectives that Dr. Jasinski would use in his
16 abuse potential studies?
17 A. Yes.
18 Q. Do you remember why you and Dr. Reder
19 were discussing the use of such questionnaires
20 for OxyContin?
21 A. Yes. One of the issues for OxyContin
22 was what the role of pharmacodynamics would be,
23 the relationship between blood level and opioid
24 effect in analyzing the results. All of -- most
25 of the opioid effects -- most of the abuse

81

1 CURTIS WRIGHT, IV, MD, MPH
2 studies -- most of the -- I'm not making myself
3 clear.
4 There's a difference between high,
5 like and pay money for. And cloudy, confused,
6 hallucinating, sick, dizzy. And the difference
7 is those checklists could be interpreted by
8 patients. If I took a patient and asked him how
9 high are you, I have no idea what answer I would
10 get. And if I gave him a standard adjective
11 checklist for -- that's used by the Addiction
12 Research Center, some of the questions would be
13 utterly baffling. If I asked you what
14 soap-boxing was, you might guess but you wouldn't
15 have any real idea what that was. If I asked if
16 you were on the nod, I hope you would not know
17 what that meant.
18 So what I wanted Purdue to do at that
19 time -- now, want/suggest that it might be
20 helpful, not a regulatory requirement, was can
21 you develop an opioid effect, not abuse
22 liability, but opioid effect measurement that
23 could be used to try to link the pharmacokinetic
24 blood levels of the drug to the pharmacodynamic
25 effects of the drug. And take as a starting

82

1 CURTIS WRIGHT, IV, MD, MPH
2 point adjective checklist items, adverse events,
3 and as I remember the application, Purdue did
4 wrestle with this issue, found that most of the
5 adjectives pertaining to addicts were completely
6 unresponsive in normal volunteers. PK volunteers
7 or patients. And I think they actually developed
8 a pretty good measurement of opioid effect, what
9 its relationship would be to abuse I don't know.
10 Q. That's my question. Do you have any
11 idea how this could be related to abuse?
12 A. In exactly the same way that -- for
13 mu-opioids, there is a -- I don't want to say
14 hypothesis. There's a perception that they're no
15 special, or certainly there was in '92 to '94,
16 there are no special attributes that measure
17 addiction -- measure abuse potential, that a
18 mu-opioid is a mu-opioid is a mu-opioid is a
19 mu-opioid is a mu-opioid. And that what you're
20 really measuring is the relative potency of the
21 opioids. How many milligrams of this one equals
22 how many milligrams of that one when you're doing
23 these studies.
24 That's pretty much where the thinking
25 was at that time. That thinking was different

83

1 CURTIS WRIGHT, IV, MD, MPH
2 for a partial agonist and a mixed
3 agonist/antagonist and for other kinds of drugs
4 in the class.
5 I would say that these measures
6 probably measured how strong an opioid effect
7 somebody had, and that one could infer from that
8 that this was an abusable drug, but we already
9 knew that.
10 Q. Right. But let's point it towards
11 comparative purposes. Do you know what studies
12 that Purdue used a modified checklist amongst
13 these adjectives where they compared an immediate
14 release to a controlled release drug?
15 MR. STRAUBER: Objection to the form
16 of the question.
17 A. Since the goal was to assess these
18 opioid tools in patients, and mostly in
19 pharmacokinetic subjects, but I wanted to see if
20 it would work in patients, I certainly hoped they
21 did it and I seem to remember reviewing some of
22 those results, the strength of the conclusions I
23 draw from those I don't know today.
24 Q. Actually, why don't we look at one
25 and we could discuss it with some data in front

84

1 CURTIS WRIGHT, IV, MD, MPH
2 of us.
3 A. Data always helps.
4 (Wright Exhibit 5 for identification,
5 document bearing Bates production number
6 8001000296 through 8001000313.)
7 Q. If it helps, I'm looking at table 7
8 on 308 where I think they have a summary of
9 pharmacokinetics.
10 A. Yes. I just got there, I'm just
11 looking at the -- this appears to be the draft --
12 first draft of the report. I'm not sure this has
13 my review comments on it.
14 Q. I don't think it does. I think I
15 have the review handy, but if you want, I'll show
16 it to you --
17 A. I don't remember instances where
18 there usually were significant differences
19 between my numbers upon review and Purdue's
20 numbers upon submission. And here's a table for
21 this study -- what's your question, sir?
22 Q. My question is looking at table 7, it
23 has apparently some of the data for the modified
24 drug effect questionnaire you had suggested
25 Purdue use back in '92, correct?

85

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Yes.
3 Q. This is a comparative to IR oxycodone
4 and CR oxycodone in pain patients, correct?
5 A. I believe so, yes.
6 Q. And it looks like there's, oh, ten or
7 so categories, right?
8 A. Yes, sir.
9 Q. And that's a combination of both the
10 questions and the observations or is this just
11 the questions?
12 A. I think those were just questions. I
13 think we asked -- the score as I remember it we
14 simply asked for a visual analog rating for each
15 of these issues.
16 Q. Looking at the scores, do you see a
17 clinically significant difference between the
18 numbers for CR oxycodone and IR oxycodone?
19 A. As dosed here, no.
20 Q. Okay.
21 A. But what that means is that on a
22 milligram per milligram basis, if I understand
23 the dosing in the study, 80 milligrams of
24 OxyContin was giving you the abuse effect of 40
25 milligrams of immediate release oxycodone.

86

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. You're saying that the total daily
3 dose of the patients on the immediate release was
4 only 40?
5 A. No. Per single dose.
6 Q. Per single dose.
7 A. I think there may be a fundamental
8 confusion.
9 Q. Okay.
10 A. When someone abuses a drug they're
11 not taking it around-the-clock. They're just
12 taking it dose by dose. When someone takes the
13 80 milligrams here -- as I understand the study,
14 and I have not -- if I were to be definitive
15 about it I'd have to spend more time reviewing
16 the results, but as I understand it, this was an
17 equal daily dose study where the total daily dose
18 was the same, but in one case the IR was given
19 four times a day and the CR was given twice a
20 day.
21 So that would mean that the pill size
22 for the CR would have to be twice that of the
23 IR. So as dosed, I don't see any difference in
24 the abuse liability scores in the study. On a
25 pill for pill, you'd have to give two of the IR

87

1 CURTIS WRIGHT, IV, MD, MPH
2 to be as many milligrams as the CR.
3 Q. Do you see where there's a note there
4 with an asterisk that says "adjusted to
5 80-milligram dose"?
6 A. Yes.
7 Q. Do you know what that means?
8 A. That means that the total -- if it
9 means what it should mean, the scores for both
10 groups were adjusted to a total 80 milligram
11 daily dose.
12 Q. I'm going to show you the next
13 exhibit.
14 (Wright Exhibit 6 for identification,
15 Notes of Discussion.)
16 Q. Do you recall discussing with
17 Dr. Reder in 1993 OxyContin being tested for use
18 in non-cancer pain patients?
19 A. I remember that we had discussions
20 about it. These notes appear to be notes of that
21 kind of discussion.
22 Q. Do you remember talking to him about
23 using OxyContin in clinical trials involving
24 osteoarthritis patients?
25 A. I do not remember the specific

88

1 CURTIS WRIGHT, IV, MD, MPH
2 conversation, but I do remember talking to him
3 about the use of that as a pain model.
4 Q. Looking at this it states that, I
5 guess the third sentence, "of greatest importance
6 is the fact that Dr. Wright said that for certain
7 individuals in the division and in the agency,
8 the use (i.e., long-term) in osteoarthritis is
9 unwarranted. The way the protocols are written,
10 it looks as if Purdue Frederick is attempting to
11 make labeling claims for pain for
12 osteoarthritis."
13 Did you mention that to Dr. Reder
14 back in '93?
15 A. I don't know if I said it that way or
16 not. This may be how Robert heard it. I know
17 what my concern was at the time. Will that help
18 you?
19 Q. Please.
20 A. There was a serious and emerging
21 problem in controlled release opioids during that
22 period of time at the Food and Drug
23 Administration. The ICH guidances and
24 discussions about the ICH guidances and
25 discussions about the FDA's guidances in pain

89

1 CURTIS WRIGHT, IV, MD, MPH
2 continued, and it was becoming progressively
3 clearer that there was a desperate need for
4 placebo controlled studies in chronic pain.
5 It also had become progressively
6 clear that patients with chronic malignant pain,
7 cancer pain, and their physicians were not only
8 not interested in participating in placebo
9 controlled studies but considered participating
10 in such studies -- to enrolling patients in such
11 studies to be unethical and barbaric. And some
12 were quite gratuitive about it.
13 The European community was taking a
14 strong position periodically that placebo
15 controlled trials in chronic conditions like
16 chronic pain were difficult and perhaps
17 unethical. That posed a problem because there
18 were no validated comfortable models for chronic
19 nonmalignant pain. There were models for
20 arthritis, there were models for back pain, there
21 were models for neuropathic pain, but there were
22 no models for that because most of the drugs that
23 were tested in those models were indicated for
24 the disease rather than for a pain condition.
25 And there was concern that if you allowed a study

90

1 CURTIS WRIGHT, IV, MD, MPH
2 in arthritis patients, that the company would
3 come forward and say this is a great drug for
4 arthritis.
5 Well, it's not. This is a drug for
6 pain. Drugs for arthritis are drugs for
7 arthritis. They treat pain, they treat swelling,
8 they improve mobility, they have other
9 antiinflammatory or disease modifying
10 characteristics that a simple pain medicine
11 wouldn't have. It might improve function but
12 your joints would be just as swollen as when you
13 didn't take it.
14 I felt -- I talked about the use of
15 arthritis and low back pain as pain models with
16 multiple companies seeking opioid indications,
17 and each time I did my level best to make it
18 clear that if you got through this, you weren't
19 going to get a label that said that you are a
20 great drug for arthritis. You might get a label
21 that said you were a great drug for pain and your
22 clinical trials section might say that patients
23 with arthritis not adequately managed by
24 arthritis drugs were treated.
25 So that's where that -- that was my

1 CURTIS WRIGHT, IV, MD, MPH
2 thinking at the time.
3 Q. So as to avoid a situation where the
4 drug would become synonymous with treating an
5 entire category of pain as opposed to an
6 intensity of pain.
7 A. Not precisely. The agency had very
8 specific guidances for drugs that were indicated
9 for the treatment of arthritis. And also for
10 drugs that were indicated for modifying the
11 course of arthritis. And if a drug wanted to
12 make an arthritis claim and within the indication
13 sections wanted to say is indicated for the
14 treatment of arthritis or the management of pain
15 due to arthritis, there were things that they had
16 to do that Purdue hadn't done or didn't look like
17 was going to do and probably wouldn't succeed if
18 they did do.
19 Q. Gotcha.
20 Looking at the next page, about
21 midway down, do you see where it says "exclusion
22 criteria"?
23 A. Yes.
24 Q. An exclusion criteria "Dr. Wright
25 suggested we have an exclusion such as 'patient

1 CURTIS WRIGHT, IV, MD, MPH
2 excluded if he/she has satisfactory management of
3 pain with full dose NSAID'. Also at some point
4 we should consider the substance abuse
5 exclusion. We should try to learn what the risk
6 for a recovering abuser in pain is.""
7 Do you remember saying something to
8 that effect to Dr. Reder?
9 A. I don't remember saying it. It
10 certainly was an issue that was very much on my
11 mind at the time. And it persists to this day.
12 If you never study patients with addiction,
13 patients with prior history of abuse, patients
14 with alcoholism, patients with whatever it is,
15 and you try to exclude them from your clinical
16 trials portfolio, you will not know what the risk
17 is for that population.
18 Now, at that time every single
19 sponsor in every single drug class other than
20 treatments for addiction excluded those
21 patients. Everyone. Every division, everywhere
22 throughout the agency. And I thought that was
23 wrong. I thought that you should figure out how
24 to address that either in a separate study or you
25 should address it in your enrollment criteria in

1 CURTIS WRIGHT, IV, MD, MPH
2 the study.
3 That could not be justified in terms
4 of the review criteria -- in terms of the
5 guidances at the time. It has since become a
6 topic for risk assessment and management and has
7 been discussed as to how you might do that safely
8 today.
9 The downside is of course how would
10 you tell a physician in a clinical trial how he
11 could safely enroll a patient with a past history
12 of drug abuse into an opioid trial. Probably
13 can, but how do you do it. And do you need a
14 special protocol, and what's the risk and how do
15 you advise them of the risk and how do you manage
16 it. Those are still tough questions today.
17 Q. And it has to do with of course the
18 risk of, I guess we talked about it, you didn't
19 want to use the term "relapse," but "out of
20 remission" of the addiction?
21 A. Well, the terms are tough because if
22 somebody's got active addiction and they switch
23 to another drug, is that a relapse or is that
24 just switching to another drug?
25 Q. Right.

1 CURTIS WRIGHT, IV, MD, MPH
2 A. There's lots of risk associated with
3 this. Overdose, inappropriate use, increased
4 risk of mortality. Being a drug addict is a
5 dangerous business.
6 Q. I don't think it pays very well
7 either.
8 A. No. And as a result, the IRB --
9 remember, the agency can want something, the
10 sponsor can want something, and the institutional
11 ethics boards can say I don't think that that's a
12 proper thing.
13 MR. McNAMARA: Why don't we break for
14 lunch right now.
15 (Luncheon Recess: 12:15 p.m.)
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17
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25

1 CURTIS WRIGHT, IV, MD, MPH
2 AFTERNOON SESSION
3 12:50 p.m.
4
5 CURTIS WRIGHT, IV, MD, MPH,
6 resumed, having been previously duly sworn, was
7 examined and testified further as follows:
8 CONTINUED EXAMINATION BY MR. McNAMARA:
9 Q. Good afternoon, Dr. Wright. Can I
10 show you our next exhibit.
11 (Wright Exhibit 7 for identification,
12 Project Team Contact Report, 10/22/92.)
13 A. This appears to be a memorandum of a
14 telephone call in '92 between Dr. Reder and
15 myself.
16 Q. Okay, it says here for reason for
17 call, "discussed drug abuse and dependence
18 section of opiate labeling." And under content
19 of discussion it says "Dr. Wright was open to
20 including short definition of dependence, abuse
21 and addition." I assume "addiction" was meant
22 there.
23 Do you remember Dr. Reder asking you
24 about Purdue including some definitions for those
25 terms in their drug abuse and dependence section

1 CURTIS WRIGHT, IV, MD, MPH
2 of their OxyContin label?
3 A. No. I truly don't remember this
4 phone call. I do remember that one of the issues
5 we talked about in terms of the labeling was the
6 extent to which expository material about
7 addiction should be placed in the label.
8 What we were going to put in the drug
9 abuse and dependence section was something that
10 was being looked at extensively all the time from
11 1990 through '95, '97. Mostly through -- '90 to
12 '94. And there was considerable discussion
13 about it.
14 Q. You don't recall them asking you,
15 saying that they wanted to include definitions in
16 the section beyond what might be in had a typical
17 opioid label, do you?
18 MR. STRAUBER: I object to the form
19 of that question.
20 A. All I remember about the discussion
21 was that Purdue had concerns about whether
22 physicians would be as comfortable with the drug
23 addiction terminology as I was. I thought that
24 was a fair concern. And a lot of discussion on
25 whether we needed to put definitions in the

97

1 CURTIS WRIGHT, IV, MD, MPH
2 package insert.
3 Q. You had done work on MS Contin you
4 said, right?
5 A. Yes.
6 Q. What about some of the other opioids
7 out there like Percocet. Any other drugs besides
8 MS Contin?
9 A. If you accept that I was part of the
10 review team, I had worked on most of the opioids
11 that came through the agency. Percocet was not
12 one. That actually went to a different division
13 because of its acetaminophen component. But the
14 strong opioids, the drug abuse staff, which
15 became a group and which its membership morphed
16 over the ten years, wrestled with most of the
17 opioid labels.
18 So I was involved with many of them,
19 heavily involved with some of them, had
20 supervisory or review responsibility for nearly
21 all of the strong opioids.
22 Q. So you're fairly familiar with the
23 labeling for those strong opioids?
24 A. I was -- ten years ago I was.
25 Q. Let's say at this time, were you

98

1 CURTIS WRIGHT, IV, MD, MPH
2 fairly familiar with the labels of the strong
3 opioids?
4 A. Yes, and they were not good.
5 Q. And did they have any definitions on
6 these terms?
7 A. They had very different definitions
8 on these terms. I was concerned about the opioid
9 labeling during this period because some of these
10 drugs had never been reviewed at all. They were
11 labels from before when the FDA had the statutory
12 authority to require testing, some of them were
13 from very early in that period and some of them
14 were from very late.
15 So there was a great deal of
16 heterogeneity between drug products that probably
17 weren't all that different.
18 (Wright Exhibit 8 for identification,
19 document bearing Bates production number
20 8113900235.)
21 A. This appears to be another contact
22 report.
23 Q. Between you and Dr. Reder?
24 A. Yes.
25 Q. It looks like the date is April 23 of

99

1 CURTIS WRIGHT, IV, MD, MPH
2 1993.
3 A. Yes.
4 Q. It says "reason for call. Describe
5 the open protocol OC 92-1101, and ask if we can
6 begin to use it at one center." It says the name
7 Dr. Spalding. And it says under content of
8 discussion, "Dr. Wright said to keep the study
9 simple and be certain the study is not used as a
10 marketing ploy." And that's in quotes.
11 Do you recall the conversation with
12 Dr. Reder about this?
13 A. No, but I have no reason to doubt
14 that it occurred.
15 Q. Do you remember what the open
16 protocol OC 92-1101 was about?
17 A. No.
18 Q. Do you know what you meant about a
19 marketing ploy?
20 A. Absolutely.
21 Q. Could you explain.
22 A. Right about that time elsewhere in
23 the agency there had been some pretty seriously
24 scandalous behavior by a commercial sponsor,
25 fortunately I forget which one, in which a

100

1 CURTIS WRIGHT, IV, MD, MPH
2 research protocol number and an IND request had
3 been used as a thinly veiled mechanism for paying
4 high volume prescribers large sums of money for
5 not doing any work.
6 These later came to be called
7 variants of what was called a ceding study. And
8 in that particular case -- in some cases, and
9 again, I can't give the particulars because they
10 weren't in my division and I don't know, there
11 were actually charges filed against some firms
12 for inappropriate promotional behavior.
13 I think what I meant to Dr. Reder in
14 this telephone call was that I wanted -- if they
15 were going to do a study, I wanted to see a
16 legitimate study with a legitimate purpose and at
17 legitimate levels of reimbursement for the
18 investigators.
19 Q. And with an open label study, there
20 would be more potential for this kind of ceding
21 to occur.
22 A. Yes, sir.
23 Q. The investigators would know I'm only
24 using their product, getting paid money to use
25 their product -- understood, okay.

101

1 CURTIS WRIGHT, IV, MD, MPH
2 I'll show you the next exhibit.
3 (Wright Exhibit 9 for identification,
4 8113900315 through 8113900323.)
5 A. This appears to be a memorandum of a
6 team meeting that was held on August 30th, 1993.
7 Q. This would have been an internal team
8 meeting at Purdue, right?
9 A. Yes.
10 Q. You weren't a party to it.
11 A. No.
12 Q. If I can focus your attention to page
13 316, page ending 316 on the Bates ranges, do you
14 see 1.6, medication odor?
15 A. Yes.
16 Q. It states that "Robert Reder opened a
17 discussion on the recent clinical
18 (patient/pharmacist) study coordinates and
19 reports that OxyContin tablets packaged in
20 multiple dose containers emitted an odor."
21 Had you ever heard anything like that
22 about OxyContin?
23 A. No.
24 Q. Was it ever brought to your attention
25 that the acrylic or the eudragit used in making

102

1 CURTIS WRIGHT, IV, MD, MPH
2 the tablets may exhibit an odor?
3 A. But that is not unusual. The people
4 in the agency who would hop right on that would
5 be the chemists.
6 Q. That could be a compromising factor
7 to blind studies, correct, if a medication has a
8 certain odor?
9 A. It depends. It depends on how the
10 placebo was made. If the same eudragit was made
11 for the placebo and for the active, you couldn't
12 tell the difference. But if you could see a
13 difference between batches and that difference
14 was meaningful, when people inspect the
15 difference between active and placebo, they tend
16 to be really looking.
17 And it's not clear how often that
18 actual patients in the trial can look that close
19 and tell that difference because they only get
20 one treatment. They don't get both.
21 Q. I notice here it says looking at the
22 sentence again, "Robert Reder opened the
23 discussion in the recent clinical
24 (patient/pharmacists) study coordinates." So
25 apparently few patients had noticed.

103

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Yes. Something stunk.
3 Q. Do you see any reference in that
4 paragraph to the placebos having an odor?
5 A. No. If the study was ongoing, no one
6 would know which pill was which. The blind would
7 still be running, so you wouldn't know.
8 Now, I don't know which protocol he
9 was talking about. It's a potential problem, but
10 you're absolutely right, it did.
11 Q. I guess the problem comes because
12 there could be bias by the investigators if they
13 were to learn that the study drug had a
14 particular odor as opposed to the drug that you
15 were comparing it against.
16 A. If they knew which was which. And if
17 they could identify active from placebo and they
18 were of a mind, they could influence the
19 results. And that's why trying to get the two
20 dosage forms so you can't readily tell them apart
21 is considered an important part of the study.
22 Q. Looking on page ending in 319,
23 looking under -- there's a section marked
24 potential studies at the bottom. If I could
25 direct your attention there, it states that Mike

104

1 CURTIS WRIGHT, IV, MD, MPH
2 Innaurato – did you have contact with Mike
3 Innaurato?
4 A. I think I interacted with him over MS
5 Contin.
6 Q. But you don't recall interacting with
7 him over OxyContin?
8 MR. STRAUBER: You're going back to
9 the time when Dr. Wright was at the FDA?
10 Q. When you were at the FDA.
11 A. I don't know.
12 Q. "Mike Innaurato said that an
13 OxyContin versus Percocet comparative study would
14 be useful for marketing purposes. Though such a
15 study has previously been conducted and published
16 in abstract form, it was a single dose study
17 using non-GNP released material. Mike Innaurato
18 stated that a multiple dose study would be best
19 to support claims relating to relief of post
20 surgical pain, low back pain and herpetic
21 neuralgia pain. Mike Innaurato stated marketing
22 would like to position differently than MS
23 Contin."
24 I assume you know the study he's
25 referring to, OC 88-1105, a single dose study.

105

1 CURTIS WRIGHT, IV, MD, MPH
2 A. I'm sure I did ten years ago. But
3 can you refresh my recollection on which study
4 88-105 study is.
5 Q. A single dose study comparing
6 OxyContin, Percocet, placebo and I believe single
7 entity immediate release oxycodone for 180 post
8 op patients. Albert Sunshine was the lead
9 investigator.
10 A. Right, Sunshine, okay.
11 Q. Mr. Innaurato suggests here that they
12 do further comparative studies to best support
13 claims relating to relief of post surgical pain,
14 low pack pain and herpetic neuralgia pain. That
15 seems to be studies focused on specific pain
16 syndromes as opposed to the intensity of pain,
17 correct?
18 A. Sure.
19 Q. This goes back a little to what we
20 discussed earlier about the concerns with
21 osteoarthritis not being a drug for the treatment
22 of a particular kind of pain but for an intensity
23 of pain, that being –
24 MR. STRAUBER: I object to the form
25 of the question.

106

1 CURTIS WRIGHT, IV, MD, MPH
2 A. That's not quite right.
3 Q. Then please –
4 A. That's not quite right. Everybody
5 who's got pain has to have some diagnosis. And
6 physicians want to know what kind of diagnosis
7 the patient has in trying to decide whether these
8 study results or this drug or whatever it is
9 you're offering is good for their patients
10 because their patient has pain from
11 osteoarthritis, arthritis, whatever it might be.
12 What becomes – where this gets
13 tricky is if the painful condition has dimensions
14 that go beyond pain but go into disability, go
15 into inflammation, go into a clinical course for
16 the condition that has – that are not addressed
17 by the drug under question, this is best
18 developed for arthritis in that a drug for
19 arthritis should address the inflammation and
20 should address functionality, not just pain
21 relief.
22 So I'm not – if you're asking my
23 opinion now of this, it is perfectly appropriate
24 to want to know how the drug works for
25 appropriately selected patients with certain

107

1 CURTIS WRIGHT, IV, MD, MPH
2 kinds of pain. But it is drifting in the wrong
3 direction when you say everybody with arthritis
4 needs narcotics.
5 Q. And the same would be if everybody
6 post op pain needed a controlled release opioid
7 around-the-clock for an extended period of time.
8 A. Certainly there are many surgeries
9 that do not require that kind of analgesic.
10 Q. And I guess the same would be true of
11 low back pain, that there are kinds that could
12 require such an opioid and there's others that
13 would not.
14 A. I'm not sure whether it's kinds, but
15 there's certainly intensities. The general
16 suggestions among the pain management community
17 are to use something like the WHO ladder, if you
18 were, then you would pick patients at the
19 appropriate step of the ladder and that would be
20 the population.
21 Q. Reading on – well, the last sentence
22 says, "Mike Innaurato states marketing would like
23 to position differently than MS Contin."
24 Were you ever told by anyone at
25 Purdue that they wanted to position OxyContin

108

1 CURTIS WRIGHT, IV, MD, MPH
2 differently than MS Contin?
3 MR. STRAUBER: You're back again in
4 the time that Dr. Wright was with the FDA?
5 Q. The documents that I'm showing you
6 with regards to the early '90s when you were
7 still at the FDA, I think you can safely presume
8 I'm talking about when you were at FDA.
9 A. I don't know if it was specifically
10 brought to my attention that Purdue's marketing
11 department wanted to position the drug
12 differently from MS Contin. And I'm not sure
13 that that would have been an issue prior to
14 approval.
15 Q. The next paragraph states that
16 "Robert Reder stated that the FDA suggested that
17 we do not issue claims supporting the general use
18 of a Schedule II opioid in patients with
19 nonmalignant pain."
20 Do you remember giving Robert Reder a
21 suggestion of that type?
22 A. Actually, we discussed that in one of
23 the last exhibits. What I think -- the issue
24 that was on my mind was I don't want you to say
25 that every patient with arthritis or

109

1 CURTIS WRIGHT, IV, MD, MPH
2 osteoarthritis needs a Schedule II opioid.
3 Q. This here says with nonmalignant
4 pain. Do you recall ever talking to him in terms
5 of low back pain or some of the other --
6 A. Oh, yes. Those were the study
7 designs that we were talking about.
8 Q. Right. And do you recall giving him
9 a similar message as you talked about with
10 osteoarthritis with regards to low back pain?
11 A. My concern would have been
12 generalized to any condition, any nonmalignant
13 position, low back pain, osteoarthritis,
14 headache, neuralgia and neuropathic pain.
15 Q. "Robert Reder indicated that
16 decisions to make additional claims could be
17 developed after the product is marketed. Jim
18 Conover agreed with Robert Reder but added that
19 any study conducted in patients with nonmalignant
20 pain could be included in the clinical study
21 section of the package insert. Robert Reder
22 added that any proposed marketing claims in their
23 supporting studies should be first reviewed with
24 our legal and regulatory departments. Perhaps
25 the marketing concepts could be reviewed now."

110

1 CURTIS WRIGHT, IV, MD, MPH
2 What's the significance of putting
3 clinical study information in the clinical study
4 section of a product label?
5 A. When the clinical study section --
6 not all studies done by a sponsor make it into
7 the clinical study section of the product
8 labeling. Studies have to reach a certain
9 threshold of appropriateness and adequacy to get
10 into that section.
11 In general, it's easier to defend
12 promotional information or materials relevant to
13 that -- to such claims if the label has that
14 language in it.
15 I'm a little entertained by this
16 because having the regulatory and clinical people
17 of the company arguing over what the FDA is or
18 isn't going to allow is interesting but I'm not
19 sure carries much meaning.
20 Q. My next exhibit is going to be the
21 December 5th, 1995 label. However, I think you
22 already have that. And I think you might have a
23 better copy than I do.
24 A. I'm not sure. I have the
25 January 23rd, 1996 version.

111

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. That's fine I think.
3 OxyContin was approved in December of
4 '95. Do you recall that?
5 A. I don't remember the date, but '95
6 sounds like the right year.
7 Q. So I won't -- actually, if we could
8 mark yours because mine is -- well, we'll get on
9 the same page. Let me give you I believe the
10 March 2000 label.
11 A. I'm not sure by March of 2000 it
12 hadn't been changed somewhat.
13 Q. I'll ask you about that.
14 (Wright Exhibit 10 for
15 identification, document bearing Bates production
16 number 7501020320 through 7501020327.)
17 Q. The section I'm going to focus on is
18 the drug abuse and dependence section on page
19 ending 325 of the exhibit. Bates ending 325.
20 A. Yes, sir.
21 Q. I think if you look at the January
22 1996 label, I don't think that subsection has
23 been changed. Or changed between March 2000 and
24 January 1996.
25 MR. STRAUBER: Are you asking him a

112

1 CURTIS WRIGHT, IV, MD, MPH
2 question or is that just an observation?
3 Q. I was asking a question.
4 MR. STRAUBER: You're asking whether
5 it was changed?
6 A. I don't know if it was changed or
7 not. Do you wish me to examine it line by line
8 and determine if it's the same? I truly don't
9 know what changes -- if changes were made.
10 MR. STRAUBER: You're saying yes, you
11 want him to do it?
12 A. It looks certainly very similar, if
13 not identical.
14 Q. Now, looking at the sentence right
15 underneath drug abuse and dependence -- first of
16 all, the drug abuse and dependence section is
17 located in the product labeling I guess under
18 the -- well, it comes -- would you say it's under
19 the precautions section or is it just a separate
20 section on itself?
21 A. It is both considered one of the
22 precautions and it's also a separate section on
23 its own. I remember that during this period we
24 felt that it was important to put the drug abuse
25 and dependence section next to overdosage for

113

1 CURTIS WRIGHT, IV, MD, MPH
2 obvious reasons. And also to begin to try to
3 encourage sponsors to wrestle with use and
4 addiction because we were seeing off-label use of
5 a number of drugs that were not approved for use
6 in the treatment of addiction in the treatment of
7 addiction.
8 Q. So looking at the drug abuse and
9 dependence section, it says underneath that
10 "OxyContin is a mu-agonist opioid with an abuse
11 liability similar to morphine and it's a
12 Schedule II controlled substance."
13 From that sentence, "abuse liability
14 similar to morphine," is that referring to the
15 legal abuse liability or the medical abuse
16 liability?
17 MR. STRAUBER: I object to the form
18 of the question. Or both? Is that part of your
19 question?
20 Q. Yes, or both.
21 A. I don't think it's particularly clear
22 from the context what it's referring to, whether
23 it's referring to those two groups. The degree
24 of sophistication in thinking about abuse
25 liability relative to patients and abuse

114

1 CURTIS WRIGHT, IV, MD, MPH
2 liability relative to addicts or abusers was
3 pretty primitive back then.
4 Q. Looking at the next sentence, it
5 says, "Oxycodone products are common targets for
6 both drug abusers and drug addicts," correct?
7 A. Affirmative.
8 Q. And then the last sentence says,
9 "Delayed absorption as provided by OxyContin
10 tablets is believed to reduce the abuse liability
11 of a drug."
12 A. That is correct.
13 Q. Now, do you recall if that sentence,
14 "delayed absorption as provided by OxyContin
15 tablets is believed to reduce the abuse liability
16 of a drug," was in the MS Contin label?
17 A. I don't recall.
18 Q. Do you know if that was in any other
19 drug label involving a controlled release
20 opioid?
21 A. I don't know.
22 Q. Do you recall ever seeing that
23 language in any controlled release opioid label
24 besides OxyContin?
25 A. No. But I don't think it would be.

115

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Why?
3 A. Although the agency personnel are
4 called upon to provide a common standard, there
5 is learning product by product and label by
6 label. By the time OxyContin came along there
7 were a number of things happening in the pain
8 treatment area that were bothersome. And this
9 was -- in this particular case -- I do not
10 remember extensive discussion about this line,
11 which, frankly, as I read it, is a relatively
12 weak statement.
13 But it's probably as much as Purdue
14 could have said in trying to accede to my
15 request, which I do remember making, that they
16 talk somehow about the abuse liability of their
17 product instead of just oxycodone.
18 Q. You had made a request that they talk
19 more about the abuse liability of the controlled
20 release form as opposed to just the drug itself
21 oxycodone?
22 A. Right. We had by that time some
23 significant differences -- how far do you want me
24 to go in explaining this, because it's complex?
25 Q. Please, go ahead.

116

1 CURTIS WRIGHT, IV, MD, MPH
2 A. There was increasing evidence that
3 dosage form mattered in terms of abuse
4 liability. This was most significant with people
5 that wanted to bring forward novel dosage forms
6 that substantially enhanced abuse liability of a
7 product.
8 We'd just been through right about
9 this time, and I can't remember the relative
10 timing because it's a long time ago, we'd just
11 been through a number of discussions with respect
12 to people who wanted to make inhaled morphine,
13 morphine nasal spray, various and sundry kinds of
14 tobacco alternative products. And I think the
15 agency was getting ready for a change because
16 four or five years after this there was a clear
17 bright line distinction that we're going to look
18 at the abuse vulnerability for tampering and use
19 as directed for dosage forms.
20 At the time the DEA took a very
21 strong position that they did not care about
22 dosage forms. They regulated drug substances,
23 and drug product were going to be scheduled
24 according to the drug substance, not the drug
25 product.

117

1 CURTIS WRIGHT, IV, MD, MPH
2 The emerging thinking in the drug
3 abuse staff was that it was going to be important
4 to try to provide some guidance to people who
5 were going to have to prescribe the product.
6 Most of the controlled release
7 products had been approved before that, before
8 that thinking had gotten to that stage. I don't
9 think for MS Contin there was much thinking about
10 that at all, but I don't know. I was not at the
11 agency for the original approval of MS Contin.
12 So my comment no but there wouldn't
13 have been was because right around this time the
14 concept of the dosage form mattered and we ought
15 to say something about that was beginning to
16 emerge.
17 Q. You mentioned dosage form mattered
18 and I think you gave a couple of examples of how
19 an inhaled product or other kind of products
20 could, as you said, increase the abuse
21 liability. Correct?
22 A. That's correct, sir.
23 Q. What studies had been done up to then
24 that the delayed absorption that a controlled
25 release product may have reduce the abuse

118

1 CURTIS WRIGHT, IV, MD, MPH
2 liability?
3 A. How far back do you want me to go?
4 Q. Well, how about 1995, about the time
5 of OxyContin approval.
6 A. There was a fair amount of
7 accumulated evidence by then that the lower and
8 the slower, the less abuse liability that one
9 could anticipate. This had been an issue for a
10 long time because drugs in some dosage forms had
11 relatively low abuse liability and in other
12 dosage forms had very severe abuse liability.
13 The National Institutes of Drug Abuse
14 in this period was taking a very strong position
15 that the difference between cocaine hydrochloride
16 and smoked crack cocaine had a basis in
17 pharmacokinetics and pharmacodynamics and that
18 they could measure those differences. They did a
19 number of studies looking at that issue, and
20 certainly for cocaine. They were very
21 comfortable that the arterial cocaine levels and
22 the magnitude and speed arise could be very
23 readily demonstrated to relate to the magnitude
24 of the effect and the abuse liability.
25 The barbiturates research done around

119

1 CURTIS WRIGHT, IV, MD, MPH
2 that time showed that the rate of rise in the
3 central nervous system correlated well with
4 liking. The nicotine research that had been done
5 strongly suggested that that was the case for
6 nicotine. I'm explaining some of the differences
7 between the nicotine replacement products and
8 cigarettes.
9 And there been actually some work
10 done with opioids, both what I'll call survey or
11 soft science looking at the street price of
12 various opioid dosage forms and some harder
13 science looking at actual abuse liability when
14 they gave the drug slower and lower than when
15 they gave the drug more rapidly.
16 So I think we were pretty confident
17 by 1995 that as a general principle this was
18 correct.
19 Q. What do you mean by lower when you
20 say lower and slower?
21 A. That if you produced peak blood
22 levels that were higher, you'd get increased
23 abuse liability. And if you got the same blood
24 levels and faster, you could produce increased
25 abuse liability. And conversely, if you slowed

120

1 CURTIS WRIGHT, IV, MD, MPH
2 it or you dropped the blood level, either one or
3 both would reduce the subjective effects of the
4 drug as they related to liking and drug effect in
5 drug-seeking behavior.
6 Q. You mentioned there had been
7 potential studies with regards to opioids by this
8 time.
9 A. Yes.
10 Q. Do you remember what those were?
11 A. I'd have to go look in my files.
12 Most of the work that had been done had been done
13 in the other direction. It had been done in
14 terms of speeding up opioids. Smoked versus
15 injected. It had been done looking at which
16 dosage forms commanded which prices and what
17 liking you saw.
18 Off the top of my head I can't say
19 when, which opioid rate studies had been done by
20 that time. Since that time there's been some.
21 Q. Have there been any involving
22 OxyContin that you know of?
23 A. I don't think I can answer that right
24 now because I don't remember all of the opioids
25 that were used in those studies. Most of them

121

1 CURTIS WRIGHT, IV, MD, MPH
2 prototypically were done with morphine.
3 Q. Would this be comparing -- you
4 mentioned the one you had some knowledge of
5 involving Buprenorphine, and actually, you didn't
6 identify what the immediate release opioid was.
7 A. Buprenorphine.
8 Q. Just a controlled release versus the
9 immediate release?
10 A. That was the first time I knew of
11 that someone had taken the pharmaceutical dosage
12 form and knocked it head to head against the
13 immediate release dosage form.
14 Q. When was that done?
15 A. The study was started in '98, '99 and
16 ran until about 2001, 2002. I can't remember.
17 It turned out to be an amazingly difficult study
18 to do for a variety of technical reasons.
19 Q. Were most of them related to the
20 study medication which has this mixed agonist --
21 A. No, most of them were related to --
22 when you do these kinds of studies, especially
23 the more treatment arms you add, you're asking
24 someone to check into a residential treatment
25 facility for a week or two weeks or three weeks

122

1 CURTIS WRIGHT, IV, MD, MPH
2 or a month. And there are relatively few people,
3 even drug addicts, whose idea of how to spend
4 their summer is to check into a clinical
5 pharmacology research unit. So recruitment for
6 these studies proved to be very challenging and
7 very long.
8 Q. So you said that was the first one
9 that you know of where there was actually a
10 head-to-head comparison between the controlled
11 release form of an opioid and an immediate
12 release?
13 A. The first one where somebody tried to
14 do everything right. Identical delivery, the
15 actual clinical dosage form and approved
16 parenteral dosage form of exactly the right
17 amount. Both were given in multiples of the
18 clinical dose, which is relatively uncommon.
19 Drug abusers usually take multiple doses, not the
20 approved dose. All of those things were done and
21 Dr. Bigelow I think was proud of the results.
22 Q. Let's look on the next sentence back
23 in the product label, drug addiction. Drug
24 dependence, psychological dependence. Those
25 terms are used fairly much interchangeably,

123

1 CURTIS WRIGHT, IV, MD, MPH
2 right? Addiction and psychological dependence?
3 A. No. They're not used interchangeably
4 by all parties. What I believe was intended here
5 was to try to round up those concepts to reflect
6 the fact that when you're talking about the
7 patients who have that problem, it doesn't matter
8 whether you call them drug addicts or people with
9 drug dependence or people with psychological drug
10 dependence. You're dealing with the same group
11 of people.
12 Q. Gotcha. "For these people, drug
13 dependence, psychological dependence, is
14 characterized by a preoccupation with the
15 procurement, hoarding and abuse of drugs for
16 nonmedicinal purposes. Drug dependence is
17 treatable, utilizing a multidisciplinary
18 approach, but elapse is common." You'd agree
19 with that, right?
20 A. That's right.
21 Q. "Iatrogenic addiction to opioids
22 legitimately used in the management of pain is
23 very rare. Drug-seeking behavior is very common
24 in addicts. Tolerance and physical dependence in
25 pain patients are not signs of psychological

124

1 CURTIS WRIGHT, IV, MD, MPH
2 dependence."
3 I think we talked about that earlier
4 in terms of tolerance and physical dependence in
5 pain patients and whether they have some
6 diagnostic value with regards to addiction.
7 A. I think one could probably change
8 this if one wished.
9 Q. To?
10 A. Are not necessarily.
11 Q. Here also the "not" is italicized,
12 correct?
13 A. Yes.
14 Q. If you look at the '96 one in front
15 of you, was it italicized or underlined? Or was
16 there any special font for the "not"?
17 A. It was underlined. Now, that is a
18 concept that was very common in the treatment
19 guidelines that were being written right around
20 that period. When you start looking at the AHCPR
21 guidelines and the American Pain Society
22 guidelines, they're pretty definitive about the
23 fact they don't want physical dependence or
24 tolerance to be perceived as dependence in
25 chronic pain patients. And the reason is that if

125

1 CURTIS WRIGHT, IV, MD, MPH
2 you did that, you'd be more likely to hurt a pain
3 patient.
4 Q. If I can, I'm going to show you the
5 next exhibit, and you can take a look at it,
6 although we're only going to talk about one
7 specific section of it.
8 (Wright Exhibit 11 for
9 identification, document bearing Bates production
10 number 8002017468 through 8002017497.)
11 A. This appears to be some version of
12 the annotated package insert.
13 Q. If you look at the first page where
14 it says "application summary, annotated package
15 insert including patient instructions," do you
16 know if this would be the version -- well, this
17 would be the version that gets submitted as part
18 of the new drug application, correct?
19 A. All of them would be versions. I
20 mean, there were many versions that were
21 submitted as part of the new drug application.
22 They'd all look about like this.
23 Q. Do you remember when the new drug
24 application was submitted?
25 A. No.

126

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Does December 1994 sound about
3 right?
4 A. When it was it approved?
5 Q. December of 1995. Does that sound
6 right?
7 A. Then December of 1994 sounds about
8 right.
9 Q. If you'll look at the last page where
10 it has the date on this label, do you see where
11 it says December 16th, 1994?
12 A. Yes.
13 Q. So this would be about around the
14 time --
15 A. This would be about the time of
16 submission.
17 Q. Of the submission.
18 A. But just of submission.
19 Q. Let's if we could look at -- and the
20 purpose of having an annotated version I guess
21 is, on the left is the information about the
22 package insert as it is and the right would be,
23 roughly stated, the reference for that section?
24 A. Where you find it, what justification
25 you would find for it, where you would look in

127

1 CURTIS WRIGHT, IV, MD, MPH
2 the NDA to discuss it.
3 Q. Can you turn to the page Bates ending
4 487. This is the section that says "drug abuse
5 and psychological dependence."
6 A. Uh-huh.
7 Q. And underneath psychological
8 dependence, addiction/drug abuse it says
9 "psychological dependence (addictio)n to opioids
10 is characterized by an overwhelming preoccupation
11 with the procurement, hoarding and abuse of these
12 drugs for nonmedicinal purposes." To the right
13 it says MS Contin tablets package insert.
14 A. Yes.
15 Q. So I guess the reference to support
16 would be the already approved MS Contin package
17 insert for that description. And that's sort of,
18 I think you had a similar description of
19 addiction earlier in terms of the main
20 manifestation or symptomatic basis for that
21 diagnosis, right?
22 A. All of these definitions end up
23 dancing around the same concept and trying to say
24 them in different ways.
25 Q. Next sentence says, "psychological

128

1 CURTIS WRIGHT, IV, MD, MPH
2 dependence is best treated utilizing a
3 multidisciplinary approach but recidivism is
4 common." I think we already talked about that.
5 The sentence after that says,
6 "iatrogenic addiction is very rare and tolerance
7 as well as physical dependence are not signs of
8 psychological dependence; nor is psychological
9 dependence necessarily accompanied by tolerance
10 and physical dependence."
11 Looking to the right of that
12 sentence, it seems to cite Porter 1980 and
13 Fishbain 1992. Are you familiar with those two
14 references?
15 A. I've looked at them. I can't quote
16 them from memory. Porter is Porter and Jick I
17 believe. And Fishbain was a survey on --
18 Fishbain was an article on transference in
19 prescription of opioids.
20 Q. Do you remember if the Fishbain -- it
21 was a review article basically --
22 A. If it's the article I think it is, it
23 was an expository article talking about
24 countertransference issues and issues pertaining
25 to the use of opioids that cited in the course of

129

1 CURTIS WRIGHT, IV, MD, MPH
2 the argument a number of surveys and studies and
3 articles that had been dealt with in that -- that
4 dealt with relevant issues as they came up.
5 Q. Now, if you received something like
6 this from a drug company, would you look at those
7 references and make sure that they would actually
8 support what the language in the label that was
9 being proposed?
10 A. Yes and no. If a statement was
11 controversial, was not consonant with what we
12 already believed, then those references would be
13 examined fairly carefully. If the statement came
14 in and it was the same kind of statement that you
15 saw in multiple applications and you were very
16 familiar with the literature, then you wouldn't
17 go chasing down those references.
18 Q. Would you say you're very familiar
19 with the Porter and Jick 1980 letter to the
20 editor which is referenced here?
21 A. No, I would not say that I'm very
22 familiar anymore with Porter and Jick. What I
23 was familiar with at that time were the
24 discussions in and around the HCRP guidelines,
25 which from my perspective trumped any

130

1 CURTIS WRIGHT, IV, MD, MPH
2 individuals' opinions or contributions.
3 Q. And those guidelines indicated
4 iatrogenic addiction is very rare?
5 A. Yes.
6 Q. Do you know what those guidelines are
7 based on?
8 A. A consensus development process that
9 went -- that is described in the document.
10 Frankly, at the time I must confess a certain
11 civil service behavior in that I sought out what
12 the best available government advice was, read it
13 and said this makes sense to me.
14 (Wright Exhibit 12 for
15 identification, Porter and Jick Letter to the
16 Editor.)
17 A. This is the Porter and Jick letter to
18 the editor.
19 Q. And this is I guess dated 1980. It's
20 kind of hard to see on this particular copy. But
21 have you ever seen this before?
22 A. Yes.
23 Q. Have you ever talked to Drs. Porter
24 or Jick about this?
25 A. No.

131

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Have you ever talked to Drs. Porter
3 and Jick at all?
4 A. No.
5 Q. I'm going to read through it rather
6 briefly since it's rather short. To the editor.
7 "Recently, we examined our current files to
8 determine the incidence of narcotic addiction in
9 39,946 hospitalized medical patients who were
10 monitored consecutively. Although there were
11 11,882 patients who received at least one
12 narcotic preparation, there were only four cases
13 of reasonably well-documented addiction in
14 patients who had no history of addiction. The
15 addiction was considered major in only one
16 instance. The drugs implicated were merperidine
17 in two patients, Percodan in one and
18 hydromorphone in one. We conclude that despite
19 widespread use of narcotic drugs in hospitals,
20 the development of addiction is rare in medical
21 patients with no history of addiction."
22 Looking over the text, do you see
23 where it says "the addiction was considered major
24 in only one instance"?
25 A. Yes.

132

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you know what the distinction
3 would be between a major addiction and a minor
4 addiction?
5 A. I would have to seek more closely to
6 determine what the instance -- what that
7 difference would be.
8 Q. In your treatment of addicted
9 patients, would you refer to some addicts as
10 major addicts and minor addicts?
11 A. It depends on what they mean by
12 addiction. And that's the problem with articles
13 from this period. If what addiction means was
14 that there was an episode or two of drug-seeking,
15 or somebody had evidence of tolerance, or
16 somebody thought there might be an issue of
17 addiction, that might very well be classified as
18 minor addiction.
19 They did the Tramadol study. They
20 ended up having to classify whether they thought
21 this was a clear cut evidence of a major drug
22 dependence syndrome or whether the evidentiary
23 weight was lower than that.
24 The Boston Collaborative Drug Study
25 was one of the icons -- drug program was one of

1 CURTIS WRIGHT, IV, MD, MPH
2 the icons of the early days of
3 pharmacoepidemiology. In fact, the current risk
4 management/risk assessment guidelines asks for
5 companies to try to make use of such programs or
6 to establish such programs when they're dealing
7 with uncommon risks of their drugs. Risks where
8 clinical trials are not an appropriate mechanism
9 to find them.
10 I don't think that Porter and Jick by
11 itself could be considered dispositive proof that
12 addiction -- that iatrogenic addiction is rare.
13 I am more convinced when I look at every
14 generation, every decade of physicians looking at
15 this issue which has been an issue that's been of
16 concern to American medicine for over a hundred
17 years. Each time physicians look, what they find
18 is that properly managed patients have relatively
19 few problems with dependence. But when they look
20 at catchment populations that end up not doing
21 well and ending up in high end tertiary pain
22 management center or ending up in trouble, that
23 they find that those patients have a relatively
24 high instance of drug dependence. And that's
25 what you would expect. The prognosis rate of

1 CURTIS WRIGHT, IV, MD, MPH
2 schizophrenia is low but the rate of
3 schizophrenics in mental hospitals is high.
4 Q. Are you talking about pain clinics as
5 being akin to places where you'd find most
6 addicts?
7 A. No. What I'm saying is that -- to
8 try to -- this is an issue that people care
9 about. And they've tried different ways to look
10 at it. The Boston Collaborative Drug
11 Surveillance Program was the program that did
12 some of the -- if I'm correct -- did some of the
13 basic research in negative detailing, adverse
14 events of drugs, large scale
15 pharmacoepidemiologic surveillance, risk factors
16 for medication. It's a pretty prestigious
17 program. I'd believe Porter and Jick if they
18 told me something.
19 So you have that data point. You
20 have the heroin studies from the 1910s. You have
21 the burn center unit studies, you have a series
22 of studies of people trying to wrestle to the
23 ground what this is.
24 And frankly, I took the position that
25 that was not the major problem, that the

1 CURTIS WRIGHT, IV, MD, MPH
2 frequency of iatrogenic dependence, and I've
3 always taken this position, that the frequency of
4 iatrogenic dependence is much lower than the
5 likelihood that the practitioner will be faced
6 with someone with an active addiction problem
7 that they're going to have to manage.
8 Q. It's much lower -- you're saying
9 you're more likely to find a pain patient who's
10 not an addict than is an addict?
11 A. No. What I'm trying to say is that
12 when you have an addiction or abuse problem
13 that's turning up in your practice, the rate
14 among individuals who have active addiction or
15 abuse problems is much higher than the rate among
16 legitimate pain patients who are being treated.
17 And that's in properly treated chronic pain
18 patients.
19 Q. Right, which has a lot of
20 qualifications to it which we talked about
21 before. And I'm trying to understand, pain
22 patients ending up, say, in a pain management
23 clinic -- let me back up.
24 You alluded to it before, there have
25 been a lot of studies related to patients in

1 CURTIS WRIGHT, IV, MD, MPH
2 multidisciplinary pain management clinics where
3 there's a higher rate of abuse of their
4 medications reported, correct?
5 MR. STRAUBER: No, that's not what he
6 said.
7 MR. McNAMARA: Well, he could agree
8 with me or not.
9 Q. Are you familiar with such studies?
10 A. Yes. I'm aware of multiple reports
11 of such studies and they report frequencies that
12 are much higher than Porter and Jick.
13 Q. And these would be studies done by
14 such folks as Dr. Charles Chabal?
15 A. Yes.
16 Q. And Dr. Lawrence Robins?
17 A. Yes.
18 Q. And these would be patients who are
19 chronic pain patients presumably going to pain
20 management clinics, correct?
21 A. Prevalent cases in pain management
22 clinics.
23 Q. The personnel at the Boston -- well,
24 the patients at the Boston Collaborative Drug
25 Surveillance Program would have been, according

1 CURTIS WRIGHT, IV, MD, MPH
2 to this, hospitalized patients within those
3 hospitals that were examined by that program,
4 correct?
5 A. Right.
6 Q. Presumably they would be more acute
7 pain patients, correct?
8 A. Not necessarily. I've looked -- for
9 other drugs I've looked at some of the Porter and
10 Jick Boston collaborative reports. And they
11 didn't differentiate for many of their drugs
12 between acute and chronic treatment. And this
13 was a period in history where patients were not
14 burn rushed out of the hospital very rapidly
15 because of cross-containing concerns. Burn
16 patients could be in the hospital for months,
17 vascular disease patients or severe metabolic
18 patients can be in the hospital sometimes for
19 years. That was not common but it was not rare
20 during these years and during my training years.
21 Q. You'd agree that there's nothing in
22 this particular letter that indicates how long
23 any of these 11,882 patients were in the
24 hospital.
25 A. Absolutely correct.

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. In fact, it says who received at
3 least one narcotic preparation, right?
4 A. Yes.
5 Q. In fact, there's not much mentioned
6 in terms of duration of dose, correct?
7 A. That's correct.
8 Q. Dose level.
9 A. Nope.
10 Q. We know a couple of the drugs
11 involved, apparently.
12 A. Yes.
13 Q. Is there any occasion that any of
14 these patients were followed up on after they
15 left the hospital?
16 A. This is a letter to the editor, and
17 it is what it is. And part of the problem with
18 research in this area, and it is a problem of
19 research in this area, is that you can't do the
20 study that you'd like to do. You can't take
21 10,000 pain patients, randomize them to opioid
22 and non-opioid treatment and follow them for ten
23 years and see what happens.
24 In those settings where it's either
25 ethically impossible to do a study or it's not

139

1 CURTIS WRIGHT, IV, MD, MPH
2 clear where or how you would do it, you try to
3 put together what you think you know from all of
4 the various bits that you can find.
5 And people have tried to do that.
6 They've done it in a very difficult way. There
7 are investigators who have written reports that
8 if the patient ever asked for more medicine than
9 I thought they should have, that's drug-seeking
10 and they're an addict. And that's true, there
11 are literally studies of this genre where the two
12 practitioners sat down and said how much do you
13 think you ought to have, and he took more than
14 that so I think that was addiction.
15 Q. Well, you mentioned some of the
16 problems with it. Then what are the reliable
17 data set that practitioners or even someone at
18 the FDA who's looking at a drug label can draw
19 upon to reach a conclusion about whether or not
20 iatrogenic addiction is very rare?
21 A. As with most safety issues, there's
22 not a reliable data set. There's what you have.
23 In this particular case what practitioners have
24 was groups like QDP4 and the pain society saying
25 we've gone through these, we've looked at all of

140

1 CURTIS WRIGHT, IV, MD, MPH
2 them, we've argued for weeks or months, and
3 here's the guidance that we can give you.
4 I think that they're right because
5 there are a lot of different kinds of data that
6 point in exactly the same direction.
7 MR. STRAUBER: When you reach an
8 appropriate point, can we take an afternoon
9 break?
10 MR. McNAMARA: Sure.
11 Q. The data set as related to chronic
12 pain patient, though, does appear to point in a
13 different direction, correct?
14 A. No.
15 Q. You wouldn't say that the studies
16 involving -- that Dr. Chabal and Dr. Robins did,
17 those don't definitively say --
18 A. No. Because there's a scientific
19 problem with -- this issue ends up being one that
20 you have to wrestle with, and it has to do -- and
21 it's a -- I can't remember the technical term for
22 it from my training, but it has to do with things
23 like the prognosis of schizophrenia.
24 This is an issue where this came up.
25 If you look at the prognosis for head injury

141

1 CURTIS WRIGHT, IV, MD, MPH
2 patients, the prognosis for schizophrenia is
3 actually pretty good. Most people with
4 schizophrenia that get treatment, they do pretty
5 well. But when you go to a hospital area and you
6 say okay, what's filling most of your beds and
7 what will fill most of your beds are individuals
8 with very severe, very difficult to treat
9 schizophrenia. What you're really talking about
10 is the process by which individuals move through
11 the healthcare system and where they tend to end
12 up.
13 You also end up having to talk about
14 the quality of care. And the reason for this is
15 that when you end up talking about what's going
16 to happen to you if you have chronic pain and
17 you're treated by a Catherine Foley or Russ
18 Portnoy or one of the major pain centers, your
19 risks are probably going to be lower than if
20 you're managed single-handedly by a very stressed
21 nurse practitioner in rural Iowa.
22 Q. That's very interesting. If I
23 understand what you're saying then, there should
24 be some -- let me try to rephrase this.
25 The distinction, if I understand you

142

1 CURTIS WRIGHT, IV, MD, MPH
2 right, is there will be a group that might be
3 more vulnerable to problems because they may have
4 refractory pain syndromes, they may not be able
5 to get the adequate treatment, there may be a
6 greater vulnerability than, say, a pain patient
7 who has not had problems with pain management,
8 correct?
9 MR. STRAUBER: I object to the form
10 of the question. I don't believe that's what he
11 did say.
12 MR. McNAMARA: Then he can correct
13 me.
14 MR. STRAUBER: Sure.
15 A. What I was trying to say was where
16 you look in the healthcare system can lead you to
17 different beliefs about what the actual rate of
18 an event is. Where you look, where you're
19 sitting, what you're doing will lead you to
20 different conclusions because at different places
21 things are more or less common.
22 There's very little disagreement that
23 I know of among those who treat both addiction
24 and pain, that individuals who have addiction and
25 pain are difficult patients to treat and have a

143

1 CURTIS WRIGHT, IV, MD, MPH
2 poorer prognosis than people who don't have
3 addiction and pain. That's so strongly believed
4 that it comes to you from your state board of
5 quality assurance saying these are things you
6 need to think about when treating addiction and
7 pain. Psychiatric disorders in people with
8 addiction are tough to treat. They're not
9 untreatable, but they're tough to treat.
10 So if you ask what happens to
11 somebody who's tough to treat, they end up in, if
12 the system is working properly, in treatment
13 facilities whose bread and butter is treating the
14 patients that are tough to treat.
15 So when we talked earlier today about
16 the guidelines and guidelines for treatment and
17 what you're supposed to do, one of the things
18 that was in those guidelines was treat them, see
19 what happens, and if you end up treating them and
20 it either isn't going well or you're treating
21 them for a long period of time, seek periodic
22 consultation, expert consultation to make sure
23 that you're doing the right thing.
24 From my perspective, I claim no -- I
25 don't claim knowledge that isn't out there. And

144

1 CURTIS WRIGHT, IV, MD, MPH
2 there's a lot that's not known about addiction,
3 pain and treating pain in patients with
4 addiction. And it's still a lively debate about
5 what the real rate of iatrogenic dependence is as
6 it is dependent upon what -- because no one's yet
7 successfully studied it in the way that you could
8 study the cross-sectional rate of diabetes.
9 But I think you can -- I think one
10 can reach the conclusion from a study of other
11 prevalent sampling that if you go -- if a group's
12 hard to treat and you go to the place where the
13 people who are hard to treat go, you're going to
14 find a lot of them. If a group's easy to treat,
15 they're going to get treated, get well and
16 they're going to go on about their business.
17 MR. McNAMARA: Why don't we take a
18 break.
19 (Recess taken.)
20 BY MR. McNAMARA:
21 Q. Doctor, right before you break you
22 mentioned AHCPR guidelines which discussed
23 iatrogenic addiction, correct?
24 A. Yes, sir.
25 Q. Do you remember the date on those

145

1 CURTIS WRIGHT, IV, MD, MPH
2 guidelines?
3 A. No, I'd have to look it up.
4 Q. What does AHCPR stand for again?
5 A. Healthcare Policy and Research.
6 American -- I don't know the next noun, it is the
7 body of the United States Government at that time
8 that wrote guidelines on pain management, that
9 wrote guidelines on many things associated with
10 healthcare. They were fairly conservative
11 consensus guidelines.
12 Q. You mentioned about Porter and Jick
13 in the Boston Collaborative Project. I think you
14 said something along the lines if Porter and Jick
15 told me something, I'd listen to it. Is that
16 what you said?
17 A. If the reports from a public health
18 perspective -- yes, I said that.
19 Q. Would you agree with Dr. Jick that
20 his review that's part of that letter to the
21 editor does not contain information regarding
22 whether people taking OxyContin are at risk of
23 addiction?
24 A. I agree. It couldn't. It wasn't
25 available.

146

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. How about MS Contin?
3 A. I'm not even sure given that period
4 of time that MS Contin had achieved a large
5 enough market share.
6 Q. You mentioned that there's still a
7 live and real debate over the issue of iatrogenic
8 addiction to opioids.
9 A. About the exact number, yes.
10 Q. So it's not been conclusively shown
11 that less than 1 percent of pain patients taking
12 their opioid medications get addicted?
13 MR. STRAUBER: That's not what he
14 said.
15 MR. McNAMARA: I'm asking him the
16 question.
17 A. I don't think I can answer that.
18 Part of my issue with this question is I am
19 knowledgeable about pain management. But there
20 are people who are far more knowledgeable than me
21 about pain management. My issue is I have been
22 much more slanted toward managing addiction.
23 Q. Well, you are also apparently very
24 familiar with the studies that have been -- the
25 studies out there with regards to addiction

147

1 CURTIS WRIGHT, IV, MD, MPH
2 amongst pain patients, correct?
3 A. I'm familiar with them. I'm not -- I
4 would not want to claim to be an expert in them.
5 Q. Do you know of any single study that
6 shows that chronic -- amongst chronic pain
7 patients there's a less than 1 percent chance of
8 them becoming addicted to their opioid
9 medications?
10 A. Probably one.
11 Q. Which one would that be?
12 A. The registry study that was done by
13 Purdue Pharma on OxyContin.
14 Q. What registry study is that?
15 A. In and around -- it is common for
16 companies to be asked to conduct Phase 4 studies
17 of --
18 Q. I'm sorry, Doctor, I'm going to
19 interrupt you if I may. My question was what
20 study was it. I am aware that there was a study
21 that -- a registry study. I'm just asking is
22 there any published studies. And you indicated
23 this registry study. Is it a published study?
24 A. I don't know. I thought you asked me
25 what studies I knew of. I'm sorry.

148

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. The registry study that was done with
3 regards to OxyContin was an open label -- it was
4 related to an open label protocol, correct?
5 A. Long term follow-up protocol.
6 Q. And you've seen that?
7 A. I've seen reports from it.
8 Q. Have you seen a final report from
9 it?
10 A. I think so.
11 Q. Do you remember when that was?
12 A. No. It was within the last year.
13 Q. I just wanted to show you if I could
14 this exhibit.
15 (Wright Exhibit 13 for
16 identification, Fishbain Review Article.)
17 A. This is the Fishbain review on drug
18 abuse, dependence and addiction in chronic pain
19 patients.
20 Q. I believe it's dated 1992.
21 A. Affirmative.
22 Q. Looking at the -- within the abstract
23 do you see the reference where it says "within
24 these seven studies"?
25 A. Yes.

149

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. And it says, "The prevalence
3 percentages for the diagnoses of drug abuse, drug
4 dependence and drug addiction were in the range
5 of 3.2 percent to 18.9 percent," correct?
6 A. Yes.
7 Q. And then it states "it is concluded
8 that these diagnoses occur in a significant
9 percentage of chronic pain patients," correct?
10 A. Yes.
11 MR. STRAUBER: Could you read the
12 next sentence for completeness?
13 Q. "However, there is little evidence in
14 these studies that addictive behaviors are common
15 within the drug pain population," correct?
16 A. That's correct. There's a problem,
17 though.
18 Q. You could talk to Mr. Strauber about
19 that if you'd like to discuss it at the end of
20 your deposition.
21 A. All right.
22 Q. You mentioned Dr. Foley and
23 Dr. Portnoy as two of the -- would you call them
24 preeminent pain management specialists in the
25 country?

150

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Well-recognized experts in pain
3 management.
4 Q. Do you know that Dr. Portnoy as part
5 of his guidelines for the long-term opioid
6 therapy for patients suggested a relative
7 contraindication for patients with substance
8 abuse history? Are you aware of that?
9 A. I'm aware of that. I don't agree.
10 Q. Can you look back at I guess what was
11 the draft label. Which date?
12 MR. STRAUBER: Is that Exhibit 11?
13 MR. McNAMARA: I assume so, yes.
14 A. I found Exhibit 11. Is that the one
15 you mean?
16 Q. Yes, sir. Page 488, do you see the
17 section where it says "abuse potential in human
18 trials"?
19 A. Yes. Yes, I do.
20 Q. It says here, "In ex-addict prisoner
21 volunteers, parenteral oxycodone was considered
22 to have comparable abuse liability to parenteral
23 morphine in doses that are equianalgesic to those
24 studied in patients with pain. Whether or not
25 the controlled release oral dosage form would

151

1 CURTIS WRIGHT, IV, MD, MPH
2 have the same abuse liability has not been
3 studied."
4 Do you remember seeing this
5 language?
6 A. No. But I accept that I did.
7 Q. This sentence here about whether or
8 not the controlled release oral dosage form would
9 have the same abuse liability has not been
10 studied, do you know if that was carried over
11 into the final printed labeling?
12 A. I believe it was not.
13 Q. Do you know why it was taken out?
14 A. I do not know. I can conjecture. I
15 can only conjecture. Do you wish me to?
16 Q. Yes.
17 A. In general, whether or not X has been
18 studied is not very helpful language in the
19 package insert. And there's an inherent bias
20 against that. Some physicians read that as it's
21 true but they just haven't proved it. Some
22 physicians read it as it's false and they didn't
23 want to study it. And it's not language that's
24 considered very helpful.
25 Q. Well, apparently the language that

152

1 CURTIS WRIGHT, IV, MD, MPH
2 was put in to the label instead was that "delayed
3 absorption as provided by OxyContin tablets is
4 believed to reduce the abuse liability of a
5 drug," correct?
6 A. That was certainly -- that was --
7 yes, that went into the package insert.
8 Q. So that would seem to suggest that
9 it's been studied and it's generally accepted, if
10 not proved, for this particular drug, correct?
11 A. No. Believed means just that. It's
12 believed. Might be a consensus belief, it might
13 be an expert opinion. It's more than conjecture,
14 but if there is evidence, you usually make some
15 statement that there is evidence.
16 Q. Do you know how the sentence "delayed
17 absorption as provided by OxyContin tablets is
18 believed to reduce the abuse liability of a drug"
19 got into the OxyContin label?
20 A. Yes. As a consequence of back and
21 forth iterations of labeling between Purdue and
22 the Food and Drug Administration.
23 Q. Do you know if Purdue asked to have
24 that sentence put into the label?
25 A. I truly do not.

153

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you know if you suggested it for
3 them?
4 A. I certainly could have. I don't
5 know.
6 Q. Do you recall if in its NDA Purdue
7 submitted any medical or scientific support for a
8 claim that delayed absorption as provided by
9 OxyContin tablets is believed to reduce
10 oxycodone's abuse potential?
11 A. Could you repeat the question,
12 please.
13 Q. Sure. Do you recall if in its new
14 drug application Purdue submitted any medical or
15 scientific support for a claim that delayed
16 absorption as provided by OxyContin tablets is
17 believed to reduce oxycodone's abuse potential?
18 A. I don't know anymore. I truly
19 don't.
20 (Wright Exhibit 14 for
21 identification, document bearing Bates production
22 number 8001039123 through 8001039135.)
23 A. This appears to be a section of the
24 original new drug application initially submitted
25 for OxyContin.

154

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. This appears to be part of the
3 clinical data section, correct?
4 A. Affirmative.
5 Q. And that means the data as to human
6 subjects, right?
7 A. The data initially filed.
8 Q. And looking at page ending Bates 124,
9 in the first paragraph underneath overdose and
10 drug abuse potential, do you see -- well, why
11 don't I just read through it. "Oxycodone
12 products, both single entity and combination
13 products, are scheduled under the Controlled
14 Substances Act." And there's the cite. "All
15 oxycodone products are listed as Schedule II.
16 Oxycodone controlled release tablets should also
17 at present be placed in Schedule II. Both
18 preclinical," and cites Deneau 1957, "and human
19 studies," cites Martin 1966, "suggest that
20 oxycodone is roughly equivalent to morphine as an
21 abusable substance." And there's a reference to
22 another part of the NDA, correct?
23 A. Affirmative.
24 Q. "No specific studies of this
25 controlled release formulation have yet been

155

1 CURTIS WRIGHT, IV, MD, MPH
2 conducted to ascertain if it has a lower abuse
3 potential."
4 A. Correct.
5 Q. So apparently when they submitted
6 their clinical data section their NDA in December
7 of '94, there had been no specific studies of the
8 controlled release formulation as to whether it
9 has a lower abuse potential.
10 A. Correct.
11 Q. Have you also had a chance to look at
12 the references to this particular section?
13 A. Yes.
14 Q. Do you see references to any of the
15 studies you referred to regarding benzodiazepine
16 drugs, nicotine drugs or anything like that?
17 A. No.
18 Q. Did you see any references to what
19 you called soft science or surveys with regards
20 to abuse potential?
21 A. No. There's a problem though.
22 Q. Again, you can explain it to your
23 attorney and talk about it at the end.
24 You mentioned you may have been the
25 person, for lack of a better term, the progenitor

156

1 CURTIS WRIGHT, IV, MD, MPH
2 of the "delayed absorption as provided by
3 OxyContin tablets is believed to reduce the abuse
4 liability of a drug," correct?
5 A. It's certainly possible. I don't
6 know whether I -- I don't know.
7 Q. So the label they submitted said we
8 haven't studied whether or not the oral dosage
9 form -- controlled release oral dosage form might
10 have a different abuse liability, correct?
11 A. Correct.
12 Q. And the label that came out said
13 delayed absorption is believed to reduce the
14 abuse liability of a drug.
15 A. Correct.
16 Q. Are you aware of any studies Purdue
17 did between December of 1994 and approval of the
18 label in December of 1995 that showed that
19 OxyContin itself or -- let me withdraw and try
20 that again.
21 Do you recall any studies that Purdue
22 submitted to the FDA between December '94 and
23 December '95 to support a claim that controlled
24 release opioids had a lower abuse potential than
25 other opioids?

157

1 CURTIS WRIGHT, IV, MD, MPH
2 A. No, I do not.
3 Q. Are you aware of any studies that
4 Purdue conducted between December of '94 and
5 December of '95 as to whether OxyContin would
6 have a lower abuse potential than immediate
7 release opioids? And no one at FDA conducted
8 such studies, correct, as to OxyContin?
9 A. No one at FDA conducted studies with
10 respect to OxyContin, that is correct. I do not
11 believe Purdue conducted any clinical studies,
12 new clinical studies during the review period
13 that would answer that question.
14 What I do not know is what summaries
15 of the literature, supplements to the NDA or
16 references discussed with Purdue during that time
17 would have been brought forward in support of
18 that language.
19 Q. Are you aware of any literature that
20 occurred between December of '94 and December of
21 '95 on that specific issue about lower abuse
22 potential? I guess any new information.
23 A. I'm at a disadvantage here because
24 when these drugs come in, it's relatively common
25 for the review staff to look at the adverse event

158

1 CURTIS WRIGHT, IV, MD, MPH
2 experience for other drugs of the class. I'm
3 aware of the fact that there were other
4 controlled release opioids that had come rolling
5 in in and around that period.
6 And I honestly can't say exactly what
7 we knew and what we didn't know during that
8 period other than there was a general agreement
9 that controlled release drugs that slowed
10 absorption were very likely to have less
11 intrinsic risk to the patients.
12 Q. Why was that important to tell
13 doctors?
14 A. Because we believed that it was
15 important to tell doctors something. If you look
16 through the analgesic labels, there was no
17 guidance. There was no -- it was replete with
18 not studied, never considered, didn't think about
19 it or it was completely missing.
20 One of the ways to begin to get the
21 pharmaceutical industry to address an issue is to
22 start saying you have to talk about it in
23 labeling. And I think earlier in the day we
24 discussed a variety of communications where I had
25 taken the position during the review process that

159

1 CURTIS WRIGHT, IV, MD, MPH
2 this company should begin to think about this
3 kind of issue and begin to think about the
4 methodology that they would use for addressing
5 this kind of issue. It was one of the reasons
6 that they were asked to do the registry study.
7 Q. The label doesn't say we'll look into
8 it further to do clinical studies, does it?
9 A. The label makes an extremely weak
10 statement about a class of drugs. That was
11 believed to be true and by me is still believed
12 to be true.
13 Q. But has still not been tested with
14 regards to OxyContin and oxycodone in immediate
15 release form.
16 A. No. If it had been, it would have
17 said OxyContin, not drugs -- controlled release
18 drugs like OxyContin are believed. It would be
19 OxyContin has been shown. It's a different
20 statement.
21 Q. Were you ever contacted by sponsors
22 of other controlled release opioids after the
23 OxyContin label to ask whether or not they could
24 include language about delayed absorption
25 reducing the abuse liability of their product?

160

1 CURTIS WRIGHT, IV, MD, MPH
2 A. I don't know. I do not remember
3 being so contacted.
4 Q. You mentioned it's a very weak
5 statement about a class of drugs -- I'll move
6 on.
7 Does OxyContin have delayed mu-opioid
8 activity?
9 A. I don't understand the question.
10 What do you mean "delayed mu-opioid activity"?
11 Q. Why don't I show you something and
12 maybe you'll understand. I'd show you Exhibit 22
13 but we're only going to talk about a very small
14 portion of this.
15 MR. STRAUBER: Did you say 22?
16 Q. I'm sorry. Exhibit 15.
17 (Wright Exhibit 15 for
18 identification, document bearing Bates production
19 number 8003007024 through 8003007048.)
20 Q. If I could just direct your attention
21 to the first page and then to page ending 7041.
22 This apparently is a revised version of the draft
23 insert we were just looking at.
24 A. It looks like one of the versions
25 that went back and forth.

161

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. And it's dated -- this particular
3 version, according to the cover letter, is -- the
4 cover letter is dated August 16th, 1995,
5 correct?
6 A. Yes.
7 Q. And it's from Purdue to Dr. Bedford.
8 A. Yes.
9 Q. And in the second paragraph of the
10 cover letter it says, "Attached please find a
11 revised package insert which contains our
12 suggestions for revision. This PI also reviews
13 the initial reviewer comments."
14 Who was the initial reviewer? Would
15 that be you and the rest of your team or would
16 that just be you?
17 A. At this point in time I don't know.
18 There were three other physicians involved in the
19 primary review of OxyContin. And I don't know
20 from this document whether "initial" means me or
21 it means one of the three other people that were
22 looking at that.
23 Q. Which would have been Mike Klein?
24 Who was the third?
25 A. There was Mike Klein, there was

162

1 CURTIS WRIGHT, IV, MD, MPH
2 Belinda Hayes, there was -- I'm blocking on his
3 name. Jack Longmeyer and Doug Kramer.
4 Q. Is that the same Doug Kramer you work
5 with now?
6 A. Yes.
7 Q. He was also part of the team that
8 looked at the OxyContin label?
9 A. No. I think he just looked at one of
10 the medical reviews for one of the studies.
11 Q. Looking at the section on 7041, drug
12 abuse and drug dependence, there's an underlined
13 statement that says, "Delayed mu-opioid activity
14 as provided by OxyContin tablets is believed to
15 reduce the abuse liability of a drug."
16 Do you know who inserted that
17 sentence in there, if that was FDA or Purdue?
18 A. I have no idea. It's not a very good
19 sentence. From the document I just simply can't
20 tell whether that underlined version is what the
21 primary reviewer shoved in or whether it was
22 Purdue's. I just don't know.
23 Q. Understood.
24 (Wright Exhibit 16 for
25 identification, document bearing Bates production

163

1 CURTIS WRIGHT, IV, MD, MPH
2 number 8003007060 and 8003007076.)
3 A. This looks like this is two versions
4 later.
5 Q. This is correspondence on August 31st
6 of 1995?
7 A. Yes.
8 Q. Between Purdue and Dr. Bedford about
9 another revision to the label?
10 A. Yes.
11 Q. And you said it's two versions
12 later. This says version 011, and I think the
13 August 16 letter said 006.
14 A. That's not two versions later.
15 That's five versions later.
16 Q. Looking at page ending 7076, again,
17 it's the drug abuse and dependence section. And
18 it looks like there's an alteration to the
19 sentence we just read. "Delayed absorption," and
20 crossed out is mu-opioid activity, "as provided
21 by OxyContin tablets is believed to reduce the
22 abuse liability of a drug."
23 A. I see that.
24 Q. Apparently that's the time when that
25 got changed?

164

1 CURTIS WRIGHT, IV, MD, MPH
2 A. I think so. Again, I don't know
3 whether that was the kineticist or the
4 pharmacologist or who it was.
5 Delayed mu-opioid activity is a
6 phrase I've never heard. I mean, it's not how
7 these things are normally said. And that might
8 have been the kineticist. Or it might have been
9 the company. I just don't know.
10 Q. Do you have any specific recollection
11 of anyone at Purdue asking if they can include
12 the phrase "delayed absorption as provided by
13 OxyContin tablets is believed to reduce the abuse
14 liability of a drug"?
15 A. I don't know. We go back and
16 forth -- this is like the eleventh version of the
17 label. And each time the company would say we're
18 not comfortable saying that, we're not sure we
19 have the justification for it.
20 I never got the feeling that they
21 were dredging for claims. I mean, you sometimes
22 get that feeling when they're negotiating -- when
23 the company's negotiating. You get the feeling
24 they're trying to dredge. But I just don't
25 know. Somewhere around version 15 I lost count.

165

1 CURTIS WRIGHT, IV, MD, MPH
2 (Wright Exhibit 17 for
3 identification, Medical Officer Review.)
4 Q. Do you recall doing a medical officer
5 review for OxyContin?
6 A. I think I did a number of them.
7 Yes.
8 Q. What is a medical officer review?
9 A. What was your question?
10 Q. What is a medical officer review?
11 What is it?
12 A. It can mean slightly different
13 things. Every document that comes into the
14 agency that contains new clinical information or
15 purported conclusions from clinical information
16 needs to be examined-- I won't say need to, but
17 is usually examined by a medical officer who
18 examines it to see if what the company has
19 submitted is likely to be true, what the quality
20 of the data is, what conclusions can be drawn
21 from it. And this review, once signed and final,
22 becomes part of the administrative effort for the
23 drug.
24 Q. So it's a rather important document
25 to be accurate on back when you were at the FDA?

166

1 CURTIS WRIGHT, IV, MD, MPH
2 A. It's always important to be
3 accurate. Only God is perfect.
4 Q. Right. It was something that you
5 would do in the ordinary course of business as a
6 medical officer at the FDA?
7 A. Yes.
8 Q. And it would be part of the ordinary
9 course of your business, as you said, to do such
10 reviews when you'd get new clinical data,
11 correct?
12 A. Yes.
13 Q. Looking at this Exhibit 17, aside
14 from the cover page, do you recognize Exhibit
15 17?
16 A. It certainly looks like my original
17 medical officer review for the integrated summary
18 of safety.
19 Q. Integrated summary of safety would
20 mean you'd take all the clinical data as to
21 safety information and basically summarize it?
22 A. No.
23 Q. What does it mean?
24 A. The integrated summary of safety is a
25 specific document or jacket produced by the

167

1 CURTIS WRIGHT, IV, MD, MPH
2 pharmaceutical firm and submitted as part of
3 their AND application. This would be a review of
4 what Purdue submitted in terms of their
5 integrated summary of safety.
6 Q. Understood. Looking at the first
7 page, the sentence that starts "controlled
8 studies of the CR form." Do you see where I am
9 on the first paragraph underneath summary?
10 A. "Controlled studies of the CR form
11 against immediate release of oxycodone suggest
12 slightly lower peak to trough."
13 Q. "Used as directed in an adverse event
14 profile as good as currently available in QID
15 formulations." Do you recall that being
16 accurate?
17 A. No. If I had it to write over again,
18 I would probably say an adverse event profile as
19 good as the immediate release formulation studied
20 in the clinical trial.
21 Q. Okay. Looking down to the sentence
22 under background where it says "because of the
23 differences." It's the short paragraph right
24 above "deaths."
25 A. The sentence reads "because of the

168

1 CURTIS WRIGHT, IV, MD, MPH
2 differences in profile, it would be theoretically
3 possible for the CR drug to have a safety profile
4 that is better, worse or similar to the IR
5 form."
6 Q. What did you mean by that?
7 A. That in discussions within the
8 agency, no conclusion had been reached in general
9 as a principle whether the safety profile, and by
10 that I mean the emergence of any adverse event
11 associated with the drug, would by definition be
12 better, worse or about the same. And there had
13 been extensive discussion about that.
14 Q. And by saying it could be better,
15 worse -- you basically are agnostic. It's not,
16 right?
17 A. Right.
18 Q. Looking on page 2, if I could direct
19 you to the portion that says "withdrawal
20 symptoms," it notes "symptoms of withdrawal were
21 observed in seven patients in five clinical
22 studies." And after discussing some of those
23 issues, at the end, the last sentence says, "The
24 label should contain the usual physical
25 dependence language."

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Yes.
3 Q. Do you know if the OxyContin label
4 contained the usual physical dependence
5 language?
6 A. At this point in time I don't know
7 what I meant by the "usual physical dependence
8 language." What I would say today is the
9 OxyContin label should contain physical
10 dependence language that warns about the
11 possibility of withdrawal and suggestions on how
12 to prevent it and manage it.
13 Q. Are you aware of any differences
14 between the portion of the OxyContin label that
15 discusses withdrawal symptoms and the MS Contin
16 label that discusses withdrawal symptoms?
17 A. I haven't compared the two.
18 Q. You have the OxyContin label handy I
19 believe. So let me get you the MS Contin label.
20 If you could look at the March of 2000 exhibit,
21 please.
22 MR. STRAUBER: Number 10.
23 (Wright Exhibit 18 for
24 identification, MS Contin Product Label.)
25 Q. I'm going to focus your attention to

1 CURTIS WRIGHT, IV, MD, MPH
2 page -- they're numbered. The pages aren't
3 numbered. The lines are numbered on mine. The
4 OxyContin one has a section marked tolerance and
5 dependence located on page ending 323. And the
6 MS Contin one --
7 A. There don't appear to be page numbers
8 on the MS Contin one.
9 Q. No, there are not. If I can direct
10 you to --
11 A. There's a section called drug
12 dependence in the MS Contin label.
13 Q. Right, starting at 440, and the
14 section I want to point you to --
15 A. 440?
16 Q. Line 440. If I could start with the
17 OxyContin label, and starting in the middle
18 column after the statement overdosage, it says
19 "if OxyContin is abruptly discontinued." Do you
20 see that? In the middle column down towards the
21 bottom.
22 A. Yes.
23 Q. Do you see where it says "if
24 OxyContin is abruptly discontinued in a
25 physically dependent patient, an abstinence

1 CURTIS WRIGHT, IV, MD, MPH
2 syndrome may occur. This is characterized by
3 some or all of the following." And it lists a
4 series of symptoms including restlessness,
5 lacrimation, rhinorrhea, yawning, perspiration,
6 chills, myalgia and mydriasis.
7 A. Yes.
8 Q. Other symptoms also may develop,
9 including irritability, anxiety, backache, joint
10 pain, weakness, abdominal cramps, insomnia,
11 nausea, anorexia, vomiting, diarrhea or increased
12 blood pressure, respiratory rate or heart rate.
13 A. Yes.
14 Q. Can I direct you to the MS Contin
15 label starting at line 454. Do you see where it
16 says "if MS Contin is abruptly discontinued"?
17 A. Yes. Restlessness, lacrimation,
18 rhinorrhea, yawning, perspiration, gooseflesh,
19 restless sleep, and mydriasis during the first 24
20 hours. These symptoms often increase in severity
21 and over the next 72 hours may be accompanied by
22 a long list of things. Sweating, diarrhea,
23 ketosis, disturbances in acid-base balance,
24 cardiovascular collapse. Without treatment most
25 observable symptoms disappear in 5 to 7 days.

1 CURTIS WRIGHT, IV, MD, MPH
2 And then there's a phase of secondary or chronic
3 absence may last from two to six months.
4 Q. Is that what you meant by the usual
5 physical dependence language under the concept of
6 withdrawal symptoms in your medical officer
7 review?
8 A. No.
9 Q. Fair enough. Looking at your medical
10 officer review, at page 3 underneath patients, do
11 you see where it says last paragraph, towards the
12 bottom, "the patients enrolled into controlled
13 studies ranged widely in length of exposure from
14 one day to 22 weeks and in mean total daily dose
15 from 10 milligrams to 720 milligrams of CR
16 oxycodone." It says "duration ranged from a few
17 days to 32 weeks controlled and open label
18 studies with a modal exposure of five to seven
19 days."
20 What does that mean, "modal exposure
21 of five to seven days"?
22 A. That the most frequent exposure was
23 five to seven days. As I remember this data set,
24 there was a significant frequency of -- there was
25 a high frequency of two-week crossover studies

1 CURTIS WRIGHT, IV, MD, MPH
2 and single dose analgesia studies which would
3 tend to lower both the modal frequency and the
4 average frequency.
5 Q. Do you know how many patients used --
6 there's some reference to 22 weeks and 32 weeks,
7 et cetera. Do you know how many patients used
8 OxyContin for more than a month --
9 A. It would be very few.
10 Q. Does it sound right that about 11
11 patients used between 13 and 22 weeks?
12 A. Probably right. I don't know.
13 That's on the order of magnitude.
14 Q. Would you say about 434 out of 445
15 were under 29 days?
16 A. That's certainly possible.
17 Q. Looking ahead in your MOR, you're
18 talking about I guess starting on page 4, second
19 paragraph -- second section, adverse events in
20 clinical settings.
21 Was there a claim at some point by
22 the company that they sought a superiority --
23 well, let me rephrase that.
24 Did Purdue seek a superiority claim
25 in terms of adverse event profiles for OxyContin

1 CURTIS WRIGHT, IV, MD, MPH
2 as compared to immediate release opioids?
3 A. At various times during the
4 development of the drug they talked about that as
5 a hope. In a number of versions of the package
6 insert -- this I actually do remember. In a
7 number of versions of the package insert, the
8 tables, the summary tables, if they were looked
9 at would give an impression of a better safety
10 profile for CR versus IR.
11 Because of some unbalanced
12 randomization and the distribution of the
13 patients across the different studies, I felt
14 that a claim of superiority was not justified,
15 and I believe I expressed that to Purdue and I
16 think I did my best to see that my suggestions
17 pertaining to any such claims were incorporated
18 into the final version of the label.
19 Q. And we looked at the label. Do you
20 recall seeing anything in the label about a claim
21 of superiority in terms of adverse events?
22 A. The only possible such claim is that
23 very class specific language with respect to
24 abuse liability. For the adverse events I think
25 I tried very hard not -- to see that no such

1 CURTIS WRIGHT, IV, MD, MPH
2 language crept in.
3 Q. Purdue claimed, nevertheless, that
4 OxyContin had a better adverse event profile than
5 immediate release opioids despite it not being in
6 the label. Would that be a problem from a
7 regulatory standpoint?
8 A. Making claims that are not in the
9 label is a regulatory problem. How severe a
10 problem and how it should be addressed and
11 corrected is something that DDMAC would do. I
12 couldn't advise.
13 Q. OxyContin -- for the efficacy
14 studies, OxyContin was compared twice -- Q12H
15 versus immediate release drugs Q6H, correct?
16 A. Yes, sir.
17 Q. So BID versus QID, correct?
18 A. Yes.
19 Q. And it says IR oxycodone. Do you
20 know what product was used for the IR oxycodone?
21 A. My understanding was that that was a
22 Purdue immediate release product.
23 Q. Do you know if some of the studies
24 actually used were oxycodone?
25 A. They certainly could have. I don't

1 CURTIS WRIGHT, IV, MD, MPH
2 know.
3 Q. The Purdue immediate release product
4 that was used, do you know if it had been
5 marketed?
6 A. At this point in time I don't know.
7 Q. Do you know if that was an
8 appropriately indicated Q6H product or an
9 appropriately indicated Q4H product for pain
10 relief?
11 A. Most of the IR oxycodone products
12 that are combo products are indicated Q4 to 6
13 hours. They all have the same sort of label.
14 One to two tablets Q4 to 6 hours PRN pain.
15 That's the standard on the label, varying
16 somewhat with some products.
17 Immediate release oxycodone is a
18 funny drug because it is available from a number
19 of manufacturers, or at least was at that time
20 from a number of manufacturers who never
21 submitted an NDA at all.
22 I can't comment on the FDA position
23 on that, although in general there was a general
24 sentiment that products that were not on the
25 market as that product made by that manufacturer

1 CURTIS WRIGHT, IV, MD, MPH
2 needed a new drug application. But there was
3 controversy over that, and I don't pretend to be
4 an expert in that law.
5 Oxycodone and hydrocodone and some
6 other drugs, if you look them up in the standard
7 works of pharmacology are Q4 to 6 hour drugs.
8 Sometimes they're Q4, sometimes they're Q6.
9 Generally in clinical trials you're forced to
10 make a choice. And in most of the trial IR/CR
11 switch trials like that you try to find an even
12 multiple of the longer duration drug to dose the
13 shorter duration drug.
14 Could someone make a case that IR
15 oxycodone was a Q4 hour drug? I think you
16 could. Certainly in some patients it would be.
17 Q. Looking at your medical officer
18 review, you had found that OxyContin provided
19 equivalent -- let me just step back because I
20 think this is sort of generally discussed.
21 Actually, it might be on the first page. It's
22 the sentence we talked about earlier under
23 background, OxyContin is a BID dosage form of an
24 old QID drug, correct?
25 A. Yes.

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you recall finding that OxyContin
3 had provided equianalgesic effect dosed BID
4 against immediate release oxycodone compounds
5 dosed QID?
6 A. By the standards of today, no. By
7 the standards of an IR switch in 1992, probably.
8 Q. This is '95.
9 A. '92, '95, whenever the right number
10 was. As I said before, we weren't sure what the
11 right level -- where to set the right level of
12 efficacy for drug substances that we knew worked,
13 that were old drugs that had known risk profiles
14 pretty much, that were brought forward in CR
15 dosage forms, usually as 505 B2 implications.
16 So there was a lot of confusion at
17 that time as to how much was enough.
18 Q. Well, looking at today's standards,
19 if you find OxyContin worked as well at relieving
20 pain dosed twice a day as compared to a drug
21 which is clinically used Q4H but in the studies
22 was dosed Q6H, haven't you found OxyContin does
23 not work as well as immediate release opioids
24 when they are dosed in the normal clinical form?
25 A. Depends on the total daily dose.

1 CURTIS WRIGHT, IV, MD, MPH
2 Because there's two questions you're wrestling
3 with. One is when do you dose it, and the other
4 is how much of it do you dose in a 24-hour
5 period.
6 If you had found for the immediate
7 release oxycodone that there was -- that the
8 patients were crashing from an analgesic
9 perspective in the troughs, or if you found
10 pharmacokinetically that the troughs were much
11 deeper, then you'd worry about that. We did
12 worry about that for a number of products.
13 Particularly difficult for some of the
14 antihistamines.
15 Q. Looking at the last page of your
16 medical officer review, page 9, you give your
17 summary and conclusions. I'm sorry, I have to
18 back you up one page to page 8. Do you see where
19 it says "dropouts"?
20 A. Yes.
21 Q. "Total of 157 patients, 32 percent
22 discontinued from the completed clinical trials
23 out of the total of 491 patients. This 491 total
24 represents the 445 individual patients exposed to
25 CR oxycodone initially as well as 46 patients who

1 CURTIS WRIGHT, IV, MD, MPH
2 were exposed a second time." And then you state
3 the two primary reasons for withdrawal. I guess
4 from the studies, right?
5 A. Yes, sir.
6 Q. Were for adverse experiences, 58 or
7 11.8 percent of patients enrolled, and for
8 ineffective treatment, 63 or 12.8 percent, which
9 account for most of the discontinuations.
10 Do you remember those numbers to be
11 accurate?
12 A. I have no idea at this point.
13 Q. And you state here "three studies
14 have substantial discontinuation rate due to
15 ineffective treatment because titration and
16 rescue were not permitted."
17 What is rescue medication?
18 A. Rescue medication is smaller or small
19 amounts of an analgesic medication that's given
20 in the course of treatment with a primary
21 analgesic to manage breakthrough pain or to
22 manage ineffective analgesic response for any
23 other reason.
24 Q. Is it customary to use rescue
25 medication on a daily basis?

181

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Oh, yes.
3 Q. Even if you're taking a controlled
4 release product?
5 A. Yes.
6 Q. Even if you're taking it
7 around-the-clock as prescribed?
8 A. Yes.
9 Q. Is it customary to take it twice a
10 day?
11 A. There are -- I'm having trouble with
12 "customary" because there are significant
13 numbers of patients whose daily regimen includes
14 both their baseline opioid and either their
15 breakthrough or the rescue medication.
16 Q. Okay.
17 A. It's more usual than not.
18 Q. Is it more usual to take it as a
19 result of instant pain or as a result of the drug
20 not working long enough, the baseline opioid?
21 A. Depends on the setting. One of the
22 problems in the analgesic pain models that we
23 used, especially the single dose analgesic pain
24 models, is that after about four to six hours of
25 asking somebody how their pain is, they begin

182

1 CURTIS WRIGHT, IV, MD, MPH
2 asking for rescue a lot.
3 And one of the usual standards for
4 determining duration of analgesic effect is to
5 look at the time to 50 percent rescue. That's
6 one of the keys. It was a rare drug among the
7 longer half-life drugs where the 50 percent
8 rescue point was further out than the
9 remedication interval. Half, a third, two-thirds
10 of the patients could be remedicated before the
11 nominal remedication rate.
12 Q. Do you know if any of the clinical
13 trials, if OxyContin was dosed Q8H instead of
14 Q12H?
15 A. I don't think it was dosed Q8H.
16 Q. Are you aware either at the FDA or
17 now of any clinical data about OxyContin being
18 dosed Q8H as compared to Q12H?
19 A. There have even been some
20 publications about it.
21 Q. Do you know how often OxyContin is
22 dosed Q8H by physicians as opposed to Q12H?
23 A. I can give you a range but I don't
24 know that it's right. About 16 percent of the
25 time.

183

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. 16?
3 A. Yes.
4 Q. Looking on page 9 where you have your
5 summary and conclusions, you have under the --
6 you note, "A potential risk associated with CR
7 oxycodone is the possibility for immediate
8 release of the oxycodone if the tablets are
9 crushed."
10 A. The statement where it says "crushing
11 of the CR oxycodone tablets can lead to immediate
12 rather than controlled release of oxycodone."
13 Q. You're looking at number 6. I was
14 looking up top. It doesn't really matter.
15 Another one of your conclusions that
16 you said are supportable is number 1, "CR
17 oxycodone is of acceptable risk when administered
18 on a BID basis." Correct?
19 A. Yes.
20 Q. Did you find that based upon the
21 clinical studies that OxyContin was an effective
22 analgesic when dosed Q12H?
23 A. Based on the clinical and
24 pharmacokinetics studies, yes.
25 Q. Did the clinical and pharmacokinetic

184

1 CURTIS WRIGHT, IV, MD, MPH
2 studies that compared OxyContin to immediate
3 release opioids, were they always involved with
4 immediate release opioids that were dosed on a
5 QID basis?
6 A. I think so.
7 Q. Did you ever -- were any studies
8 ever -- do you recall any of the clinical studies
9 ever showing that OxyContin dosed BID was a more
10 effective analgesic than immediate release
11 opioids dosed QID?
12 A. I don't think so.
13 (Wright Exhibit 19 for
14 identification, document bearing Bates production
15 number 8113900101 through 8113900102.)
16 A. How may I help you?
17 Q. This is apparently a contact
18 report -- actually, it's two now that I look at
19 it. Let's look at the second page. It looks
20 like a contact report from September 1992.
21 A. Yes, sir.
22 Q. I'm going to direct your attention to
23 the paragraph that says, "Dr. Wright was then
24 informed," I guess it's the second full
25 paragraph, "was then informed that there were

185

1 CURTIS WRIGHT, IV, MD, MPH
2 other aspects of our oxycodone program besides
3 the core program. We mentioned the special
4 population studies which he thought were a good
5 idea. Then we discussed the competitive
6 studies. He said it was very difficult to claim
7 clinical superiority."
8 Do you remember having that kind of a
9 discussion with Dr. Reder or Dr. Fitzmartin or
10 anyone else at Purdue?
11 A. I don't remember having the
12 discussion. I have no reason to doubt the
13 minutes and I had those kind of discussions all
14 the time.
15 Q. And according to this you told them
16 that the sponsor must demonstrate clinical
17 superiority with appropriate dosing of the
18 competitor drug. Traditional studies may not be
19 able to show this.
20 Do you know what you meant there?
21 A. Yes, the effect size, if someone
22 wanted to show that a drug was better than
23 another drug, they would need to study both drugs
24 in a design that included a placebo, to do that
25 twice, and to have a statistically significant,

186

1 CURTIS WRIGHT, IV, MD, MPH
2 clinically relevant end point superiority.
3 That's the usual standard for a superiority claim
4 in that period at the agency.
5 Q. Looking at the last sentence of that
6 section -- of that paragraph, you state that "the
7 IR drug would have to be labeled Q6H, not Q4 to
8 6H," right?
9 A. Yes.
10 Q. You were telling them if you're going
11 to make a competitor claim, you need to have a
12 Q6H IR drug and not one that might be a Q4 to a
13 Q6H, correct?
14 A. I don't think that's what I -- I
15 don't know what I meant at that time. It's
16 certainly possible.
17 If you were going to make the claim,
18 then you'd have to make exactly the claim that
19 you described, that if you had a drug, you'd have
20 to pick a drug that QID dosing was an appropriate
21 dosing schedule for the drug.
22 Part of the difficulty with this is
23 that there is no single entity oxycodone, or
24 wasn't at that time, a high level of use of
25 single entity oxycodone immediate release. Most

187

1 CURTIS WRIGHT, IV, MD, MPH
2 of it was in the combination products.
3 And in actual clinical use
4 around-the-clock dosing with combos was actually
5 relatively uncommon. Very few patients actually
6 achieved that level of dosing.
7 If they wanted a competitive claim, I
8 think the impression I gave them was that this
9 would be challenging, there would be a lot of
10 discussion about it and I didn't know how it
11 would end up.
12 Q. Now, you mentioned at that time there
13 weren't too many single entity immediate release
14 oxycodone products. There are now more, correct,
15 today?
16 A. I'm not sure. I just simply don't
17 know about the competitive marketplace in that.
18 Q. Do you know if the use of single
19 entity oxycodone products has increased since
20 1992?
21 A. The use of single entity oxycodone
22 has certainly increased since OxyContin has been
23 on the market. Whether the use of single entity
24 immediate release oxycodone has increased, I
25 would suspect based on the increase of use of

188

1 CURTIS WRIGHT, IV, MD, MPH
2 most opioids that it has, but I don't know for
3 sure.
4 MR. STRAUBER: Before you turn to
5 your next exhibit, could we take a short break?
6 MR. McNAMARA: Yes. Could we keep it
7 real short though?
8 MR. STRAUBER: Yes.
9 (Recess taken.)
10 (Wright Exhibit 20 for
11 identification, document bearing Bates production
12 number 8810119940.)
13 A. Looks like another discussion of a
14 label version annotation between Robert Reder and
15 this looks like it's interior.
16 Q. This is after you started at the
17 company, correct?
18 A. Yes, this is after I started at the
19 company.
20 Q. This is an e-mail from you to
21 Dr. Reder and some other folks about a revision
22 to the OxyContin label, correct?
23 A. Uh-huh. I think so.
24 Q. You joined in December '98, you
25 joined Purdue?

189

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Yes.
3 Q. And in the spring of 2001 there was
4 some discussion with the FDA about revising the
5 OxyContin label, correct?
6 A. Yes.
7 Q. And what role did you have in the
8 revision of the OxyContin label in the spring of
9 2001?
10 A. Not much. I was — I think they kept
11 me informed as a courtesy and asked me if I had
12 any input. But I was not — neither negotiating
13 and managing it nor had authority over it.
14 Q. In this particular instance it looks
15 like you were asked for some assistance on
16 language to offer to the FDA as a warning
17 precaution in the label and promotional pieces,
18 correct?
19 A. No. I think this is a situation
20 where I offered some language.
21 Q. Well, looking at the e-mail that
22 preceded yours on Thursday, March 29th, it says
23 from Robert Reder to, and it has Dr. Haddox,
24 Dr. Santa Paolo, it has you and it has Patricia
25 Richards. It says "all, how about this as a

190

1 CURTIS WRIGHT, IV, MD, MPH
2 start for in-house discussion."
3 A. Yup.
4 Q. And therefore you replied. So
5 Dr. Reder sent this to you in order to —
6 A. Sent it to everybody as a start.
7 Q. Well, not to everybody.
8 A. Well, these were the people that
9 would be thinking about it. The person who had
10 the greatest power there would be Patty Richards
11 and David Haddox. Patty is the medical officer.
12 David is the risk management expert. But what
13 Robert — and I looked at it and said how about
14 this.
15 Q. Okay, and Dr. Reder had offered up
16 language about oxycodone, the active ingredient
17 in OxyContin tablets, is a drug with a long
18 history of abuse, oxycodone is highly sought
19 after. It is abused in a manner similar to abuse
20 seen with morphine, hydromorphone or heroin.
21 This must be kept in mind when prescribing or
22 dispensing OxyContin. That was his.
23 And your response to it was "wahoo,
24 neat first chop. Thanks, Robert. How about
25 genericizing it and adding a contact sentence."

191

1 CURTIS WRIGHT, IV, MD, MPH
2 What did you mean by genericize?
3 A. This wouldn't be the next time — the
4 first time that we have to wrestle with the
5 problems of opioid dependence. And one of the
6 questions is how much did this apply to any
7 controlled release opioid or how much of this was
8 specific to OxyContin.
9 So when I said genericizing it, I'm
10 sorry -- by the way, I'm sorry that my language
11 was intemperate, but I thought that Robert had
12 done a good job.
13 So the first question was what does
14 genericizing it mean, it says maybe we should use
15 this kind of language for all controlled release
16 opioid products. And the context sentence was
17 how we should put someplace to call to get more
18 information.
19 Q. Was there a goal by Purdue that any
20 changes to the OxyContin label on the issues of
21 misuse, abuse and diversion be not just applied
22 to OxyContin but classwide to other opioids?
23 A. I don't know. I couldn't —
24 Q. Okay.
25 A. It's hard for me to answer for a

192

1 CURTIS WRIGHT, IV, MD, MPH
2 whole company because I'm only an executive
3 director in clinical.
4 Q. Gotcha. Did you ever look at any of
5 the suggested revisions for the OxyContin label
6 in the spring and summer of 2001?
7 A. I sure could have. I don't know.
8 Because e-mail is easy, people send me stuff.
9 Q. I'll make it real easy if I just
10 focus us on the language that's most important in
11 this particular instance.
12 (Wright Exhibit 21 for
13 identification, document bearing Bates production
14 number 9101803708 through 9101803709 and
15 9101803722.)
16 A. This appears to be a regulatory
17 submission of Cynthia McCormick to Chris Prue,
18 the regulatory specialist on OxyContin.
19 Q. This is back in June of 2001,
20 correct?
21 A. Yes, sir.
22 Q. Looking at the body of the cover
23 letter to the submission, the second paragraph
24 says "attached is PPLP's response to your
25 recommendations in both the red lined strike-out

1 CURTIS WRIGHT, IV, MD, MPH
2 version and a clean copy of the revised text. We
3 agree with most of the recommendations made in
4 the May 23, 2001 document and have incorporated
5 suggested changes in several places. Most
6 notably, we have created language in a black box
7 warning and incorporated the suggested language
8 regarding abuse, liability and diversion."
9 Do you see that?
10 A. Yes.
11 Q. The last paragraph on that page says,
12 "As you indicated to PPLP during our meeting on
13 April 23rd and subsequently at our May 31st, 2001
14 meeting at the Drug Enforcement Administration,
15 we understand it to be your intention to treat
16 all pharmaceutical companies equally and apply
17 the same standards to all Schedule II and III
18 narcotics as are being requested of PPLP."
19 Do you remember seeing this
20 submission?
21 A. No. But again, I didn't have -- I
22 was not on the team that was tasked with
23 preparing this.
24 Q. Looking at page ending 722, there's
25 the section on misuse, abuse and diversion of

1 CURTIS WRIGHT, IV, MD, MPH
2 opioids. Do you see that?
3 A. Yes.
4 Q. Do you see the sentence "development
5 of addiction to opioids"? It's I guess the
6 fourth paragraph down.
7 A. Yes.
8 Q. It says, "Development of addiction to
9 opioids in properly managed patients with pain is
10 rare. Concerns about abuse, addiction and
11 diversion should not prevent the proper
12 management of pain." And there's a citation to
13 NIDA.
14 A. Uh-huh.
15 Q. Do you know if the FDA accepted that
16 language?
17 A. I don't know.
18 Q. Are you familiar with that NIDA
19 publication in the annotation?
20 A. I think I may be. It's a
21 discussion -- it was prepared about mid-year by
22 NIDA with respect to drug abuse.
23 Q. Do you know the basis for NIDA saying
24 that opioid -- sorry, saying the development of
25 addiction to opioids in properly managed patients

1 CURTIS WRIGHT, IV, MD, MPH
2 with pain is rare?
3 A. No.
4 Q. Do you know if they relied upon the
5 1980 letter to the editor by Drs. Porter and
6 Jick?
7 A. I don't know.
8 (Wright Exhibit 22 for
9 identification, document bearing Bates production
10 number 9101804000 and 9101804012.)
11 A. Looks like they're going back to the
12 label versions again.
13 Q. Looking at the label section here,
14 misuse, abuse and diversion of opioid section,
15 page ending 012, there is a strike-out version of
16 looks like a note to sponsor. Do you see that?
17 A. Yes.
18 Q. It says, "Note to sponsor, this
19 information is misleading. The incidence of
20 addiction is no greater or less than expected in
21 the general population. The 'rare' statement
22 should be omitted in favor of the more positive
23 advice found in the second sentence."
24 I assume based upon the dates of
25 these letters that that was referring to the

1 CURTIS WRIGHT, IV, MD, MPH
2 June 7th version we just looked at.
3 A. I couldn't be certain of that.
4 Q. That version did talk about -- I
5 believe it did have that statement that --
6 A. Rare.
7 Q. Yes. Right. And in that version it
8 said the development of addiction to opioids in
9 properly managed patients with pain is rare. And
10 this note to sponsor says the 'rare' statement
11 should be omitted in favor of the more positive
12 advice found in the second sentence. Which,
13 looking at this version, concerns about abuse,
14 addiction and diversion should not prevent the
15 proper management of pain. That's now the first
16 sentence, and a new second sentence is added.
17 "The development of addiction to opioid
18 analgesic in properly managed patients with pain
19 is as uncommon as that seen in the general
20 population."
21 A. Uh-huh.
22 Q. Do you remember ever looking at that
23 suggested language?
24 A. No. I don't remember. I don't think
25 I did.

1 CURTIS WRIGHT, IV, MD, MPH
2 (Wright Exhibit 23 for
3 identification, document bearing Bates production
4 number 9101804075 through 9101804076.)
5 Q. If I could direct your attention to
6 the paragraph "we have reviewed." The third
7 one. "We have reviewed the revised draft package
8 insert with your latest comments and believe that
9 we are close to resolution on the outstanding
10 issues. We would like to amend the sentence
11 still under discussion in the misuse, abuse and
12 diversion of opioid section to read 'the
13 development of addiction to opioid analgesics in
14 properly managed patients with pain is rare and
15 thought to be a function of a given patient's
16 predilection to becoming addicted'."
17 A. Yes, sir.
18 Q. So this is yet another suggested --
19 A. Another go-around on what can be put
20 in the second sentence.
21 Q. And did you have any input in that
22 sentence?
23 A. No.
24 Q. Do you know if that language was
25 adopted? About the predilection?

1 CURTIS WRIGHT, IV, MD, MPH
2 A. I have no idea. It's important to
3 remember that with respect to OxyContin, I
4 have -- I believe and still believe that I have
5 specific restrictions with respect to
6 presentations to the government. And so I would
7 not have been participating in telephone calls
8 with the agency discussing label language.
9 Q. But with regards to talking with
10 Dr. Reder, Dr. Haddox, Patricia Richards about
11 suggested language --
12 A. To the best of my knowledge, I have
13 no restrictions on working in that way. In
14 general, Purdue has been very sensitive to not
15 asking me to engage in any activities that might
16 even come close.
17 Q. I only have one copy of this but you
18 may have it. It's the current labeling.
19 (Wright Exhibit 24 for
20 identification, Current Labeling.)
21 Q. If I could direct you to I guess page
22 10 of the OxyContin label, if you'll look at the
23 last page, I think this is the current label,
24 right? If you look at the very last page it has
25 a date of July 18th, 2001.

199

1 CURTIS WRIGHT, IV, MD, MPH
2 A. I do not know what current version of
3 the OxyContin label that we're working off of.
4 So I can't help you there.
5 Q. Well, do you see on page —
6 MR. STRAUBER: I'd just like to note
7 that there's numerals in handwriting at the
8 bottom of the page. I assume that's not part of
9 the exhibit, it was added?
10 MR. McNAMARA: It was added after.
11 It was downloaded off the Purdue site.
12 Q. Looking on page 10, do you see the
13 section towards the bottom "misuse, abuse and
14 diversion of opioids"? It should be underneath
15 the warning section.
16 A. I'm having trouble. Page 10, which
17 paragraph?
18 Q. Look for the section underneath
19 warnings where there's the bold warning under
20 section misuse, abuse and diversion.
21 A. I found the section.
22 MR. STRAUBER: The page has the
23 number 9 written on it.
24 Q. Underneath misuse, abuse and
25 diversion — actually, it starts on the next

200

1 CURTIS WRIGHT, IV, MD, MPH
2 page. Do you see the top sentence that says
3 "concerns about abuse, addiction and diversion
4 should not prevent the proper management of
5 pain"?
6 A. Yes.
7 Q. The next sentence states, "The
8 development of addiction to opioid analgesics in
9 properly managed patients with pain has been
10 reported to be rare. However, data are not
11 available to establish the true incidence of
12 addiction in chronic pain patients."
13 A. How may I help you?
14 Q. Do you agree that the data are not
15 available to establish the true incidence of
16 addiction in chronic pain patients?
17 A. I agree with that statement as
18 written, but it's subject to interpretation.
19 Only insofar as true means is it 7 percent,
20 8 percent, a 10th of a percent, 1 in 100,000?
21 Whether it's common or rare, whether it can be
22 measured using clinical problem methodology or
23 survey methodology or pharmacovigilance
24 methodology I think has been answered and I think
25 it is an uncommon or rare event. I still think

201

1 CURTIS WRIGHT, IV, MD, MPH
2 it's an uncommon or rare event.
3 Q. Does it appear that the FDA disagrees
4 with you? They rejected the language about it
5 being as uncommon as in the general population.
6 A. I don't even know what that language
7 means.
8 Q. And they rejected the language that
9 it's rare to instead come up with it's reported
10 to be rare or has been reported rarely or
11 whatever the language is now.
12 A. I don't know what the FDA believes.
13 I don't work for it anymore, I don't work there
14 anymore. What I know is that the company went
15 back and forth multiple times about this label,
16 and this is language that both could live with.
17 That's literally all I know. If
18 they've accepted it as language that they could
19 live with and if Purdue accepted it as language
20 that they could live with.
21 Q. You mentioned before when we
22 discussed that there's a real debate with regards
23 to the instance rate of addiction with chronic
24 pain patients taking opioids, correct?
25 A. I've thought about that because I had

202

1 CURTIS WRIGHT, IV, MD, MPH
2 a chance to rest a little bit. Actually, I think
3 the debate's about the quality of the evidence,
4 not about the rate of addiction.
5 Q. Would you agree that studies such as
6 those done by Dr. Chabal and Dr. Robins have
7 found percentages of abuse — just stay with
8 abuse, that are much higher than, say, other
9 studies done by some other investigators?
10 A. In highly selected populations, yes.
11 Q. And I guess that highly selective
12 population goes both ways, correct?
13 A. Absolutely.
14 Q. Highly selected population may
15 mean —
16 A. Selected for or selected against.
17 Q. Hospitalized patients in acute pain
18 as compared to possibly outpatients attending a
19 multidisciplinary pain management center.
20 A. It's more than that. I have feelings
21 of difficulty in this area. Most of the papers
22 that you're referring to or citing or that exist
23 in this area are essentially case series.
24 They're saying we looked at the last 20, 40, 30,
25 72, 150, whatever the number is patients we ran

203

1 CURTIS WRIGHT, IV, MD, MPH
2 through the service. And we established a
3 definition of what we thought addiction or abuse
4 was, sometimes very parochial, sometimes very
5 good. And we say in this case series we saw X.
6 In this context we know that the rate
7 of alcoholism and drug dependence in the general
8 population is somewhere between 5 and 15 percent,
9 depending on age, where you are and whether
10 you're looking at a medical population or not.
11 The people who study alcoholism in
12 IAAA are very concerned about overrepresentation
13 of alcoholics in populized locations. So I don't
14 know what one can infer about the general
15 population from these case series. They don't
16 mean nothing, but they have an uncertainty about
17 them, and they have some distortions of the data
18 about them in exactly the same way that you could
19 have distortions if you looked only at single
20 dose anesthesia study.
21 So when I say that there's
22 controversies about the data, there's
23 controversies about the strength of the data,
24 there's a lot of evidence that the rate of
25 iatrogenic addiction cannot be large, or it would

204

1 CURTIS WRIGHT, IV, MD, MPH
2 have been picked up on a number of
3 population-based survey instruments looking for
4 how old are people when they start drug abuse,
5 how many people are using drug abuse, what kind
6 of conditions do people have when they have drug
7 abuse. If it was large, it would begin to light
8 up the drug abuse screens and the drug abuse
9 surveys. You get between large and rare and
10 there's discussion over what that number is.
11 Q. You would agree that a risk to taking
12 a drug does not have to be large to be serious,
13 correct?
14 A. Some risks that are very small are
15 very serious.
16 Q. Do you know if the FDA has forced
17 other drug companies to add boxed warnings
18 regarding abuse on their labels for opioids?
19 MR. STRAUBER: I object to the form
20 of the question.
21 A. I don't know. I don't know.
22 Q. Do you know if Purdue has added to
23 the MS Contin label a boxed warning about abuse
24 on its label?
25 A. I do not know. I know there has been

205

1 CURTIS WRIGHT, IV, MD, MPH
2 work going forward on changing the MS Contin
3 label, as there's always maintenance work done on
4 those labels and on the safety sheets. But I
5 don't know if it's been submitted yet and I don't
6 know if it's been reviewed yet.
7 Q. Are you aware of any Purdue
8 promotional pieces that stated that while the
9 rate of addiction to opioids has been reported to
10 be rare, we don't know the data? The incidence
11 data for sure? Are you aware of anything like
12 that?
13 MR. STRAUBER: Objection to the form
14 of the question. You can answer.
15 A. I'm not in the review loop for
16 promotional materials. That's risk management
17 and drug safety. So I don't know whether there
18 are or aren't.
19 Q. If you did see promotional pieces
20 done by Purdue which indicated that less than 1
21 percent of pain patients taking their opioids
22 become addicted to their medication, would you
23 have alerted Purdue that you're not sure that
24 that number is in fact established?
25 A. I'm relatively comfortable that that

206

1 CURTIS WRIGHT, IV, MD, MPH
2 number less than 1 percent is probably a good
3 number.
4 Q. Based upon?
5 A. The registry study.
6 Q. Okay, what if you saw this in 1998,
7 before the registry study had been completed?
8 A. At that time the guidances from
9 authoritative bodies that I should trust would
10 have said that it was very rare or rare. And
11 less than 1 percent, that's a fairly conservative
12 number based on that. So I'm not sure I would
13 have alerted anybody that I thought that this was
14 a bad number. I might have asked let's talk
15 about how we would justify this number, but less
16 than 1 percent is not a bad number.
17 Q. Well, doesn't -- as we discussed,
18 doesn't it depend somewhat on the selected
19 patient groups?
20 A. I'd have to know more about the promo
21 piece and who it was going out to. There's sort
22 of three things that -- I don't know, as I said,
23 I'm not an expert in drug marketing. And I'll
24 leave it at that.
25 Q. What if it's going out to patients?

207

1 CURTIS WRIGHT, IV, MD, MPH
2 A. In what context?
3 Q. In the context of a videotape a
4 doctor could show them in their office where a
5 narrator would say in fact, less than 1 percent
6 of pain patients taking their opioids become
7 addicted to their medication.
8 A. And your question again?
9 Q. Well, would you have found that to be
10 troubling and something you would have alerted
11 Purdue as I'm not sure that that number is
12 appropriate in that context?
13 A. Based on the AHCPR guidelines and
14 NIDA's stuff, I'm not sure I would have found
15 that troubling. If it had been 1 in 10,000 or 1
16 in 100,000, then I might begin to wonder.
17 Q. Suppose this videotape is played at
18 multidisciplinary pain management centers where
19 you know there's been studies reporting as high
20 as 28 percent of the patients abusing the drug,
21 would that affect your answer?
22 MR. STRAUBER: I object to the form
23 of that question.
24 A. If it were played at centers that had
25 already studied their rates and knew their rates

208

1 CURTIS WRIGHT, IV, MD, MPH
2 to be higher, I would expect the centers to tell
3 us.
4 Q. Well, you had a study by Dr. Chabal
5 where he reported his center found I believe a
6 rate of about 27 percent in Washington, correct?
7 A. I'd have to review that. Do you have
8 it here?
9 Q. Actually, I don't. Do you recall
10 Dr. Robins' studies where he found abuse in his
11 center?
12 A. I recall -- what I recall at this
13 time right here is that individuals who selected
14 their patients in their population sometimes
15 selecting them because they were concerned about
16 them reporting a case series. But I don't know
17 the numbers associated with everybody's case
18 series.
19 With all of these issues, greater
20 specificity is often good until it gets in the
21 way of communicating at all. Partially the
22 problem I have, and I continue to have it, is it
23 kind of misses the boat because if I have two
24 things that I worry about, one is the risk that
25 somebody with chemical dependency will abuse the

209

1 CURTIS WRIGHT, IV, MD, MPH
2 drug, and the risk that somebody without chemical
3 dependency will develop chemical dependency, the
4 risk of abuse of the drug by somebody with
5 chemical dependency is probably much greater than
6 the risk that somebody will develop a new case of
7 iatrogenic addiction.
8 Q. So in those instances, if not a
9 contraindication, should there have been a
10 specific warning to patients with a past history
11 of chemical dependence?
12 A. I don't know. That's why I continue
13 to go to conferences and read reports on what to
14 do with patients with chemical dependency. There
15 are 25 million of them in America. They're 10
16 percent of the population. They're getting older
17 and I'm really reluctant to make them therapeutic
18 orphans.
19 The AHCPR made very aggressive
20 statements don't avoid using opioids in this
21 population, don't exclusively use non-opioid
22 medications in this population. Now, has their
23 risk increased? I think so. But what is not
24 clear is how to find them well and how to manage
25 them well.

210

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. I think my question wasn't -- I said
3 putting aside a contraindication, should there be
4 at least a separate warning to these particular
5 persons that they may be at a higher risk to
6 develop addiction based upon their past history?
7 I'm not talking about orphanizing them. I'm just
8 saying giving them a specific warning to them and
9 their prescribers that they may be a subset group
10 of chronic pain patients who are at higher risk.
11 A. I'd like to figure out how. I'm not
12 saying that it's impossible. I'm not saying --
13 this is a group that I've advocated for for 20
14 years. They're a group of people that are
15 treated very badly by the healthcare system in
16 general, that have lots of trouble getting access
17 to good treatment.
18 And where influential government
19 agencies have told me be real careful about
20 marginalizing them, be real careful about doing
21 anything that might make getting treatment to
22 them harder.
23 Q. I only have one copy of this.
24 (Wright Exhibit 25 for
25 identification, Call Report, document bearing

1 CURTIS WRIGHT, IV, MD, MPH
2 Bates production number 7912511060.)
3 Q. Based upon that, Dr. Wright, I'm
4 going to ask you to read -- well, first of all,
5 have you ever seen this before?
6 A. No.
7 Q. Have you ever seen a pharmaceutical
8 sales representative's call report before?
9 A. No.
10 Q. Do you know Russell Johnson?
11 A. No.
12 Q. Do you know a doctor named Charlotte
13 Sitler de Flumere?
14 A. No.
15 Q. Can you read in the notes/memos
16 section what's stated?
17 A. Yes. "Dr. De Flumere asked about
18 dosing and conversion. Left conversion guide.
19 She was impressed with back pain clinical and had
20 to be reminded of the two to morphine ratio. She
21 is coming around and continue to help her with
22 titration. She did say she does dose Q8 hour to
23 some patients with addiction problems and feel
24 they have to take pills. Discussed asymmetrical
25 dosing."

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Now, the section of that call report
3 where it says dosing Q8H, it appears to say that
4 the doctor doses OxyContin Q8H for the addicts
5 because they feel they have to take that many
6 pills. Am I --
7 A. No, it says she does dose Q8H for
8 some patients with addiction problems and feel
9 they have to take pills.
10 Q. You've treated pain patients, correct
11 who are -- who also have substance abuse
12 problems?
13 A. Yes.
14 Q. Do you recall giving them an
15 additional daily dose of medication because they
16 feel they needed to take more pills?
17 A. It's a hard question to answer
18 because every patient where I'm most familiar
19 with this is methadone maintenance patients. And
20 methadone maintenance patient who are the group
21 that would have pain and addiction problems
22 continuously negotiate about their methadone
23 dose. They continuously negotiate about how much
24 drug they're getting and how long it's lasting
25 and how they feel about it and what they want and

1 CURTIS WRIGHT, IV, MD, MPH
2 what's coming up and what's not coming up.
3 I don't know what to do with this
4 call report because it tells me a little too much
5 and a little too little.
6 Q. Let's look at this one.
7 MR. STRAUBER: I'd just like to note
8 because you did not give me a copy of this
9 exhibit, so I didn't have a chance to look at
10 it. It doesn't say anything about taking more
11 pills.
12 MR. McNAMARA: No, it says Q8H,
13 correct?
14 MR. STRAUBER: It does say Q8. But
15 it doesn't say anything about more pills or
16 medicine.
17 Q. Doctor, if you're going to take Q8H
18 you're -- if you take OxyContin dosed Q8H, you're
19 going to take more number of OxyContin tablets
20 than if you were taking it Q12H, correct?
21 MR. STRAUBER: Your question is
22 confined to number of tablets?
23 MR. McNAMARA: Yes.
24 A. You take more tablets but the
25 question is what dose of drug are you giving TID

1 CURTIS WRIGHT, IV, MD, MPH
2 and what dose of drug are you giving Q8.
3 (Wright Exhibit 26 for
4 identification, Call Report, document bearing
5 Bates production number 7912533279.)
6 A. This is another -- appears to be
7 another contact report for Dr. Sitler de Flumere
8 in the Memphis Psychiatric Group.
9 Q. Could you read the notes/memo
10 section.
11 A. Staples, Burt. Notes/memo. "She
12 does go TID and has one QID patient. It's due to
13 addicts having to take pills for the mind game."
14 Q. Does that give you any greater
15 insight as to what the doctor may be doing?
16 A. Dr. De Flumere might be titrating
17 patients with pain and addiction.
18 Q. And giving them pills for the mind
19 game, as Mr. Staples interprets it?
20 A. Well, that's how the sales rep put
21 it. Before I talk about what I thought, I'd need
22 to talk to the doctor and ask her what she thinks
23 she's doing. These are sales reps.
24 Q. Right. Now, in treating pain
25 patients, do you recall -- who had addiction

1 CURTIS WRIGHT, IV, MD, MPH
2 problems, you discussed methadone. What about
3 OxyContin, had you ever given any pain patients
4 who also had addiction problems OxyContin?
5 A. No. I was not in the pain treatment
6 business. I was out of the pain treatment
7 business and into the government regulation
8 business before OxyContin came on the market.
9 Q. Was there any controlled release
10 opioids back then?
11 A. Pretty much MS Contin.
12 Q. And did you ever dose MS Contin out
13 because the addicts sort of -- because the
14 addicts thought they needed more pills?
15 A. No. But I negotiate -- but clinic
16 was an exercise in negotiating methadone dose.
17 Forever and a day. Sometimes overtly, and that
18 was relatively easy, and sometimes through a
19 litany of symptoms and concerns.
20 Q. Dr. Wright, do you know if OxyContin
21 creates less chances for addiction than immediate
22 release opioids?
23 A. I don't know. I do know that there's
24 less cycles of drug use with a BID drug or a QID
25 drug or a once-a-week drug than with a Q4 to 6

1 CURTIS WRIGHT, IV, MD, MPH
2 hours drug. There are some theories of addiction
3 that part of the process is that over and over
4 and over again cycle of drug lag, drug loss, drug
5 gain, drug absence, drug effect. We still don't
6 know.
7 Q. It's just not clear one way or
8 another how that might actually potentiate
9 addiction?
10 A. There are people who believe
11 strongly. I have to articulate that respectable
12 people believe strongly that there's a condition
13 effect associated with how often somebody goes
14 through the drug lag/drug loss cycle. I know
15 some scientists at NIDA have --
16 Q. If you're taking a controlled release
17 product and you need to take rescue twice a day,
18 you're going to have to condition the BID product
19 in that lag that you're discussing, correct?
20 A. Yes, but it depends on how much
21 rescue they're taking and what the relative
22 amounts are. The usual recommendations for
23 rescue is that the dose of rescue is much smaller
24 than the dose of maintenance drug. And it forms
25 a bump on the PK profile, not a peak that

217

1 CURTIS WRIGHT, IV, MD, MPH
2 dominates it.
3 Q. And the rescue medication that one
4 would take for OxyContin would normally be
5 another opioid analgesic, correct? In order to
6 serve as a rescue medication.
7 A. What kind of dose range are you
8 talking about with OxyContin?
9 Q. Let's --
10 A. I mean, if somebody's taking low
11 doses of OxyContin, you might get by with a
12 non-opioid rescue. If they're taking 400 or 800
13 a day, you need a rescue.
14 Q. Would you say there's evidence that
15 OxyContin's virtually nonaddictive?
16 A. No.
17 Q. Would you say that's an inaccurate
18 statement to say OxyContin's virtually
19 nonaddictive?
20 A. Yes.
21 Q. And if personnel at Purdue were
22 saying that to doctors, they would be acting
23 contrary to what the labeling says?
24 A. They would certainly be in violation
25 of our policies. I know of nothing in the label

218

1 CURTIS WRIGHT, IV, MD, MPH
2 that says virtually nonaddictive.
3 (Wright Exhibit 27 for
4 identification, document bearing Bates production
5 number 9100939555 through 9100939557.)
6 A. How may I help you?
7 Q. Have you ever seen this before?
8 A. No.
9 Q. It appears to be a memo from training
10 and development to the entire sales -- entire
11 field force of Purdue, correct?
12 A. Yes.
13 Q. It appears to be dated November 4,
14 1996.
15 A. Yes.
16 Q. It says "subject, planning an
17 effective presentation."
18 A. Yes.
19 Q. And it looks like the title of it is
20 "if I only had a brain."
21 A. That's correct.
22 Q. Apparently there's some discussion
23 about the Wizard of Oz. I'm going to skip ahead
24 to where it says "As doctors' scheduling demands
25 are getting tighter, you need to more effectively

219

1 CURTIS WRIGHT, IV, MD, MPH
2 plan your presentations." Do you see that?
3 A. Yes.
4 Q. It says, "How can we build an
5 effective presentation." And looking at number
6 2, it says, "Know your listener and his/her
7 needs/wants. Gather facts about your customer
8 prior to the call. Firing at a target in the
9 dark is not very promising. As you prepare to
10 fire a message, you need to know where to aim and
11 what you want to hit."
12 And then it says in quotes, "The
13 physician wants pain relief for these patients
14 without addicting them to an opioid."
15 Does that sound like a fairly common
16 desire of most prescribers to pain patients?
17 A. Could you repeat that question,
18 please.
19 Q. Why don't I rephrase it.
20 Isn't that what you want as a
21 physician, pain relief for your patient without
22 addicting them to an opioid?
23 A. No, that's not what I want. I'd like
24 pain relief at the minimum risk possible for the
25 patient. I have problems with the second part of

220

1 CURTIS WRIGHT, IV, MD, MPH
2 that sentence because it's a nonmedical
3 sentence. It says I want to give you pain relief
4 without addicting you to an opioid. Well, we've
5 already had several hours discussion over the
6 fact that when we treat a pain patient properly
7 with opioids, we're not addicting them to an
8 opioid. Addiction is uncommon.
9 Q. I understand that. However, in this
10 particular training and development memo sent out
11 to the entire field force, they are rightly or
12 wrongly summarizing what is the message that
13 physicians may want to hear, correct?
14 A. No.
15 Q. You don't think that's what's going
16 on here?
17 A. I don't think that's what's going
18 on.
19 Q. You don't think the point of trying
20 to plan an effective presentation is geared
21 towards a physician so that they will purchase
22 more product? Or prescribe more product.
23 A. This presentation appears to be aimed
24 at the sales force to talk to them about how to
25 present an effective presentation.

221

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Right.
3 A. I don't know who wrote it. I don't
4 know if they even had knowledge of the
5 pharmaceutical industry. I mean, I just don't
6 know. They could have. But if this was a
7 psychologist or a training specialist or somebody
8 who had been hired by the company, I truly don't
9 know, to say okay, here's what we want you to
10 do. Put together a presentation for the entire
11 sales force to talk about how to make an
12 effective presentation. They're going to try to
13 use examples that reach to the experience of the
14 person they're trying to teach. I'm a teacher, I
15 do the same thing.
16 But I don't know much about lawyers
17 so I can't help you there. But if -- so I've
18 written training documents in other fields where
19 I've said things that were inappropriate about
20 how safety programs work or how oversight works
21 or how you would run a program because I really
22 was talking out of my area just trying to say
23 okay, find the message that they want, find the
24 target that they want and try to hit it. That's
25 all. I don't know that this means --

222

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Okay. So you don't know what this
3 person's background was, but as far as I believe
4 what you said, is that statement about without
5 addicting them to an opioid, would you say that's
6 medically inaccurate or scientifically
7 inaccurate?
8 A. I have problems with the subjunctive
9 clause, the physician wants pain relief for these
10 patients without addicting them to an opioid.
11 Don't get me wrong, physicians want opioid level
12 relief without risk of addiction. They wanted
13 that for years. But this is the kind of language
14 that is exactly the kind of morphine resistance
15 language, lay language that drives the pain
16 treatment people crazy.
17 A patient has severe pain, mucositis
18 following radiation therapy is a good example for
19 me because I've seen it and it's just awful. And
20 you have a patient who has it, it takes them half
21 an hour to swallow a cling peach. You know that
22 you could relieve their pain and they say I don't
23 want to be --
24 Q. I think we're getting a little far
25 away from what the question was.

223

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Please forgive me.
3 Q. Looking ahead, number 3, do you see
4 where it says, "Have a well-formulated approach.
5 A single thought or sentence that will best lead
6 you to your objective."
7 And in quotes it says "according to
8 the FDA stated in the OxyContin package insert,
9 drug addiction is characterized by a
10 preoccupation with the procurement, hoarding and
11 abuse of drugs for nonmedicinal purposes. Delayed
12 absorption as provided by OxyContin tablets is
13 believed to reduce the abuse liability of the
14 drug."
15 Do you see how those two sentences
16 are put together?
17 A. Yes.
18 Q. It talks about "develop the hook."
19 You mentioned some description of what that would
20 be.
21 And moving down where it says "know
22 the subject. This is the what, who, where, when,
23 why, how that explains or reinforces your
24 objective. The subject must relate to your
25 listener and correspond to your approach." It

224

1 CURTIS WRIGHT, IV, MD, MPH
2 states "OxyContin can provide pain relief to your
3 patients allowing them to sleep through the night
4 while potentially creating less chances for
5 addiction than immediate release opioids."
6 Do you see that?
7 A. Yes.
8 Q. That language is not in the OxyContin
9 approved label, correct, that OxyContin
10 potentially creates less chances for addiction
11 than immediate release opioids?
12 A. That's correct.
13 Q. While you pointed out that it's
14 subject of some folks who have examined this
15 issue about controlled release drugs and lag time
16 issues and whatnot, it is far from accepted by
17 all addictionologists, correct?
18 MR. STRAUBER: I object to the form
19 of the question. You can answer.
20 A. I don't understand it.
21 MR. STRAUBER: Why don't you repeat
22 it.
23 Q. I'll withdraw the question.
24 While there have been some -- you
25 mentioned before that there were some

225

1 CURTIS WRIGHT, IV, MD, MPH
2 addictionologists who support the notion that --
3 A. Dosage form matters.
4 Q. Yes, that dosage form matters but
5 also that this particular point that a controlled
6 release potentially creates less chances of
7 addiction than immediate release opioid.
8 A. Yes.
9 Q. Is that a majority of
10 addictionologists?
11 A. I don't know. I don't think so.
12 Q. Looking down further, number 6, under
13 "ask for a specific action," in quotes is the
14 sentence, "What two OA patients can you think of
15 right now who could benefit from OxyContin
16 tablets? Can you place a prescription for
17 OxyContin in their charts right now?"
18 I think we discussed before OxyContin
19 would not be appropriate for all osteoarthritis
20 patients, correct?
21 A. That's correct.
22 Q. It would only be within that
23 specified indication where I think at this time
24 was around-the-clock for more than a few days.
25 A. Moderate to severe pain where

226

1 CURTIS WRIGHT, IV, MD, MPH
2 around-the-clock opioids are appropriate for more
3 than a few days.
4 Q. You mentioned this was -- this didn't
5 strike you as written by a medical person,
6 correct?
7 A. What I said was I don't know who
8 wrote this and I don't know the reason they wrote
9 it.
10 Q. Okay.
11 A. If this was written to provide
12 messages that you should use in selling
13 OxyContin, then I would expect to have been
14 through the whatever the color the folder is
15 clearance process, and I don't think this would
16 have cleared.
17 If this is a presentation put
18 together by an expert in selling, and I don't
19 know which it is, then it may very well be put
20 together by someone who does not know what the
21 restrictions on promotion are.
22 Q. Do you know who Dennis Merlo is?
23 A. No.
24 Q. Have you ever met him?
25 A. No.

227

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. You said this probably wouldn't have
3 cleared I guess whatever folder you're referring
4 to, this particular memo. Why wouldn't it have
5 cleared?
6 A. For the reasons that you discussed.
7 When a promo piece is going to be used for
8 promotion, not necessarily for training on how to
9 sell, then it would have to go through and the
10 medical department and the legal department would
11 look at it and say are each of these messages
12 justified by the package insert, do they
13 represent fair balance on the risks and benefits
14 of the drug, is this okay, is this wise. And
15 this is a fairly positive and fairly unbalanced
16 presentation of OxyContin.
17 Q. Now, do you know if training
18 materials would have to go through the same
19 process?
20 A. I truly don't know.
21 (Recess taken.)
22 (Wright Exhibit 28 for
23 identification, document bearing Bates production
24 number 9101803798 through 9101803799 and
25 9101803800 through 9101803808.)

228

1 CURTIS WRIGHT, IV, MD, MPH
2 BY MR. McNAMARA:
3 Q. Can you look at page 3802. Would you
4 agree with me first that these are meeting
5 minutes for Purdue and -- Purdue Pharma L.P. and
6 the FDA for a meeting that apparently took place
7 on June 14 of 2001?
8 A. This is a regulatory contact report,
9 or appears to be, that was sent through Purdue's
10 e-mail to multiple recipients describing what
11 Purdue thought happened in an FDA teleconference
12 meeting.
13 Q. In fact, you were one of the
14 recipients for Joyce Mulligan.
15 A. Yes.
16 Q. Do you remember seeing these
17 minutes?
18 A. At the time I think.
19 Q. Directing you to 3802, starting with
20 the paragraph "Dr. McCormick began the labeling
21 discussion by expressing the agency's concern
22 about the clinical trials section. The trials
23 currently in the label are pain models in
24 artificial settings with regard to the
25 appropriate use of the product. The agency's

1 CURTIS WRIGHT, IV, MD, MPH
2 position is that neither the osteoarthritis nor
3 the single dose post-operative pain study
4 provided adequate data for a claim in the
5 label."
6 I think we touched upon this earlier,
7 correct?
8 A. Yes.
9 Q. That you have to find pain models to
10 test the drug where you'd have patients who are
11 willing to participate in order to be ethical to
12 do so. But at the same time you don't want to
13 create an impression that a drug, if tested for
14 this pain group, is appropriate for all patients
15 within that pain group.
16 A. Or within that diagnostic category.
17 Q. Right —
18 A. In addition, there was clearly
19 final — there appears to have been resolution
20 since 1992/1993 when these studies were --
21 OxyContin studies were planned on how to address
22 the IR/CR switch. And this is language more
23 appropriate to please do a full development
24 plan.
25 Q. Dr. McCormick stated here, "The

1 CURTIS WRIGHT, IV, MD, MPH
2 studies as they were formed and described in the
3 label are in contradiction to the indications we
4 have inserted in the label." Do you see that?
5 It's the next sentence after the single dose —
6 A. Yes. As I read it, it says she wants
7 placebo controlled studies in the intended
8 population.
9 Q. And the intended population I think
10 she --
11 A. Moderate to severe pain requiring
12 around-the-clock opioids for more than a few
13 days.
14 Q. And what she says here is the
15 intended population, and that the studies which
16 enrolled patients — was that referring to the
17 studies talked about in the clinical studies
18 section of the OxyContin label. "Enrolled
19 patients based solely on their disease state
20 rather than their pain status, and their use of
21 and failure of other non-opioid medications, send
22 a misleading message regarding the appropriate
23 use of the drug."
24 A. And continues, an agency concern is
25 the studies in the label will allow the sponsor

1 CURTIS WRIGHT, IV, MD, MPH
2 to market the drug in the ways that may be
3 misleading.
4 This is the same discussion that we
5 had earlier, that I had earlier. That's the
6 perennial problem of pain model, easy to analyze,
7 well-controlled, highly predictive, very
8 comfortable, not terribly predictive of real
9 life. In real life you don't let a patient
10 develop moderate to severe pain post operatively
11 before you give him some pain meds. But that's
12 our post op pain model. And this dilemma is
13 still unsolved.
14 Q. You said we talked about earlier, and
15 we did, we talked about earlier that one of the
16 things to avoid though of course was marketing
17 based upon disease or pain syndromes as opposed
18 to pain intensity, that being what's controlled
19 by the indication.
20 A. Marketing in a way that would leave
21 the prescriber to select inappropriate patients.
22 That's always a concern.
23 (Wright Exhibit 29 for
24 identification, Call Report, document bearing
25 Bates production number 7911443057.)

1 CURTIS WRIGHT, IV, MD, MPH
2 A. How may I help you, sir?
3 Q. This appears to be another call
4 report, correct?
5 A. Correct.
6 Q. This one with a sales rep named
7 Steven Ochu and a doctor named Valencia Martin.
8 A. Yes.
9 Q. Can I point you to where it says
10 "OxyContin, spend a few minutes, really listened
11 to what I had to say. Talk about the right
12 patients and less tablets and less abuse."
13 A. Yes.
14 Q. It appears to indicate there was a
15 discussion about OxyContin having less abuse
16 potential.
17 A. One would infer.
18 Q. Now, the label — the improved
19 labeling, and this is 1999, as we discussed, it
20 didn't actually say that OxyContin had less abuse
21 potential than controlled release — than
22 immediate release opioids, correct?
23 A. It said that controlled release
24 opioids like OxyContin were believed to have
25 lower abuse potential.

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. And to this day it's still not been
3 proven that controlled release oxycodone,
4 OxyContin has a less abuse potential than
5 immediate release OxyContin, correct?
6 MR. STRAUBER: Object to the form of
7 the question. Don't know what you mean by
8 "proven."
9 A. I think that it's — we can go
10 further than that, and that is that in — again,
11 it depends whether you mean for patients or
12 abusers. I think there's some evidence that in
13 some parts of the country OxyContin has become
14 specifically targeted as a drug of abuse.
15 Q. So then the whole paradigm would kind
16 of fall apart because it's been targeted by
17 abusers. But with regards to pain patients.
18 A. With regards to pain patients, what
19 the label says is what the label says. Drugs of
20 this class may have a reduced risk, and the
21 question is what did the rep really say and did
22 they get sloppy in their documentation. I just
23 don't know.
24 (Wright Exhibit 30 for
25 identification, Call Report, document bearing

1 CURTIS WRIGHT, IV, MD, MPH
2 Bates production number 7911450215.)
3 A. How may I help you on this one?
4 Q. This appears to be another call
5 report, correct?
6 A. Yes.
7 Q. From Mr. Ochu with regards to
8 Dr. Wheeler.
9 A. Yes, sir.
10 Q. In the notes/memo section it says "O,
11 where can I help you with pain control. H, look
12 at my name tag, kind of to see if I was with the
13 state board. I, ment long acting. I, why Rx a
14 short-acting if you have a long-acting. H, ask
15 how to dose again and was it available in the
16 hospital. A reminder on Senokot."
17 It appears that Mr. Ochu was
18 memorializing a discussion he had with
19 Dr. Wheeler.
20 A. I'm having a hard time. This is a
21 little telegraphic for me.
22 Q. Well, O being either Ochu, which
23 would seem to follow, where can I help you with
24 pain control. H, meaning he or Harold --
25 A. "Looked at my name tag to see if I

235

1 CURTIS WRIGHT, IV, MD, MPH
2 was with the state board."
3 Q. And then "I," I guess once again
4 referring to Mr. Ochu as the sales rep who made
5 this, "ment long-acting. I, why Rx a
6 short-acting if you have a long-acting."
7 Rx is sort of a shorthand for
8 prescription, right?
9 A. Usually.
10 Q. So it appears he was asking
11 Dr. Wheeler why prescribe a short-acting if you
12 have a long-acting, correct?
13 A. I guess. This is really telegraphic
14 and badly written note. How may I help you?
15 Q. Well, you know of instances of course
16 why it would be more appropriate to prescribe a
17 short-acting opioid and then a long-acting opioid
18 like OxyContin, correct?
19 A. Certainly.
20 (Wright Exhibit 31 for
21 identification, Call Report, document bearing
22 Bates production number 7911450927.)
23 A. This appears to be another one of
24 Steven Ochu's call notes.
25 Q. And in this one he apparently says

236

1 CURTIS WRIGHT, IV, MD, MPH
2 "O, show OA picture. How do you treat this
3 patient. H, I guess a short-acting, why not
4 OxyContin, less tabs and better pain control.
5 Okay he said as he was walking away. Ment
6 Uniphyl how to dose."
7 Does this not appear that Mr. Ochu
8 was once again suggesting to Dr. Wheeler why not
9 use OxyContin instead of a short-acting product?
10 A. It's a reasonable inference.
11 Q. Less tabs and better pain control.
12 Again, there would be instances when, especially
13 with osteoarthritis, when a PRN or a short-acting
14 opioid would be more appropriate than OxyContin,
15 correct?
16 A. There would be instances with
17 osteoarthritis where a non-opioid would be more
18 appropriate therapy. I don't know what picture
19 he showed and I don't know what the context was.
20 Q. But there's no -- you don't see any
21 references in the call reports we looked at to
22 moderate to severe pain where an around-the-clock
23 opioid is required for more than a few days?
24 A. Not in the three or four that you've
25 selected.

237

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. Do you know if anyone from medical
3 affairs ever looks at the call reports of sales
4 reps to see if they're discussing all the medical
5 issues with regards to the drugs in their
6 discussions with the doctors?
7 MR. STRAUBER: I object to the form
8 of the question. You seem to be suggesting that
9 the package insert has to be replicated in the
10 call reports.
11 MR. McNAMARA: Actually, Don, I'd
12 appreciate it if you'd just object to form.
13 MR. STRAUBER: I have done that
14 throughout. Things are getting a bit silly.
15 MR. McNAMARA: Once again, I'd
16 request that you just object to form as required
17 under the rule.
18 A. Would you repeat the question, I lost
19 it in the objection.
20 Q. Sure. Let me try to rephrase it.
21 Do you know if there's any mechanism
22 at Purdue where persons in your department might
23 look over the call reports of sales staff and ask
24 them, well, did you guys address issues that are
25 involved with the labeling such as the indication

238

1 CURTIS WRIGHT, IV, MD, MPH
2 for use?
3 A. I'm in clinical research. I don't
4 interface with sales.
5 Q. Well, do you know if there's a
6 mechanism?
7 A. I don't know.
8 Q. Fair enough.
9 (Wright Exhibit 32 for
10 identification, Call Report, document bearing
11 Bates production number 7911452553.)
12 A. This is Steven Ochu again.
13 Q. It appears so. It's June 22, 2000.
14 A. 6/22/2000.
15 Q. "O, by phone." Is that the one you
16 have?
17 A. Yes.
18 Q. "Dr. Wheeler, I wanted to provide you
19 a benefit that short-acting hydro can't do.
20 Showed him cess of therapy and explained why."
21 Any idea what that is?
22 A. No. I genuinely don't understand
23 that at all.
24 (Wright Exhibit 33 for
25 identification, Call Report, document bearing

239

1 CURTIS WRIGHT, IV, MD, MPH
2 Bates production number 7911452549.)
3 A. Steven Ochu again.
4 Q. This is also dated June 22nd of 2000,
5 and this is with regards to Dr. Valencia Martin.
6 And in the notes section it states "O, got her
7 attention. When you Rx a short-acting pain med,
8 why not use a long-acting and went directly to
9 cessation of therapy. You can't do this with
10 hydro and ment BD you doc the same as the short
11 act."
12 It appears at least in the first
13 clause that, once again, it's the suggestion why
14 not use a long-acting instead of a short-acting.
15 Correct?
16 A. Well, certainly the phrase why not
17 use a long-acting -- "when you Rx a short-acting
18 med, why did not use a long-acting." I don't
19 know what "went directly to cess of therapy"
20 means. "You can't do this with hydro," I don't
21 know what that means. The same -- "you doc the
22 same" -- this one's -- I don't know.
23 Q. But it appears that once again it's a
24 suggestion of use long-acting OxyContin instead
25 of a short-acting opioid, correct?

240

1 CURTIS WRIGHT, IV, MD, MPH
2 A. Yes.
3 Q. Without regards perhaps to -- well,
4 at least through this call report, there's no
5 mention of what the underlying pain was, right?
6 A. Wait a minute. I've agreed with you
7 so far because it's been tough to figure out what
8 was going on here. I guess I'm not completely
9 convinced that he's talking -- when they're
10 talking about this they're talking about
11 initiation of opioid therapy.
12 Q. Okay.
13 A. That's all. I mean, it may be that
14 he's sitting here saying when you're prescribing
15 the short-acting opioids for appropriate
16 patients, why not prescribe a long-acting. But I
17 can't tell from the memo.
18 Q. It also can't -- you can't determine
19 whether or not he's saying whenever you use
20 short-acting, why not just use long-acting.
21 A. You could infer that as well. I
22 don't know which it is.
23 Q. I believe I'm going to have some
24 questions for you once and if I get a chance to
25 look at the reports you talked about with regards

241

1 CURTIS WRIGHT, IV, MD, MPH
2 to I believe OC 970302, which would be the
3 three-year registry.
4 MR. STRAUBER: Is that a question?
5 Q. Did I properly identify the
6 three-year registry?
7 A. I don't know the number by heart.
8 Q. In any event, I may have some
9 questions of you on that. I don't have that
10 study before me right now so at this point I'm
11 going to turn it over to Don.
12 A. Be aware that I was not the physician
13 running that study and I did not write the
14 report.
15 Q. Thank you.
16 MR. STRAUBER: Let's take a
17 five-minute break. I'd like to look at my
18 notes. I think I have a few questions but it
19 will only be short, in any event.
20 (Recess taken.)
21 EXAMINATION BY MR. STRAUBER:
22 Q. Dr. Wright, I just have a few
23 questions that I'd like to ask you.
24 Do you recall the questions about the
25 statement of the package insert that says

242

1 CURTIS WRIGHT, IV, MD, MPH
2 iatrogenic addiction to opioids legitimately used
3 in the management of pain is very rare?
4 A. Yes, I remember that.
5 Q. Do you believe that statement in the
6 package insert is true?
7 A. Yes, I believe that.
8 Q. Do you believe that the statement
9 "iatrogenic addiction to opioids legitimately
10 used in the management of pain is very rare" is
11 true with regard to patients who are treated in
12 pain clinics?
13 A. Iatrogenic addiction?
14 Q. Let me repeat the question. Do you
15 believe that the statement "iatrogenic addiction
16 to opioids legitimately used in the management of
17 pain is very rare" is true with respect to
18 patients who are treated for pain?
19 A. Yes, I do.
20 Q. Do you recall saying in response to a
21 question that addiction rates can be higher in
22 patients who have pain that is difficult to
23 treat?
24 A. Yes, I do.
25 Q. When you referred to patients who

243

1 CURTIS WRIGHT, IV, MD, MPH
2 have pain that is difficult to treat, what types
3 of patients were you referring to?
4 A. I believe I was referring to patients
5 who had preexisting addiction.
6 Q. Now, if those patients become
7 addicted, would that addiction be iatrogenic?
8 A. If someone's already addicted, it is
9 not iatrogenic addiction.
10 Q. Did the OxyContin package insert have
11 any warnings that would alert physicians that
12 OxyContin should be used with extra care in
13 patients with a history of drug abuse?
14 A. Not directly.
15 Q. And what was in the package insert
16 that alerted doctors to the proper treatment of
17 patients who had a history of drug abuse?
18 A. The suggestions were scattered
19 through the package insert. There were
20 suggestions that you should use the AHCPR
21 guidelines, American Pain Society guidelines,
22 which talk about these patients. There was
23 extensive discussion of individualization of
24 dosage, selection of patients, physical
25 dependence, addiction, the differences between

244

1 CURTIS WRIGHT, IV, MD, MPH
2 tolerance and physical dependence in abuse and
3 addictions. Warnings that patients with existing
4 abuse would seek out the drug and that that was
5 more common than iatrogenic addiction. A
6 complete descriptions of withdrawal syndromes,
7 detoxification schedules, management of
8 detoxification. There's a lot in that package
9 insert about drug addiction.
10 Q. And of course it calls out the fact
11 that the drug is a Schedule II.
12 A. Yes.
13 Q. And it warns the physician to know
14 their patients, to take a history.
15 A. To individualize the dose to the
16 patient's presentation and to select the patients
17 who need this medication.
18 Q. And it warns the physician that
19 relapse is common among drug addicts?
20 A. Yes, it does.
21 Q. Let me read a sentence to you that
22 appeared in Exhibit 27 and simply tell me whether
23 it's true or false. "OxyContin can provide pain
24 relief to your patients, allowing them to sleep
25 through the night while potentially creating less

245

1 CURTIS WRIGHT, IV, MD, MPH
2 chances for addiction than immediate release
3 opioids." True or false?
4 A. True.
5 MR. STRAUBER: I have no other
6 questions.
7 EXAMINATION CONTINUED BY MR. McNAMARA:
8 Q. Would you agree, true or false, with
9 that statement that your attorney just read was
10 not included in the package insert for
11 OxyContin?
12 A. The statement was not included in the
13 package insert for OxyContin.
14 Q. And that no where in the package
15 insert for OxyContin was the statement that
16 OxyContin may potentially create less chances for
17 addiction to opioids?
18 A. That statement was not in the package
19 insert.
20 Q. So when you're saying it's true,
21 you're saying it's true based upon your own
22 personal beliefs?
23 A. Potential -- I'm saying it's true
24 because potentially, because of the adjective
25 involved, "potentially" is an adjective that is

246

1 CURTIS WRIGHT, IV, MD, MPH
2 consonant with the use of the word "may" in the
3 current package insert. Definitely, certainly,
4 proven, those would not be supportable. I'm not
5 sure they're true.
6 Q. The language used in the package
7 insert with the word "may" had to do with abuse
8 liability, correct? Not addiction.
9 A. For a patient taking the drug who
10 doesn't already have addiction, abuse liability
11 is more closely -- is presumed to be a surrogate
12 for addiction. It's how much liking, how much
13 central drug effect they get from the drug over
14 cycles of taking in a vulnerable patient in the
15 right social setting that's believed to trigger
16 addiction.
17 So if it has less abuse potential, if
18 it's got less liking, if it's got less central
19 drug effect, who would expect it to have less
20 risk, I think the statement's weak in the package
21 insert because of the lack of the head to head
22 data that you described.
23 (Testimony continued on following
24 page to include jurat.)
25

247

1 CURTIS WRIGHT, IV, MD, MPH
2 Q. I have no further questions.
3 MR. STRAUBER: Thank you.
4 (TIME NOTED: 6:04 p.m.)
5
6 CURTIS WRIGHT, IV, MD MPH
7 Subscribed and sworn to before me
this _____ day of ________, 2003.
8
9 ______________________________
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248

1 CURTIS WRIGHT, IV, MD, MPH
2 STATE OF NEW YORK) Pg__of__Pgs
3 ss:
4 COUNTY OF NEW YORK)
5 I wish to make the following changes, for
6 the following reasons:
7 PAGE LINE
8 ____ ____ CHANGE: ______________
9 REASON: ______________
10 ____ ____ CHANGE: ______________
11 REASON: ______________
12 ____ ____ CHANGE: ______________
13 REASON: ______________
14 ____ ____ CHANGE: ______________
15 REASON: ______________
16 ____ ____ CHANGE: ______________
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20 ____ ____ CHANGE: ______________
21 REASON: ______________
22 ____ ____ CHANGE: ______________
23 REASON: ______________
24 ____ ____ CHANGE: ______________
25 REASON: ______________

249

1
2 CERTIFICATE
3 STATE OF NEW YORK)
4 : ss.
5 COUNTY OF NEW YORK)
6
7 I, SUZANNE PASTOR, a Shorthand
8 Reporter and Notary Public within and for the
9 State of New York, do hereby certify:
10 That CURTIS WRIGHT, IV, MD, MPH, the
11 witness whose deposition is hereinbefore set
12 forth, was duly sworn by me and that such
13 deposition is a true record of the testimony
14 given by the witness.
15 I further certify that I am not
16 related to any of the parties to this action by
17 blood or marriage, and that I am in no way
18 interested in the outcome of this matter.
19 IN WITNESS WHEREOF, I have hereunto
20 set my hand this ____ day of __________, 2003.
21
22 ______________________
23 SUZANNE PASTOR
24
25

250

1
2 EXHIBITS
DESCRIPTION PAGE LINE
3
(Wright Exhibit 1 for identification,
4 Notice of Deposition.)................... 20 5
5 (Wright Exhibit 2 for identification,
document bearing Bates production
6 number 8002065027 through 8002065089.).... 66 24
7 (Wright Exhibit 3 for identification,
document bearing Bates production
8 number 8113900032 through 8113900043.).... 79 16
9 (Wright Exhibit 4 for identification,
document bearing Bates production
10 number 8113900019 through 8113900024.).... 79 25
11 (Wright Exhibit 5 for identification,
document bearing Bates production
12 number 8001000296 through 8001000313.).... 84 3
13 (Wright Exhibit 6 for identification,
Notes of Discussion.)..................... 87 13
14
(Wright Exhibit 7 for identification,
15 Project Team Contact Report, 10/22/92.)... 95 10
16 (Wright Exhibit 8 for identification,
document bearing Bates production
17 number 8113900235.)...................... 98 17
18 (Wright Exhibit 9 for identification,
8113900315 through 8113900323.)......... 101 2
19
(Wright Exhibit 10 for identification,
20 document bearing Bates production
number 7501020320 through 7501020327.)... 111 13
21
(Wright Exhibit 11 for identification,
22 document bearing Bates production
number 8002017468 through 8002017497.)... 125 7
23
(Wright Exhibit 12 for identification,
24 Porter and Jick Letter to the Editor.)... 130 13
25 (Wright Exhibit 13 for identification,

251

1
2 EXHIBITS
DESCRIPTION PAGE LINE
3
(Wright Exhibit 14 for identification,
4 document bearing Bates production
number 8001039123 through 8001039135.)... 153 19
5
(Wright Exhibit 15 for identification,
6 document bearing Bates production
number 8003007024 through 8003007048.)... 160 16
7
(Wright Exhibit 16 for identification,
8 document bearing Bates production
number 8003007060 and 8003007076.)...... 162 23
9
(Wright Exhibit 17 for identification,
10 Medical Officer Review.)__________ 164 25
11 (Wright Exhibit 18 for identification,
MS Contin Product Label.).............. 169 22
12
(Wright Exhibit 19 for identification,
13 document bearing Bates production
number 8113900101 through 8113900102.)... 184 12
14
(Wright Exhibit 20 for identification,
15 document bearing Bates production
number 8810119940.)____________ 188 9
16
(Wright Exhibit 21 for identification,
17 document bearing Bates production
number 9101803708 through 9101803709
18 and 9101803722.)____________ 192 11
19 (Wright Exhibit 22 for identification,
document bearing Bates production
20 number 9101804000 and 9101804012.)...... 195 7
21 (Wright Exhibit 23 for identification,
document bearing Bates production
22 number 9101804075 through 9101804076.)... 196 25
23 (Wright Exhibit 24 for identification,
Current Labeling.)...................... 198 18
24
(Wright Exhibit 25 for identification,
25 Call Report, document bearing Bates

252

1
2 EXHIBITS
DESCRIPTION PAGE LINE
3
(Wright Exhibit 26 for identification,
4 Call Report, document bearing Bates
production number 7912533279.)........... 214 2
5
(Wright Exhibit 27 for identification,
6 document bearing Bates production
number 9100939555 through 9100939557.)... 218 2
7
(Wright Exhibit 28 for identification,
8 document bearing Bates production
number 9101803798 through 9101803799
9 and 9101803800 through 9101803808.)...... 227 21
10 (Wright Exhibit 29 for identification,
Call Report, document bearing Bates
11 production number 7911443057.)........... 231 22
12 (Wright Exhibit 30 for identification,
Call Report, document bearing Bates
13 production number 7911450215.)_______ 233 23
14 (Wright Exhibit 31 for identification,
Call Report, document bearing Bates
15 production number 7911450927.)_______ 235 20
16 (Wright Exhibit 32 for identification,
Call Report, document bearing Bates
17 production number 7911452553.)........... 238 8
18 (Wright Exhibit 33 for identification,
Call Report, document bearing Bates
19 production number 7911452549.)........... 238 23
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ABBOTT 1:10,10
abdominal 171:10
ability 5:9 70:3
able 5:7 58:10 142:4 185:19
about 5:10 7:24 8:5,6 9:21 10:15 10:18,24 12:10,14,17 17:2 18:23 19:5 22:9 22:13 24:18 24:20 25:14 26:21 27:25 33:5 34:8 36:22,23,23 37:15,15 38:3,13,15 39:11,12,16 39:20,23,24 40:5 41:25 42:10 48:3 48:7 51:8 52:2,9 55:20 56:19 59:20 60:9 60:14,16 61:17 62:18 62:20 63:8 64:11 68:8 70:9,21,25 74:9,13,22 75:8 77:3 78:11 79:9 79:25 86:15 87:20,22 88:3,24,25 89:12 90:14 91:20 93:18 95:24 96:5 96:6,13,20 96:21 97:6 98:8 99:12 99:16,18,22 101:22 103:9 105:20 108:8 109:7 109:9 111:13 113:24 115:10,16 115:19 116:8,21 117:9,15 118:4,4 121:16 123:6 124:3 124:22 125:6,22 126:2,7,13 126:15,21 128:4,23 130:24 134:4,9 135:20 139:19 141:9,13,15 142:17 143:6,15 144:2,4,16 145:12 146:2,9,19 146:21 149:18 151:7 155:23 157:21 158:18,22 159:2,3,10 159:24 160:5,13 163:8 168:12,13 169:10 173:10,14 173:18 174:4,20 177:22 179:11,12 181:24 182:17,20 182:24 187:10,17 188:21 189:4,25 190:9,13,16 190:24 194:10,21 196:4,13 197:25 198:10 200:3 201:4 201:15,25 202:3,4 203:12,14 203:16,18 203:22,23 204:23 206:15,20 208:6,15,24 210:7,19,20 211:17 212:22,23 212:25 213:10,15 214:21 215:2 217:8 218:23 219:7 220:24 221:11,16 221:19 222:4 223:18 224:15 228:22 230:17 231:14,15 232:11,15 240:10,10 240:25 241:24 243:22 244:9
above 167:24
ABRAHAM 2:12
abruptly 59:15 170:19,24 171:16
absence 172:3 216:5
absolutely 99:20 103:10 137:25 202:13
absorbed 35:25
absorption 114:9,14 117:24 152:3,17 153:8,16 156:2,13 158:10 159:24 163:19 164:12 223:12
abstinence 170:25
abstract 80:11 104:16 148:22
abusable 42:17,20 74:23 83:8 154:21
abuse 5:22 6:13,14 13:4 14:15 15:4,5 25:23 26:3 26:8,11 27:15 28:5 32:2 34:9,9 34:12,18,21 34:23,24 35:4,5,7,20 36:4,21,24 37:11 38:3 38:8,11,18 39:25 40:6 40:10,12,24 41:7,9,11 41:25 42:23 43:20 44:15 45:3,4,9,20 46:13,19 47:15,17,22 49:25 50:22 54:19 55:21 56:2,9,13 56:19,25 63:13 64:23 65:14,14 66:4,7,10 74:19 77:2 77:14 78:23 78:24,25 79:2,2,9 80:16,25 81:21 82:9 82:11,17 85:24 86:24 92:4,13 93:12 95:17 95:20,25 96:9 97:14 111:18 112:15,16 112:24 113:8,10,13 113:15,15 113:24,25 114:10,15 115:16,19 116:3,6,18 117:3,20,25 118:8,11,12 118:13,24 119:13,23 119:25 123:15 127:4,8,11 135:12,15 136:3 148:18 149:3 150:8 150:17,22 151:2,9 152:4,18 153:10,17 154:10 155:2,9,20 156:3,10,14 156:24 157:6,21 159:25 162:12,15 163:17,22 164:13 174:24 190:18,19 191:21 193:8,25 194:10,22 195:14 196:13 197:11 199:13,20 199:24 200:3 202:7 202:8 203:3 204:4,5,7,8 204:8,18,23 208:10,25 209:4 212:11 223:11,13 232:12,15 232:20,25 233:4,14 243:13,17 244:2,4 246:7,10,17
abused 50:13 190:19
abuser 27:4 42:18 92:6
abusers 35:12 114:2 114:6 122:19 233:12,17
abuses 86:10
abusing 207:20
accede 115:14
accept 97:9 151:6
acceptable 31:9 73:17 183:17
accepted 10:12 18:11 152:9 194:15 201:18,19 224:16
access 210:16
accompanied 128:9 171:21
accordance 68:22
according 116:24 136:25 161:3

185:15
223:7
account
180:9
accumulated
118:7
accurate
165:25
166:3
167:16
180:11
acetaminop...
97:13
achieve 37:25
achieved
146:4 187:6
acid-base
171:23
across 174:13
acrylic
101:25
act 31:12
53:25
154:14
239:11
acting 217:22
234:13
action 1:7
225:13
249:16
actions 36:12
active 93:22
102:11,15
103:17
135:6,14
190:16
actively 44:9
activities
19:10
198:15
activity 160:8
160:10
162:13
163:20
164:5
acts 54:8,9
actual 13:19
15:13 42:11
62:19
102:18
119:13
122:15
142:17
187:3
actually
38:21 40:20
47:9 52:5
54:11 69:7
82:7 83:24
97:12
100:11
108:22
111:7 119:9
121:5 122:9
129:7 141:3
174:6
175:24
177:21
184:18
187:4,5
199:25
202:2 208:9
216:8
232:20
237:11
acute 137:6
137:12
202:17
add 4:16
75:17
121:23
204:17
added 32:6
109:18,22
196:16
199:9,10
204:22
addict 28:2
59:9 94:4
135:10,10
139:10
addicted 31:4
132:8
146:12
147:8
197:16
205:22
207:7 243:7
243:8
addicting
219:14,22
220:4,7
222:5,10
addiction
28:16,20,23
29:6,8,9,16
30:18 32:14
46:8 55:22
56:2,8,9,14
56:25 57:6
57:18,21,22
57:25 58:13
81:11 82:17
92:12,20
93:20,22
95:21 96:7
96:23 113:4
113:6,7
122:23
123:2,21
124:6
127:19
128:6 130:4
131:8,13,14
131:15,20
131:21,23
132:3,4,12
132:13,17
132:18
133:12,12
135:6,12,14
139:14,20
142:23,24
143:3,6,8
144:2,4,23
145:23
146:8,22,25
148:18
149:4 194:5
194:8,10,25
195:20
196:8,14,17
197:13
200:3,8,12
200:16
201:23
202:4 203:3
203:25
205:9 209:7
210:6
211:23
212:8,21
214:17,25
215:4,21
216:2,9
220:8
222:12
223:9 224:5
224:10
225:7 242:2
242:9,13,15
242:21
243:5,7,9
243:25
244:5,9
245:2,17
246:8,10,12
246:16
addictionol...
224:17
225:2,10
addictions
244:3
addiction/d...
127:8
addictio)n
127:9
addictive
27:21,22
58:16 61:9
149:14
addicts 26:13
26:16 35:12
77:2 82:5
114:2,6
122:3 123:8
123:24
132:9,10,10
134:6 212:4
214:13
215:13,14
244:19
adding
190:25
addition
31:24 59:17
95:21
229:18
additional
14:3 27:2
27:12,13
109:16
212:15
address
63:15,17
92:24,25
106:19,20
158:21
229:21
237:24
addressed
32:7 64:11
106:16
175:10
addressing
159:4
adequacy
110:9
adequate
72:19 73:18
142:5 229:4
adequately
90:23
adjective
51:19,21
80:13 81:10
82:2 245:24
245:25
adjectives
80:15 82:5
83:13
adjusted
37:18 87:4
87:10
administered
183:17
administeri...
27:21
administra...
3:16 6:20
6:23 10:10
56:10 71:6
88:23
152:22
193:14
administra...
165:22
Adolor 7:19
7:23,25
10:4,13
17:11,19
43:25
adopted
197:25
advanced
26:8
adverse
32:24 82:2
134:13
157:25
167:13,18
168:10
173:19,25
174:21,24
175:4 180:6
advertising
19:8,14
76:15,19
advice 27:5
130:12
195:23
196:12
advise 93:15
175:12
advocated
210:13
affairs 6:18
6:25 7:2
10:6 237:3
affect 4:23
5:2 29:16
32:13 58:23
207:21
affecting 6:10
Affirmative
114:7
148:21
154:4,23
after 4:17
6:21 9:11
10:16 80:10
109:17
116:16
128:5
138:14
159:22
168:22
170:18
181:24
188:16,18
190:19
199:10
230:5
afternoon
95:9 140:8
again 61:21
74:9 100:9
102:22
108:3 145:4
155:22
156:20
163:16

164:2
167:17
193:21
195:12
207:8 216:4
233:10
234:15
235:3 236:8
236:12
237:15
238:12
239:3,13,23
against 1:8
19:9 48:8
100:11
103:15
121:12
151:20
167:11
178:4
202:16
age 203:9
agencies
210:19
agency 14:10
14:11 15:16
68:23 71:10
71:16 72:14
73:2 88:7
91:7 92:22
94:9 97:11
99:23 102:4
115:3
116:15
117:11
165:14
168:8 186:4
198:8
230:24
agency's
71:17
228:21,25
aggressive
209:19
agnostic
168:15
ago 97:24
105:2
116:10
agonist 54:8
83:2 121:20
agonist/ant...
49:17,19
53:19,23
54:10 74:14
83:3
agree 13:5,11
13:12,14
123:18
136:7
137:21
145:19,24
150:9 193:3
200:14,17
202:5
204:11
228:4 245:8
agreed
109:18
240:6
agreement
158:8
AHCPR
124:20
144:22
145:4
207:13
209:19
243:20
ahead 5:8
68:11
115:25
173:17
218:23
223:3
aim 219:10
aimed 220:23
akin 134:5
Alabama 2:9
Albert 105:8
alcohol 26:11
alcoholics
26:13,16
37:9,15
203:13
alcoholism
26:21 27:4
92:14 203:7
203:11
alert 243:11
alerted
205:23
206:13
207:10
243:16
ALLEN 2:8
allow 110:18
230:25
allowed
13:14 89:25
allowing
224:3
244:24
alluded
135:24
Almost 56:8
along 115:6
145:14
already 28:12
83:8 110:22
127:16
128:4
129:12
207:25
220:5 243:8
246:10
alteration
163:18
alterations
57:12
altering
47:19
alternative
116:14
although
14:2 115:3
125:6
131:10
176:23
always 28:18
84:3 135:3
166:2 184:3
205:3
231:22
amazingly
121:17
amend 73:20
197:10
America 45:5
209:15
American
29:23 33:22
46:2 124:21
133:16
145:6
243:21
among
107:16
135:14,15
142:23
182:6
244:19
amongst
83:12 147:2
147:6
amount
14:24 36:23
36:25 37:18
37:19 75:23
118:6
122:17
amounts 15:2
180:19
216:22
amplify
23:23
analgesia
45:8 173:2
analgesic
12:3 54:17
107:9
158:16
179:8
180:19,21
180:22
181:22,23
182:4
183:22
184:10
196:18
217:5
analgesics
197:13
200:8
analog 51:15
85:14
analysis 7:2
analyze 52:9
231:6
analyzing
80:24
anesthesia
203:20
anesthetic
12:3
animal 41:11
Ann 11:18
annotated
125:12,14
126:20
annotation
188:14
194:19
anomaly
45:22
anorexia
171:11
another
93:23,24
98:21
154:22
163:9
183:15
185:23
188:13
197:18,19
214:6,7
216:8 217:5
232:3 234:4
235:23
answer 4:14
4:15 5:8
13:17 14:7
18:3 23:23
28:13 31:7
32:10 50:8
56:8 60:21
81:9 120:23
146:17
157:13
191:25
205:14
207:21
212:17
224:19
answered
58:7 200:24
answering
46:10
antagonist
47:20 54:11
54:13 74:17
79:6
antagonist/...
49:15 52:13
52:23
anticipate
36:4,9
37:17 39:10
61:6 118:9
antidote
53:25
antihistami...
179:14
antiinflam...
90:9
anxiety 171:9
anxious
10:17 59:19
anybody
206:13
anymore
41:6 129:22
153:18
201:13,14
anyone 17:3
25:13,18
57:9 107:24
164:11
185:10
237:2
anyone's 58:7
anything
9:20 18:25
24:4 64:17
79:8 101:21
155:16
174:20
205:11
210:21
213:10,15
anyway
72:22
Anywhere
15:8
apart 103:20
233:16
apologize
79:23
apparently
68:7 69:8
84:23
102:25
138:11
146:23
151:25
155:5
160:22
163:24
184:17
218:22
228:6

235:25
appear 87:20 140:12 170:7 201:3 236:7
APPEARA... 3:2
appeared 244:22
appears 68:3 84:11 95:13 98:21 101:5 125:11 153:23 154:2 192:16 212:3 214:6 218:9,13 220:23 228:9 229:19 232:3,14 234:4,17 235:10,23 238:13 239:12,23
appendix 67:7,7 76:14
applicable 68:18
application 15:20 49:21 70:7 82:3 125:14,18 125:21,24 153:14,24 167:3 177:2
applications 129:15
applied 191:21
apply 191:6 193:16
appointment 21:22
appreciate 237:12
approach 123:18 128:3 223:4 223:25
approaches 72:9
appropriate 28:19 30:13 30:20 33:11 33:14 37:19 67:12 68:18 74:24 79:6 106:23 107:19 133:8 140:8 185:17 186:20 207:12 225:19 226:2 228:25 229:14,23 230:22 235:16 236:14,18 240:15
appropriat... 73:20 106:25 176:8,9
appropriat... 110:9
approval 9:11 65:8 66:22 68:9 70:14 73:3 73:11 108:14 117:11 118:5 156:17
approved 18:7 19:21 19:24 73:4 76:3 111:3 113:5 117:7 122:15,20 126:4 127:16 224:9
approving 17:23
April 98:25 193:13
area 19:17 25:22 26:25 49:23 56:20 115:8 138:18,19 141:5 202:21,23 221:22
areas 14:12
argue 38:15
argued 140:2
arguing 110:17
argument 129:2
arise 118:22
arms 121:23
around 117:13 118:25 124:19 126:13 127:23 129:24 147:15 158:5 164:25 211:21
around-the... 86:11 107:7 181:7 187:4 225:24 226:2 230:12 236:22
arrange 22:11
art 59:24 60:2
arterial 118:21
arthritis 89:20 90:2 90:4,6,7,15 90:20,23,24 91:9,11,12 91:14,15 106:11,18 106:19 107:3 108:25
article 79:22 128:18,21 128:22,23 148:16
articles 129:3 132:12
articulate 216:11
artificial 228:24
ASBILL 3:9
ascertain 155:2
aside 166:13 210:3
asked 8:17 14:4 20:14 39:23 51:8 58:25 61:25 71:22 81:8 81:13,15 85:13,14 139:8 147:16,24 152:23 159:6 189:11,15 206:14 211:17
asking 14:19 29:3,5 50:10 76:16 76:20 77:3 95:23 96:14 106:22 111:25 112:3,4 121:23 146:15 147:21 164:11 181:25 182:2 198:15 235:10
asks 133:4
aspects 56:23 185:2
aspirin 46:4
assess 9:8 29:25 38:25 83:17
assessment 9:4,6,12 10:3 11:18 33:7,13 49:7 64:6 73:9 93:6 133:4
assigned 44:9 44:10
assistance 189:15
associated 11:10 31:20 94:2 145:9 168:11 183:6 208:17 216:13
assume 77:9 95:21 104:24 150:13 195:24 199:8
assurance 143:5
asterisk 87:4
asymmetri... 211:24
attached 80:14 161:10 192:24
attempt 58:17 77:23
attempting 88:10
attempts 10:16
attend 64:8
attended 5:15
attending 202:18
attention 101:12,24 103:25 108:10 160:20 169:25 184:22 197:5 239:7
attorney 155:23 245:9
attorneys 2:3 3:3,9 25:8 25:11 52:15
attractive 50:23
attributes 82:16
August 101:6 161:4 163:5 163:13
authoritative 206:9
authority 67:23 98:12 189:13
available 19:3 33:19 46:2 64:20 130:12 145:25 167:14 176:18 200:11,15 234:15
Avenue 2:4 3:10
average 173:4
avoid 91:3 209:20 231:16
aware 136:10 147:20 150:8,9 156:16 157:3,19 158:3 169:13 182:16 205:7,11 241:12
away 222:25 236:5
awful 222:19
A-D-O-L-... 7:19
a.m 1:14

B

B 250:2 251:2 252:2
bachelor's 5:12

back 11:20 12:5 14:14 22:23 31:8 70:16 74:5 77:4,8 79:14 84:25 88:14 89:20 90:15 104:8 104:20 105:19 107:11 108:3 109:5 109:10,13 114:3 118:3 122:22 135:23 150:10 152:20 160:25 164:15 165:25 177:19 179:18 192:19 195:11 201:15 211:19 215:10
backache 171:9
background 167:22 177:23 222:3
bad 51:2 59:18 206:14,16
badly 210:15 235:14
baffling 81:13
balance 171:23 227:13
balanced 19:20
barbaric 89:11
barbiturates 118:25
based 130:7 183:20,23 187:25 195:24 206:4,12 207:13 210:6 211:3 230:19 231:17 245:21
baseline 181:14,20
basic 34:4 45:6 51:3 134:13
basically 73:14 128:21 166:21 168:15
basics 6:24
basis 40:25 85:22 118:16 127:20 180:25 183:18 184:5 194:23
batches 102:13
Bates 67:2 68:2 79:18 80:3 84:5 98:19 101:13 111:15,19 125:9 127:3 153:21 154:8 160:18 162:25 184:14 188:11 192:13 195:9 197:3 211:2 214:5 218:4 227:23 231:25 234:2 235:22 238:11 239:2 250:5 250:7,9,11 250:16,20 250:22 251:4,6,8 251:13,15 251:17,19 251:21,25 252:4,6,8 252:10,12 252:14,16 252:18
BD 239:10
beam 30:15
bearing 67:2 79:18 80:3 84:5 98:19 111:15 125:9 153:21 160:18 162:25 184:14 188:11 192:13 195:9 197:3 210:25 214:4 218:4 227:23 231:24 233:25 235:21 238:10,25 250:5,7,9 250:11,16 250:20,22 251:4,6,8 251:13,15 251:17,19 251:21,25 252:4,6,8 252:10,12 252:14,16 252:18
BEASLEY 2:8
became 31:25 49:9 97:15
become 31:3 59:19 89:5 91:4 93:5 205:22 207:6 233:13 243:6
becomes 58:5 58:23 106:12 165:22
becoming 89:2 147:8 197:16
Bedford 12:12,12 18:14 66:18 161:7 163:8
beds 141:6,7
before 1:19 7:15,25 11:20 12:11 18:11 20:11 98:11 117:7 117:7 130:21 135:21,24 144:21 178:10 182:10 188:4 201:21 206:7 211:5 211:8 214:21 215:8 218:7 224:25 225:18 231:11 241:10 247:7
began 46:21 46:21,23 48:22,23,25 49:4 58:14 76:9,9,11 76:12 228:20
begin 34:20 36:21 53:25 54:4 56:12 59:10 99:6 113:2 158:20 159:2,3 181:25 204:7 207:16
beginning 31:12 50:20 59:18 117:15
begins 57:9
behavior 6:10 58:20 99:24 100:12 120:5 123:23 130:11
behavioral 6:3,5,9,21 58:21
behaviors 59:8 149:14
behind 59:24
being 28:7 34:7,20 36:14 48:11 50:5 55:9 58:10 60:19 69:15 73:3 73:4 77:11 87:17 94:4 96:10 105:21,23 124:19 129:9 134:5 135:16 140:19 160:3 167:15 175:5 182:17 193:18 201:5 231:18 234:22
belief 152:12
beliefs 142:17 245:22
believe 29:13 30:23 45:23 47:10 57:12 78:2 85:5 105:6 111:9 123:4 128:17 134:17 142:10 148:20 151:12 157:11 169:19 174:15 196:5 197:8 198:4,4 208:5 216:10,12 222:3 240:23 241:2 242:5 242:7,8,15 243:4
believed 114:10,15 129:12 143:3 152:4 152:11,12 152:18 153:9,17 156:3,13 158:14 159:11,11 159:18 162:14 163:21 164:13 223:13 232:24 246:15
believes 201:12
Belinda 66:14 162:2
belonged 24:6
belongs 35:24
below 20:17
bench 48:24
benefit 225:15 238:19
benefits 33:3 227:13
benzodiaze... 155:15
besides 16:3 17:18 97:7 114:24 185:2

best 5:9 30:3 45:25 90:17 104:18 105:12 106:17 128:2 130:12 174:16 198:12 223:5
Bethesda 27:3
better 38:6 62:18 110:23 155:25 168:4,12,14 174:9 175:4 185:22 236:4,11
between 9:23 12:18 15:8 29:15 32:11 35:3 39:18 39:18 50:17 50:19 62:22 64:14,24 71:20 80:23 81:4 84:19 85:17 95:14 98:16,23 102:13,15 111:23 118:15 119:7 122:10 132:3 137:12 152:21 156:17,22 157:4,20 163:8 169:14 173:11 188:14 203:8 204:9 243:25
beyond 20:3 96:16 106:14
bias 103:12 151:19
BID 175:17 177:23 178:3 183:18 184:9 215:24 216:18
Bigelow 122:21
bigger 38:5 64:21
binding 70:5 70:6,6 72:14
bioavailabi... 38:16 46:22 46:25
bioavailable 64:19,19
bit 34:8 36:23 41:24 55:20 60:12 202:2 237:14
bits 139:4
black 193:6
blind 102:7 103:6
blinded 50:16
blocking 162:2
blood 38:17 38:20,21,22 39:4 80:23 81:24 119:21,23 120:2 171:12 249:17
blurring 37:14
board 7:12 34:2 143:4 234:13 235:2
boards 29:22 29:22 30:23 94:11
boat 208:23
Bob 12:12 18:14
bodies 206:9
body 145:7 192:22
bold 199:19
Bonnie 22:21
bonus 12:19
book 21:22
books 48:9 48:10
Boston 132:24 134:10 136:23,24 137:10 145:13
both 9:9 26:5 31:13 33:8 34:24 39:8 41:11 65:20 66:3 85:9 87:9 102:20 112:21 113:18,20 114:6 119:10 120:3 122:17 142:23 154:12,17 173:3 181:14 185:23 192:25 201:16 202:12
bothersome 115:8
bottle 31:17
bottom 73:23 103:24 170:21 172:12 199:8,13
box 193:6
boxed 204:17 204:23
brain 36:2 56:13,15 218:20
bread 143:13
break 41:19 63:11 94:13 140:9 144:18,21 188:5 241:17
breakdown 62:12
breaks 4:20
breakthrou... 180:21 181:15
Breder 55:10
BRENNAN 3:9
briefly 131:6
bright 116:17
bring 20:15 116:5
brought 101:24 108:10 157:17 178:14
Buddy 16:18
build 10:2 219:4
bulk 46:3
bullet 76:25
bum 137:14
bump 216:25
Buprenorp... 53:17,18 54:5,6,20 121:5,7
Buprenorp... 74:20
burdens 71:12
burn 134:21 137:15
Burt 214:11
business 94:5 144:16 166:5,9 215:6,7,8
butter 143:13
B2 178:15

C

C 2:2 249:2,2
caffeine 42:21
calendar 21:20
call 8:16,16 10:20 16:25 17:5,8,21 22:11,11,12 22:15,17 23:9 49:10 71:7 95:14 95:17 96:4 99:4 100:14 119:10 123:8 149:23 191:17 210:25 211:8 212:2 213:4 214:4 219:8 231:24 232:3 233:25 234:4 235:21,24 236:21 237:3,10,23 238:10,25 240:4 251:25 252:4,10,12 252:14,16 252:18
called 7:19 8:14 10:8 17:5,12 27:5 35:4 35:18 51:15 59:23 61:16 100:6,7 115:4 155:19 170:11
calls 4:14 198:7 244:10
came 18:6 49:7 97:11 100:6 115:6 129:4,13 140:24 156:12 215:8
cancer 10:17 89:7
caplet 75:10
cardiovasc... 171:24
care 116:21 134:8 141:14 243:12
cared 76:22
careful 32:14 210:19,20
carefully 129:13
carried 151:10
carries 110:19
case 25:14,19 30:11 67:12 72:7 86:18 100:8 115:9 119:5 139:23 177:14 202:23 203:5,15 208:16,17 209:6
cases 27:6 51:3 100:8 131:12 136:21
catchment 133:20
categories 85:7
category 91:5 229:16
Catherine 141:17
Cathy 11:19
cause 61:11
causes 63:2,6
ceding 70:19 100:7,20
center 3:5 81:12 99:6 133:22 134:21 202:19 208:5,11
centers 141:18 207:18,24

208:2
central 119:3 246:13,18
CEO 10:8
certain 13:13 51:9 57:16 58:7 71:19 88:6 99:9 102:8 106:25 110:8 130:10 196:3
certainly 34:3 49:24 75:14 77:17 82:15 83:20 92:10 107:8 107:15 112:12 118:20 152:6 153:4 156:5 166:16 173:16 175:25 177:16 186:16 187:22 217:24 235:19 239:16 246:3
certify 249:9 249:15
cess 238:20 239:19
cessation 239:9
cetera 20:20 173:7
Chabal 136:14 140:16 202:6 208:4
chadbourne 1:18 3:3 25:9
challenging 122:6 187:9
chance 28:4 30:17 147:7 155:11 202:2 213:9 240:24
chances 29:16 215:21 224:4,10 225:6 245:2 245:16
change 116:15 124:7 248:8 248:10,12 248:14,16 248:18,20 248:22,24
changed 10:25 12:2 46:18 111:12,23 111:23 112:5,6 163:25
changes 32:8 56:13,16 112:9,9 191:20 193:5 248:5
changing 71:23 78:15 205:2
character 58:15
characteris... 56:14 57:17
characteris... 90:10
characteriz... 123:14 127:10 171:2 223:9
charge 22:25 26:24 54:23 55:15 65:9
charges 100:11
Charles 136:14
Charlotte 211:12
charts 225:17
chasing 129:17
check 45:23 51:24,24 121:24 122:4
checklist 58:12 80:13 81:11 82:2 83:12
checklists 51:20,21 58:18 81:7
checkout 24:2
chemical 27:7 30:11 208:25 209:2,3,5 209:11,14
chemist 5:15 65:23
chemistry 5:13
chemists 77:21 102:5
chills 171:6
choice 177:10
choose 57:4
chop 190:24
Chris 192:17
Christopher 55:10
chronic 59:7 60:4,17 89:4,6,15 89:16,18 124:25 135:17 136:19 137:12 140:11 141:16 147:6,6 148:18 149:9 172:2 200:12,16 201:23 210:10
cigarettes 119:8
circulation 35:25
circumstan... 57:3
citation 194:12
cite 128:12 154:14
cited 128:25
cites 154:18 154:19
citing 202:22
civil 1:7 130:11
claim 76:25 77:4,8,11 77:13 79:9 91:12 143:24,25 147:4 153:8 153:15 156:23 173:21,24 174:14,20 174:22 185:6 186:3 186:11,17 186:18 187:7 229:4
claimed 175:3
claims 19:23 20:3 76:15 76:18,23 88:11 104:19 105:13 108:17 109:16,22 110:13 164:21 174:17 175:8
class 35:23,23 83:4 92:19 158:2 159:10 160:5 174:23 233:20
classified 132:17
classify 58:9 132:20
classwide 191:22
clause 222:9 239:13
clean 193:2
clear 54:12 73:19 81:3 89:6 90:18 102:17 113:21 116:16 132:21 139:2 209:24 216:7
clearance 226:15
cleared 226:16 227:3,5
clearer 89:3
clearly 229:18
cling 222:21
clinic 49:2 135:23 215:15
clinical 6:25 9:14,20,22 10:5 11:11 13:25 14:5 14:12 15:18 15:20 20:18 26:10 27:9 55:17 63:14 64:23 66:4 66:5,15 69:17 71:21 76:11 87:23 90:22 92:15 93:10 101:17 102:23 106:15 109:20 110:3,3,5,7 110:16 122:4,15,18 133:8 154:3 155:6 157:11,12 159:8 165:14,15 166:10,20 167:20 168:21 173:20 177:9 178:24 179:22 182:12,17 183:21,23 183:25 184:8 185:7 185:16 187:3 192:3 200:22 211:19 228:22 230:17 238:3
clinically 60:3 85:17 178:21 186:2
clinicians 49:2
clinics 134:4 136:2,20,22 242:12
clock 57:10
close 38:19 102:18 197:9 198:16
closely 132:5 246:11
cloud 58:24
cloudy 81:5
cocaine 118:15,16 118:20,21
codeine 40:5 40:17
COHEN 2:3
collaborative 132:24 134:10 136:24 137:10 145:13
collapse 171:24
College 5:13

color 226:14
column 170:18,20
combination 46:4 74:2 74:10,16 85:9 154:12 187:2
combo 176:12
combos 187:4
come 7:12 39:14 59:22 74:21 90:3 157:24 158:4 198:16 201:9
comes 39:14 103:11 112:18 143:4 165:13
comfortable 89:18 96:22 118:21 164:18 205:25 231:8
coming 211:21 213:2,2
commanded 120:16
comment 117:12 176:22
comments 69:16,21 70:9 84:13 161:13 197:8
Commerce 2:13
commercial 99:24
commissio... 8:13
committed 71:14
common 29:11 31:16 41:6 51:12 55:25 61:13 61:16,19 62:5,6,10 62:15 74:15 114:5 115:4 123:18,23 124:18 128:4 137:19 142:21 147:15 149:14 157:24 200:21 219:15 244:5,19
communicate 18:22
communica... 208:21
communica... 20:16 23:13 34:2 158:24
community 30:23 46:8 89:13 107:16
companies 13:7 90:16 133:5 147:16 193:16 204:17
company 3:4 10:9,14,15 10:19 13:23 13:25 15:25 18:23 19:10 21:25 48:15 48:19 49:3 49:16 68:18 68:21 90:2 110:17 129:6 159:2 164:9,17 165:18 173:22 188:17,19 192:2 201:14 221:8
company's 164:23
comparable 150:22
comparative 43:3 83:11 85:3 104:13 105:12
comparator 45:11,12 46:13,18,22 47:7,10,12
compared 47:25 83:13 169:17 174:2 175:14 178:20 182:18 184:2 202:18
comparing 53:7 54:20 103:15 105:5 121:3
comparison 47:14 52:24 122:10
comparisons 48:6 72:18
competitive 185:5 187:7 187:17
competitor 185:18 186:11
complete 244:6
completed 5:17 47:9 48:11 70:22 70:23 179:22 206:7
completely 56:5 82:5 158:19 240:8
completeness 149:12
complex 40:17 115:24
complicated 30:11 58:20
complicatio... 27:13
component 97:13
components 26:6
compound 43:7
compounds 178:4
COMPPA... 1:10
comprehend 73:11
compromis... 102:6
compulsory 26:5
concept 58:13 59:22 117:14 124:18 127:23 172:5
concepts 57:8 57:22 109:25 123:5
concern 28:18,24 29:4,4,5 88:17 89:25 96:24 109:11 133:16 228:21 230:24 231:22
concerned 27:25 77:20 77:23 78:11 98:8 203:12 208:15
concerns 96:21 105:20 137:15 194:10 196:13 200:3 215:19
conclude 131:18
concluded 149:7
conclusion 139:19 144:10 168:8
conclusions 83:22 142:20 165:15,20 179:17 183:5,15
conclusively 146:10
concomitant 61:3
condition 89:24 106:13,16 109:12 216:12,18
conditions 4:22 89:15 204:6
conduct 9:24 14:3 147:16
conducted 4:6 104:15 109:19 155:2 157:4 157:7,9,11
conferences 209:13
confess 130:10
confident 119:16
confidential 67:10,14
confined 213:22
conforming 15:16
confused 81:5
confusion 86:8 178:16
conjecture 151:14,15 152:13
Conover 67:17 109:18
consecutively 131:10
consensus 29:22 130:8 145:11 152:12
consequence 152:20
consequenc... 36:11,12 78:25
conservative 145:10 206:11
consider 73:25 92:4
considerable 46:7 71:4 75:22 79:4 96:12
considerati... 73:2
considered 14:13 89:9 103:21 112:21 131:15,23 133:11 150:21 151:24 158:18
consonant 129:11 246:2
consultation 27:5 30:13 33:14 143:22,22
consumer 15:9,11,12 22:3,6,7,14 22:15,16,19
contact 8:17 16:10,13,20 16:22,24 17:2,7 57:20 64:2

64:7 95:12 98:21 104:2 184:17,20 190:25 214:7 228:8 250:15
contacted 17:4 159:21 160:3
contain 145:21 168:24 169:9
contained 19:23 169:4
containers 101:20
contains 19:4 26:5 161:11 165:14
content 95:18 99:7
context 34:18 34:22 36:16 60:25 113:22 191:16 203:6 207:2 207:3,12 236:19
contexts 34:16
Contin 16:8,9 16:16 39:17 39:18 64:12 64:15,21 97:3,8 104:5,23 107:23 108:2,12 114:16 117:9,11 127:13,16 146:2,4 169:15,19 169:24 170:6,8,12 171:14,16 204:23 205:2 215:11,12 251:11
continue 74:2 208:22 209:12 211:21
continued 3:2 89:2 95:8 245:7 246:23
continues 230:24
continuously 212:22,23
continuum 43:6
contradict 13:15
contradicti... 230:3
contraindic... 150:7 209:9 210:3
contrary 217:23
contributio... 130:2
control 32:6 35:15 57:2 234:11,24 236:4,11
controlled 31:12 33:16 35:9 39:12 39:13,15 50:15 52:25 53:7,13,16 77:13,16 83:14 88:21 89:4,9,15 107:6 113:12 114:19,23 115:19 117:6,24 121:8 122:10 150:25 151:8 154:13,16 154:25 155:8 156:9 156:23 158:4,9 159:17,22 167:7,10 172:12,17 181:3 183:12 191:7,15 215:9 216:16 224:15 225:5 230:7 231:18 232:21,23 233:3
controls 31:14 32:5
controversial 129:11
controversies 203:22,23
controversy 71:5,7 177:3
convenient 41:19
conversation 22:2 23:7 23:18 88:2 99:11
conversatio... 22:9,25 23:14
conversely 119:25
conversion 211:18,18
convinced 133:13 240:9
coordinates 101:18 102:24
coordination 9:4,7
Coosa 2:9
copy 110:23 130:20 193:2 198:17 210:23 213:8
core 185:3
correct 14:6 21:15 24:13 25:23 35:5 45:17 53:19 56:3 57:6 62:13 67:18 73:22 75:19 75:20,22 78:5,8,9 84:25 85:4 102:7 105:17 114:6,12 117:21,22 119:18 124:12 125:18 134:12 136:4,20 137:4,7,25 138:6,7 140:13 142:8,12 144:23 147:2 148:4 149:5,9,15 149:16 152:5,10 154:3,22 155:4,10 156:4,10,11 156:15 157:8,10 161:5 166:11 175:15,17 177:24 183:18 186:13 187:14 188:17,22 189:5,18 192:20 201:24 202:12 204:13 208:6 212:10 213:13,20 216:19 217:5 218:11,21 220:13 224:9,12,17 225:20,21 226:6 229:7 232:4,5,22 233:5 234:5 235:12,18 236:15 239:15,25 246:8
corrected 175:11
correlated 119:3
correspond 223:25
correspond... 65:22
correspond... 163:5
cost 54:21
cough 45:25 46:6
counsel 3:2 4:16 20:14
count 164:25
counted 14:23
countertra... 128:24
counting 15:9
countries 9:23
country 149:25 233:13
COUNTY 248:4 249:5
couple 25:22 67:6 117:18 138:10
course 28:17 28:22 66:14 67:11,13 91:11 93:9 93:17 106:15 128:25 166:5,9 180:20 231:16 235:15 244:10
courses 6:19 6:23
COURT 1:2
courtesy 189:11
cover 161:3,4 161:10 166:14 192:22
CR 71:22 85:4,18 86:19,22 87:2 167:8 167:10 168:3 172:15 174:10 178:14 179:25 183:6,11,16
crack 118:16
cramps 171:10
crashed 10:16
crashing 179:8
crazy 222:16
create 58:12 229:13 245:16
created 193:6
creates 215:21 224:10 225:6
creating 224:4 244:25
crept 175:2
criteria 91:22 91:24 92:25 93:4
Critical 32:23
crossed 163:20
crossover 172:25
cross-conta... 137:15
cross-sectio...

144:8
CROW 2:8
crushed 183:9
crushing 183:10
cumulative 14:20
current 8:10 9:2 10:22 11:13 20:15 56:20 76:3 131:7 133:3 198:18,20 198:23 199:2 246:3 251:23
currently 7:8 44:9 167:14 228:23
CURTIS 1:16 4:1,2 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1 67:1 68:1 69:1 70:1 71:1 72:1 73:1 74:1 75:1 76:1 77:1 78:1 79:1 80:1 81:1 82:1 83:1 84:1 85:1 86:1 87:1 88:1 89:1 90:1 91:1 92:1 93:1 94:1 95:1,5 96:1 97:1 98:1 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1 121:1 122:1 123:1 124:1 125:1 126:1 127:1 128:1 129:1 130:1 131:1 132:1 133:1 134:1 135:1 136:1 137:1 138:1 139:1 140:1 141:1 142:1 143:1 144:1 145:1 146:1 147:1 148:1 149:1 150:1 151:1 152:1 153:1 154:1 155:1 156:1 157:1 158:1 159:1 160:1 161:1 162:1 163:1 164:1 165:1 166:1 167:1 168:1 169:1 170:1 171:1 172:1 173:1 174:1 175:1 176:1 177:1 178:1 179:1 180:1 181:1 182:1 183:1 184:1 185:1 186:1 187:1 188:1 189:1 190:1 191:1 192:1 193:1 194:1 195:1 196:1 197:1 198:1 199:1 200:1 201:1 202:1 203:1 204:1 205:1 206:1 207:1 208:1 209:1 210:1 211:1 212:1 213:1 214:1 215:1 216:1 217:1 218:1 219:1 220:1 221:1 222:1 223:1 224:1 225:1 226:1 227:1 228:1 229:1 230:1 231:1 232:1 233:1 234:1 235:1 236:1 237:1 238:1 239:1 240:1 241:1 242:1 243:1 244:1 245:1 246:1 247:1,6 248:1 249:10
customary 180:24 181:9,12
customer 219:7
cut 132:21
CV 1:8 20:15
cycle 216:4 216:14
cycles 215:24 246:14
Cynthia 12:7 192:17

D

daily 86:2,17 86:17 87:11 172:14 178:25 180:25 181:13 212:15
dancing 127:23
dangerous 94:5
dark 219:9
data 74:25 75:3 83:25 84:3,23 134:19 139:17,22 140:5,11 154:3,5,7 155:6 165:20 166:10,20 172:23 182:17 200:10,14 203:17,22 203:23 205:10,11 229:4 246:22
date 21:15 47:9 70:24 98:25 111:5 126:10 144:25 150:11 198:25
dated 21:12 130:19 148:20 161:2,4 218:13 239:4
dates 195:24
David 190:11 190:12
day 86:19,20 92:11 158:23 172:14 178:20 181:10 215:17 216:17 217:13 233:2 247:7 249:20
days 133:2 171:25 172:17,19 172:21,23 173:15 225:24 226:3 230:13 236:23
DDMAC 175:11
de 211:13,17 214:7,16
DEA 29:23 78:20,21 116:20
deal 98:15
dealing 123:10 133:6
dealt 129:3,4
deaths 167:24
debate 71:9 144:4 146:7 201:22
debate's 202:3
decade 133:14
December 7:13 110:21 111:3 126:2 126:5,7,11 155:6 156:17,18 156:22,23 157:4,5,20 157:20 188:24
decide 59:4 106:7
decisions 109:16
decrease 47:21
deemed 67:14
deeper 179:11
deeply 71:16
defend 110:11
Defendants 1:11
define 34:9
Definitely 246:3
definition 95:20 168:11 203:3
definitions 58:11 95:24 96:15,25 98:5,7 127:22
definitive 86:14 124:22
definitively 140:17
degree 5:13 36:10,20 45:21 113:23
delayed 114:9,14 117:24 152:2,16 153:8,15 156:2,13 159:24 160:7,10 162:13 163:19 164:5,12 223:11
delivery 122:14
demands 21:10 218:24
demonstrate 57:12 59:14

61:7 185:16
demonstrat... 41:8 118:23
Deneau 154:18
Dennis 226:22
department 3:16 49:13 108:11 227:10,10 237:22
departments 109:24
depend 40:21 206:18
dependence 6:3 31:21 31:22 57:5 57:9,13,16 57:21,23 60:19 66:7 95:17,20,25 96:9 111:18 112:15,16 112:25 113:9 122:24,24 123:2,9,10 123:13,13 123:16,24 124:2,4,23 124:24 127:5,8,9 128:2,7,8,9 128:10 132:22 133:19,24 135:2,4 144:5 148:18 149:4 162:12 163:17 168:25 169:4,7,10 170:5,12 172:5 191:5 203:7 209:11 243:25 244:2
dependency 26:22 27:7 30:12 208:25 209:3,3,5 209:14
dependent 50:25 57:25 144:6 170:25
depending 203:9
depends 39:13 46:16 102:9,9 132:11 178:25 181:21 216:20 233:11
deposed 25:14,18
deposition 1:16 20:7 20:10 21:4 24:19 25:15 25:17 59:2 67:14 149:20 249:11,13 250:4
deputy 11:22 13:2
describe 37:9 42:6 99:4
described 10:10 29:21 130:9 186:19 230:2 246:22
describing 228:10
description 127:17,18 223:19 250:2 251:2 252:2
descriptions 244:6
design 15:20 20:17
185:24
designate 67:13
designed 63:14,18
designs 109:7
desirable 77:17
desire 219:16
desperate 89:3
despite 131:18 175:5
detailing 134:13
detect 57:14
determine 19:19 45:6 47:14,17,18 112:8 131:8 132:6 240:18
determined 35:15
determining 182:4
deterrence 45:9
detoxificati... 244:7,8
develop 50:24 56:13 58:14 81:21 171:8 209:3 209:6 210:6 223:18 231:10
developed 19:7 31:22 48:18 49:13 49:20 58:8 82:7 106:18 109:17
developing 73:25 74:9 74:19
development 9:5,10,13 10:3 11:11 11:12 33:11 49:11 130:8
131:20 174:4 194:4 194:8,24 196:8,17 197:13 200:8 218:10 220:10 229:23
devoted 26:2
diabetes 144:8
diagnose 58:9
diagnoses 149:3,8
diagnosis 58:17 61:2 61:6 106:5 106:6 127:21
diagnostic 33:10 59:10 60:16,20,23 124:6 229:16
diarrhea 171:11,22
diary 21:20
dichotomy 35:3
difference 38:19 39:17 50:17,18 64:13 81:4 81:6 85:17 86:23 102:12,13 102:13,15 102:19 118:15 132:7
differences 9:23 64:14 64:16 71:20 84:18 115:23 118:18 119:6 167:23 168:2 169:13 243:25
different 9:18 11:7,9 34:15,15,16 36:4,10 38:2 39:15 40:18 42:10 50:4,8,19 51:10 52:7 56:6 57:8 65:21 72:8 72:9 82:25 97:12 98:7 98:17 127:24 134:9 140:5 140:13 142:17,20 142:20 156:10 159:19 165:12 174:13
differentiate 137:11
differently 48:16 104:22 107:23 108:2,12
difficult 56:7 58:23 89:16 121:17 139:6 141:8 142:25 179:13 185:6 242:22 243:2
difficulty 34:14 186:22 202:21
dilemma 58:6 231:12
dimensions 106:13
direct 20:14 67:15 103:25 160:20 168:18 170:9
171:14 184:22 197:5 198:21
directed 116:19 167:13
Directing 228:19
direction 72:19 107:3 120:13 140:6,13
directly 31:15 63:19 64:4 239:8 239:19 243:14
director 9:3 11:6,9,22 13:2 18:14 66:17 67:21 67:23 68:17 192:3
directors 55:7
disability 106:14
disadvantage 157:23
disagreement 142:22
disagrees 201:3
disappear 171:25
disbelieve 74:7
disciplined 24:9
disclosing 25:2
discontinua... 180:14
discontinua... 180:9
discontinue 59:15
discontinued 170:19,24 171:16 179:22

discuss 66:21 83:25 127:2 149:19
discussed 25:3 56:11 76:5 93:7 95:17 105:20 108:22 144:22 157:16 158:24 177:20 185:5 201:22 206:17 211:24 215:2 225:18 227:6 232:19
discusses 80:13 169:15,16
discussing 74:13 79:7 80:19 87:16 168:22 198:8 216:19 237:4
discussion 21:25 79:4 79:14 87:15 87:21 95:19 96:12,20,24 99:8 101:17 102:23 115:10 168:13 185:9,12 187:10 188:13 189:4 190:2 194:21 197:11 204:10 218:22 220:5 228:21 231:4 232:15 234:18 243:23 250:13
discussions 43:25 65:15 74:13 87:19 88:24,25 116:11 129:24 168:7 185:13 237:6
disease 58:11 89:24 90:9 137:17 230:19 231:17
disorder 58:19
disorders 58:9,15,15 58:16,16,22 143:7
dispensing 28:2 190:22
dispositive 133:11
dispute 46:7
distinct 56:2 56:25 57:6
distinction 32:11 116:17 132:2 141:25
distinguished 6:5
distortions 203:17,19
distribution 31:25 174:12
DISTRICT 1:2,3
disturbances 171:23
diversion 38:3 191:21 193:8,25 194:11 195:14 196:14 197:12 199:14,20 199:25 200:3
diverters 38:5
diverting 38:4
division 1:4 11:23,24,25 12:3 18:14 19:8,14 62:4,4 66:17 67:22 68:17 70:6 88:7 92:21 97:12 100:10
divisions 71:20 72:2 72:4,5,9
dizzy 51:22 81:6
doc 239:10,21
doctor 144:21 147:18 207:4 211:12 212:4 213:17 214:15,22 232:7
doctors 8:14 158:13,15 217:22 218:24 237:6 243:16
document 19:2 20:11 21:10 67:2 79:18 80:3 84:5 98:19 111:15 125:9 130:9 153:21 160:18 161:20 162:19,25 165:13,24 166:25 184:14 188:11 192:13 193:4 195:9 197:3 210:25 214:4 218:4 227:23 231:24 233:25 235:21 238:10,25 250:5,7,9 250:11,16 250:20,22 251:4,6,8 251:13,15 251:17,19 251:21,25 252:4,6,8 252:10,12 252:14,16 252:18
documenta... 233:22
documents 20:16 21:4 21:9 24:4 64:10 68:19 68:21,23 108:5 221:18
doing 6:13 30:7 32:18 33:9 82:22 100:5 133:20 142:19 143:23 165:4 210:20 214:15,23
dominate 59:19
dominates 217:2
Don 43:17,17 43:19 80:7 237:11 241:11
donald 3:6 43:11
done 4:17 42:7,21 47:11 50:5 50:6 72:7 75:3 80:6,6 91:16 97:3 110:6 117:23 118:25 119:4,10 120:12,12 120:13,15 120:19 121:2,14 122:20 136:13 139:6 147:12 148:2 191:12 202:6,9 205:3,20 237:13
Don's 79:21
dosage 36:3,7 36:8,23 39:6 48:17 52:6,7,11 52:25 53:2 53:7,8,13 53:14,16 64:20 71:24 77:16 103:20 116:3,5,19 116:22 117:14,17 118:10,12 119:12 120:16 121:11,13 122:15,16 150:25 151:8 156:8 156:9 177:23 178:15 225:3,4 243:24
dose 36:24 37:2,22 54:4,7,9,10 57:14 59:11 61:7 86:3,5 86:6,12,12 86:17,17 87:5,11 92:3 101:20 104:16,18 104:25 105:5 122:18,20 138:6,8 172:14 173:2 177:12 178:25 179:3,4 181:23 203:20 211:22 212:7,15,23 213:25 214:2 215:12,16 216:23,24 217:7 229:3 230:5 234:15 236:6 244:15
dosed 85:19 86:23 178:3 178:5,20,22 178:24 182:13,15 182:18,22 183:22 184:4,9,11 213:18
doses 40:15 40:16 42:25 43:2 50:15 50:19 53:25 64:21 122:19 150:23 212:4 217:11
dosing 85:23 185:17 186:20,21 187:4,6 211:18,25

212:3
doubt 99:13 185:12
Doug 4:8 11:17 162:3 162:4
DOUGLAS 2:6
down 63:11 78:8 91:21 129:17 139:12 167:21 170:20 194:6 223:21 225:12
downloaded 199:11
downside 93:9
Dr 4:7 5:10 8:23 12:7,9 12:12 16:21 16:23 17:6 17:8 20:8 21:5,16 22:12 23:8 23:19 41:24 43:23,25 44:2,6,7,8 55:2,4,10 66:18 67:15 69:16 73:24 75:13 79:21 80:9,15,18 87:17 88:6 88:13 91:24 92:8 95:9 95:14,19,23 98:23 99:7 99:8,12 100:13 104:9 108:4 122:21 136:14,16 140:16,16 145:19 149:22,23 150:4 161:7 163:8 184:23 185:9,9 188:21 189:23,24 190:5,15 198:10,10 202:6,6 208:4,10 211:3,17 214:7,16 215:20 228:20 229:25 234:8,19 235:11 236:8 238:18 239:5 241:22
draft 84:11 84:12 150:11 160:22 197:7
draw 83:23 139:18
drawn 165:20
dredge 164:24
dredging 164:21
drifting 107:2
drives 222:15
dropouts 179:19
dropped 120:2
Drs 130:23 131:2 195:5
drug 3:16 6:3 6:12,13,20 6:22 10:9 13:4 14:11 14:15 15:4 15:5,19 18:24 19:5 19:8,14 21:24 26:11 26:13,16,21 27:4 29:20 32:16,20,21 33:6 34:8 34:20,21,23 34:24 35:4 35:13,16,20 35:23,24 36:12,13,13 36:19,21 37:12,18,20 37:24 38:4 38:5 40:13 40:17,20 41:8 42:17 42:18,20,25 43:3 45:4 45:17,19 46:13,18,20 47:7,10,12 50:11,12,23 51:5,5,18 51:18 52:6 52:7 53:15 54:2,2,5,7 56:12,19 57:2,2 59:3 59:5,10,15 65:14 66:4 66:6,10 67:22 71:5 71:23 72:3 74:18 77:14 77:21,24 78:8 81:24 81:25 83:8 83:14 84:24 86:10 88:22 90:3,5,20 90:21 91:4 91:11 92:19 93:12,23,24 94:4 95:17 95:25 96:8 96:22 97:14 98:16 103:13,14 105:21 106:8,17,18 106:24 108:11 111:18 112:15,16 112:24 113:8 114:6 114:6,11,16 114:19 115:20 116:22,23 116:24,24 117:2 118:13 119:14,15 120:4,4 122:3,19,23 122:23 123:8,9,9 123:12,16 125:18,21 125:23 127:4 129:6 132:21,24 132:25 133:24 134:10 136:24 139:18 148:17 149:3,3,4 149:15 152:5,10,18 152:22 153:14,24 154:10 156:4,14 162:11,12 162:15 163:17,22 164:14 165:23 168:3,11 170:11 174:4 176:18 177:2,12,13 177:15,24 178:12,20 181:19 182:6 185:18,22 185:23 186:7,12,19 186:20,21 190:17 193:14 194:22 203:7 204:4 204:5,6,8,8 204:12,17 205:17 206:23 207:20 209:2,4 212:24 213:25 214:2 215:24,24 215:25,25 216:2,4,4,4 216:5,5,14 216:24 223:9,14 227:14 229:10,13 230:23 231:2 233:14 243:13,17 244:4,9,11 244:19 246:9,13,13 246:19
drugs 6:10 12:4 14:16 14:21 16:4 27:21 29:20 31:15,24 32:2 34:6 36:5 38:19 42:22 44:10 44:19 46:21 46:23 47:4 47:18,23 50:13 51:24 52:22 58:23 64:24 73:5 73:6 83:3 89:22 90:6 90:6,24 91:8,10 97:7 98:10 113:5 118:10 123:15 127:12 131:16,19 133:7 134:14 137:9,11 138:10 155:16,16 157:24 158:2,9 159:10,17 159:18 160:5 175:15 177:6,7 178:13 182:7 185:23 223:11 224:15 233:19 237:5
drugstore 31:16
drug's 35:5 36:14
drug-liking 53:12
drug-seeking 120:5 123:23 132:14 139:9
DSM 58:8 60:15
due 40:18 91:15 180:14 214:12
Duffy 11:19
duly 4:3 95:6 249:12
duration 138:6 172:16 177:12,13 182:4
during 9:9 14:21 22:11 26:6,19,22 43:16 44:11 55:8 74:19 88:21 98:9 112:23 137:20,20 157:12,16 158:7,25 171:19

174:3 193:12
duties 11:9
dysphoric 43:5
D.C 2:5 3:10

E

E 2:2,2 3:11 95:2,2 249:2,2 250:2 251:2 252:2
each 32:5 36:9 50:8 85:14 90:17 133:17 164:17 227:11
earlier 21:10 56:12 105:20 124:3 127:19 143:15 158:23 177:22 229:6 231:5 231:5,14,15
early 69:3 76:21 98:13 108:6 133:2
easier 110:11
easily 34:22 59:2,4
easy 144:14 192:8,9 215:18 231:6
editor 129:20 130:16,18 131:6 138:16 145:21 195:5 250:24
effect 37:25 43:4,5 52:6 61:13,16 80:24 81:21 81:22 82:8 83:6 84:24 85:24 92:8 118:24 120:4 178:3 182:4 185:21 216:5,13 246:13,19
effective 54:16 183:21 184:10 218:17 219:5 220:20,25 221:12
effectively 218:25
effects 40:18 42:17,19 43:5 50:9 50:11,12 51:2,2,7,9 54:2,11,13 80:25 81:25 120:3
efficacy 13:20 20:3 175:13 178:12
effort 165:22
efforts 62:7
eight 35:15 71:24
either 22:10 29:22 42:16 44:14 47:20 78:24 92:24 94:7 120:2 138:24 143:20 181:14 182:16 234:22
elapse 123:18
elective 26:7
elements 29:21 33:19
eleventh 164:16
elsewhere 99:22
else's 65:23
emerge 46:21 117:16
emergence 168:10
emerging 88:20 117:2
emitted 101:20
employee 71:16
employees 6:24
encourage 113:3
end 127:22 133:20,21 141:11,13 141:15 143:11,19 149:19 155:23 168:23 186:2 187:11
ended 132:20
ending 76:13 101:13 103:22 111:19,19 127:3 133:21,22 135:22 154:8 160:21 163:16 170:5 193:24 195:15
ends 140:19
Enforcement 193:14
engage 198:15
enhanced 116:6
enough 13:18 41:17 68:25 72:13 146:5 172:9 178:17 181:20 238:8
enroll 52:8 93:11
enrolled 5:16 172:12 180:7 230:16,18
enrolling 89:10
enrollment 92:25
entertained 110:15
enthusiastic 74:22
entire 91:5 218:10,10 220:11 221:10
entirely 72:3
entity 45:24 105:7 154:12 186:23,25 187:13,19 187:21,23
enumerated 20:16
epidemiology 26:8,9
episode 132:14
equal 86:17
equally 193:16
equals 62:11 62:11,12 82:21
equianalge... 150:23 178:3
equivalent 40:15,16 154:20 177:19
especially 29:20 121:22 181:23 236:12
ESQ 2:6,10 2:15 3:6,7 3:11,14,16
essentially 51:16 202:23
establish 133:6 200:11,15
established 203:2 205:24
et 20:19 173:7
ethical 229:11
ethically 138:25
ethics 94:11
etorphine 41:4
eudragit 101:25 102:10
euphoria 61:11 62:21 63:3,7
European 89:13
evaluate 19:9
evaluation 67:22
even 45:19 63:17 68:17 72:11 73:5 78:10 122:3 139:17 146:3 177:11 181:3,6 182:19 198:16 201:6 221:4
event 142:18 157:25 167:13,18 168:10 173:25 175:4 200:25 201:2 241:8 241:19
events 32:25 82:2 134:14 173:19
174:21,24
ever 14:5 20:2,10 22:24 23:12 24:9 26:12 26:15 34:12 38:18 41:13 43:11 55:22 60:3 63:20 74:8 75:12 78:18 79:7 101:21,24 107:24 109:4 114:22 130:21,23 131:2 139:8 159:21 184:7,8,9 192:4 196:22 211:5,7 215:3,12 218:7 226:24 237:3
every 48:21 92:18,19,21 108:25 133:13,14 165:13 212:18
everybody 8:21 106:4 107:3,5 190:6,7
everybody's 208:17
everyone 58:2 92:21
everything 122:14
everywhere 92:21
evidence 116:2 118:7 132:15,21 149:13 152:14,15 202:3 203:24 217:14

233:12
evidentiary 132:22
evolution 31:13 32:4
exact 146:9
exactly 24:20 76:10 82:12 122:16 140:6 158:6 186:18 203:18 222:14
EXAMINA... 4:6 95:8 241:21 245:7
examine 30:2 112:7
examined 4:4 15:19 95:7 129:13 131:7 137:3 165:16,17 224:14
examines 165:18
example 31:2 42:22 45:16 64:18 222:18
examples 117:18 221:13
exciting 10:11 49:3 75:3
exclude 92:15
excluded 92:2,20
exclusion 91:21,24,25 92:5
exclusively 209:21
execution 20:17
executive 9:3 11:6,8 192:2
exercise 215:16
exhausted 55:7
exhibit 20:6,9 66:25 67:9 79:12,17 80:2 84:4 87:13,14 95:10,11 98:18 101:2 101:3 102:2 110:20 111:14,19 125:5,8 130:14 148:14,15 150:12,14 153:20 160:12,16 160:17 162:24 165:2 166:13,14 169:20,23 184:13 188:5,10 192:12 195:8 197:2 198:19 199:9 210:24 213:9 214:3 218:3 227:22 231:23 233:24 235:20 238:9,24 244:22 250:3,5,7,9 250:11,13 250:14,16 250:18,19 250:21,23 250:25 251:3,5,7,9 251:11,12 251:14,16 251:19,21 251:23,24 252:3,5,7 252:10,12 252:14,16
252:18
exhibits 67:13 108:23
exist 202:22
existence 31:11
existing 244:3
expect 133:25 208:2 226:13 246:19
expected 195:20
experience 27:9,11 28:14 49:14 49:17 62:5 158:2 221:13
experiences 26:11 180:6
experimental 50:20
expert 68:20 143:22 147:4 152:13 177:4 190:12 206:23 226:18
expertise 19:17 65:23
experts 150:2
expired 21:6
explain 18:19 27:17 29:14 35:2 53:22 68:24 99:21 155:22
explained 238:20
explaining 115:24 119:6
explains 223:23
exposed 179:24 180:2
expository 96:6 128:23
exposure 36:13 172:13,18 172:20,22
expressed 174:15
expressing 228:21
extended 107:7
extensive 115:10 168:13 243:23
extensively 96:10
extent 47:19 96:6
extra 243:12
extremely 159:9
ex-addict 150:20
e-mail 188:20 189:21 192:8 228:10
e-mails 23:12

F

F 95:2 249:2
faced 135:5
facilities 143:13
facility 26:20 121:25
fact 88:6 123:6 124:23 133:3 138:2 138:5 158:3 205:24 207:5 220:6 228:13 244:10
factor 36:24 37:11 102:6
factors 35:15 35:21 134:15
facts 219:7
failed 10:16
failure 230:21
fair 13:18 19:20 41:17 96:24 118:6 172:9 227:13 238:8
fairly 54:7 97:22 98:2 122:25 129:13 145:10 206:11 219:15 227:15,15
faith 68:23
fall 233:16
false 151:22 244:23 245:3,8
familiar 35:8 97:22 98:2 128:13 129:16,18 129:22,23 136:9 146:24 147:3 194:18 212:18
family 26:23
far 115:23 118:3 146:20 222:3,24 224:16 240:7
fashion 50:16
fast 37:10
faster 39:5 119:24
favor 195:22 196:11
FDA 8:2,4 10:2 11:20 12:16 13:5 13:13,16,18 14:2 15:20 16:5 17:22 20:25 21:16 22:22 23:21 23:25 24:5 24:8 43:18 49:7 78:3 98:11 104:9 104:10 108:4,7,8 108:16 110:17 139:18 156:22 157:7,9 162:17 165:25 166:6 176:22 182:16 189:4,16 194:15 201:3,12 204:16 223:8 228:6 228:11
FDA's 88:25
federal 33:21
feel 5:7 48:15 51:20,23,25 211:23 212:5,8,16 212:25
feeling 5:4 164:20,22 164:23
feelings 202:20
fellowship 6:2,4,22
felt 10:18 78:21 90:14 112:24 174:13
Fentanyl 41:4
few 73:5 102:25 122:2 133:19 172:16 173:9 187:5 225:24 226:3

230:12
232:10
236:23
241:18,22
field 218:11
220:11
fields 221:18
figure 15:8
92:23
210:11
240:7
filed 100:11
154:7
files 15:14
24:4 120:11
131:7
fill 141:7
filling 141:6
final 148:8
151:11
165:21
174:18
229:19
finally 18:11
find 8:14
17:15 27:11
42:16 43:6
59:8 126:24
126:25
133:9,17,23
134:5 135:9
139:4
144:14
161:10
177:11
178:19
183:20
209:24
221:23,23
229:9
finding 178:2
findings
60:23 70:11
fine 46:12
111:2
finishing 6:21
fire 219:10
Firing 219:8
firm 7:18
17:14 167:2
firms 17:18
22:5 100:11
first 4:3 9:11
17:20 19:5
44:11 67:16
84:12
109:23
112:15
121:10
122:8,13
125:13
154:9
160:21
167:6,9
171:19
177:21
190:24
191:4,13
196:15
211:4 228:4
239:12
Fishbain
128:13,17
128:18,20
148:16,17
Fitzmartin
185:9
five 7:11
24:25 42:5
42:10 50:3
116:16
163:15
168:21
172:18,21
172:23
five-minute
241:17
florid 57:19
Flumere
211:13,17
214:7,16
focus 40:10
56:21 67:5
101:12
111:17
169:25
192:10
focused 47:16
105:15
focusing
69:11
folder 226:14
227:3
Foley 141:17
149:22
folks 136:14
188:21
224:14
follow 30:5
73:19
138:22
234:23
followed 24:7
30:20
138:14
following
51:21 69:13
69:16 73:15
171:3
222:18
246:23
248:5,6
follows 4:5
95:7
follow-up
148:5
font 124:16
Food 3:16
6:20,22
10:9 71:5
88:22
152:22
force 218:11
220:11,24
221:11
forced 177:9
204:16
Forever
215:17
forget 99:25
forgive 223:2
form 13:9
17:25 31:6
33:25 36:3
36:23 37:3
52:6,7,25
53:2,7,8,13
53:14,16
61:23 68:10
71:24 83:15
96:18
104:16
105:24
113:17
115:20
116:3
117:14,17
121:12,13
122:11,15
122:16
142:9
150:25
151:8 156:9
156:9
159:15
167:8,10
168:5
177:23
178:24
204:19
205:13
207:22
224:18
225:3,4
233:6 237:7
237:12,16
formed 230:2
former 42:18
forms 36:7,8
39:7 48:18
52:12 57:16
64:20 77:16
103:20
116:5,19,22
118:10,12
119:12
120:16
178:15
216:24
formulate
30:4
formulated
36:6
formulation
39:14 46:6
47:19
154:25
155:8
167:19
formulations
39:15 75:24
167:15
forth 66:3
152:21
160:25
164:16
201:15
249:12
fortunately
99:25
forward 90:3
116:5
157:17
178:14
205:2
found 82:4
150:14
177:18
178:22
179:6,9
195:23
196:12
199:21
202:7 207:9
207:14
208:5,10
four 15:2,8
24:24 42:4
42:10 44:11
50:3 71:24
86:19
116:16
131:12
181:24
236:24
fourth 69:12
194:6
four-year
5:17
FRANK 2:10
frankly
115:11
130:10
134:24
frederick 1:9
3:4 16:4,12
88:10
frequencies
136:11
frequency
135:2,3
172:24,25
173:3,4
frequent
172:22
frequently
60:7
FRIEND
2:13
from 5:13 6:6
10:21 15:7
16:25 17:8
18:15 21:24
23:13,18
25:11 31:16
33:22 34:2
35:8 45:20
51:14 52:7
54:2 56:2
56:18,25
57:6 62:3,4
62:5 64:12
67:17 68:4
71:18,24
72:18 83:7
83:23 92:15
96:10 98:11
98:13,14
103:17
106:10
108:12
113:13,22
128:16
129:6,25
132:13
134:20
139:3
140:22
143:4,24
144:10
145:17
148:7,8
161:7,20
162:19
165:15,21
166:14
172:3,13,15
172:16
175:6
176:18,20
179:8,22
180:4
184:20
188:20
189:23
203:15
206:8 218:9
222:25
224:16
225:15
234:7 237:2
240:17

246:13
front 83:25 124:14
full 92:3 184:24 229:23
function 18:21 90:11 197:15
functional 67:23
functionality 106:20
functions 18:21
fundamental 86:7
funded 6:12
funny 176:18
further 95:7 105:12 159:8 182:8 225:12 233:10 247:2 249:15
future 70:6
fuzzy 51:22

G

gain 216:5
game 21:5 214:13,19
gaps 49:18
Gather 219:7
gave 81:10 117:18 119:14,15 187:8
geared 220:20
general 5:19 5:21,25 11:10 19:18 26:3 27:10 37:20 42:15 44:11 50:5 73:24 77:15 107:15 108:17 110:11 119:17 151:17 158:8 168:8 176:23,23 195:21 196:19 198:14 201:5 203:7 203:14 210:16
generalized 109:12
generally 5:4 18:16 27:20 42:6 49:25 61:8 63:9 67:16 152:9 177:9,20
generation 133:14
genericize 191:2
genericizing 190:25 191:9,14
generics 72:4
genre 139:11
genuinely 238:22
George 5:16
gets 106:12 125:17 208:20
getting 40:13 100:24 116:15 209:16 210:16,21 212:24 218:25 222:24 237:14
gist 4:21
give 4:14 17:5 25:7 31:2 37:23,24,24 51:16 53:24 57:11 76:16 86:25 100:9 111:9 140:3 174:9 179:16 182:23 213:8 214:14 220:3 231:11
given 62:18 73:2 76:21 79:23 86:18 86:19 122:17 146:3 180:19 197:15 215:3 249:14
givens 59:16
gives 70:2
giving 50:14 85:24 108:20 109:8 210:8 212:14 213:25 214:2,18
go 5:7 10:17 19:12 22:14 28:11 31:8 35:21 42:12 52:17 56:13 68:11 72:7 106:14,14 106:14,15 115:24,25 118:3 120:11 129:17 141:5 144:11,12 144:13,16 164:15 209:13 214:12 227:9,18 233:9
goal 9:24 73:14 78:7 83:17 191:19
God 166:3
goes 105:19 202:12 216:13
going 4:9 16:11 36:21 54:3 58:22 59:13,14 67:4,5,7,25 70:16 71:6 76:18 87:12 90:19 91:17 96:8 100:15 104:8 110:18,20 111:17 116:17,23 117:3,5 125:4,6 131:5 135:7 136:19 141:15,19 143:20 144:13,15 144:16 147:18 160:13 169:25 184:22 186:10,17 195:11 205:2 206:21,25 211:4 213:17,19 216:18 218:23 220:15,17 221:12 227:7 240:8 240:23 241:11
gold 46:17
gone 139:25
good 4:7 50:25 59:9 59:20 66:9 68:23 72:10 72:11,16 75:5 82:8 95:9 98:4 106:9 141:3 162:18 167:14,19 185:4 191:12 203:5 206:2 208:20 210:17 222:18
gooseflesh 171:18
Gotcha 70:15 91:19 123:12 192:4
gotten 10:19 117:8
govern 35:16
government 24:6 33:21 70:5 130:12 145:7 198:6 210:18 215:7
go-around 197:19
grants 14:12
gratuitive 89:12
great 35:22 57:14 58:10 90:3,20,21 98:15
greater 30:17 71:11 142:6 195:20 208:19 209:5 214:14
greatest 88:5 190:10
GREENVI... 1:4
ground 134:23
group 64:5,8 97:15 123:10 142:2 210:9 210:13,14 212:20 214:8 229:14,15
groups 87:10 113:23 139:24 206:19
group's 144:11,14
grows 32:8
guess 12:17 17:8 25:22 32:10 35:2 35:19 40:11 45:16 80:10 81:14 88:5 93:18 103:11 107:10 112:17 126:20 127:15 130:19 150:10 157:22 173:18 180:3 184:24 194:5 198:21 202:11 227:3 235:3 235:13 236:3 240:8
guidance 68:19,21,23 117:4 140:3 158:17
guidances 88:23,24,25 91:8 93:5 206:8
guide 15:16 211:18
guidelines 29:24 30:20 33:15,21,22 124:19,21 124:22 129:24 130:3,6 133:4 143:16,16 143:18 144:22 145:2,8,9 145:11 150:5 207:13 243:21,21

guys 237:24

H

H 234:11,14 234:24 236:3 250:2 251:2 252:2
Haddox 189:23 190:11 198:10
half 9:11 47:11 182:9 222:20
half-life 182:7
hallucinating 81:6
hand 249:20
handed 20:8
handle 15:13 49:8 71:6
hands 64:6
handwriting 199:7
handy 84:15 169:18
happen 9:17 28:10 29:14 63:16 141:16
happened 48:14 228:11
happening 30:24 115:7
happens 138:23 143:10,19
hard 38:25 130:20 144:12,13 174:25 191:25 212:17 234:20
harder 119:12 210:22
Harold 234:24
Harter 67:18 67:20,21
HAUSMAN 2:3
Haverford 5:13
having 4:3 15:8 42:23 46:10 72:8 95:6 103:4 110:16 126:20 132:20 141:13 181:11 185:8,11 199:16 214:13 232:15 234:20
Hayes 66:13 162:2
HCRP 129:24
head 8:23 62:24 72:17 72:17 120:18 121:12,12 140:25 246:21,21
headache 109:14
head-to-head 48:6 122:10
health 3:16 5:15,24 26:2,4 37:21 145:17
healthcare 29:23 33:20 141:11 142:16 145:5,10 210:15
hear 37:8 61:20 220:13
heard 34:12 55:22 60:10 61:25 63:20 88:16 101:21 164:6
heart 171:12 241:7
heavily 97:19
held 69:8 101:6
help 35:2 37:7 88:17 184:16 199:4 200:13 211:21 218:6 221:17 232:2 234:3 234:11,23 235:14
helpful 62:9 81:20 151:18,24
helps 84:3,7
hence 74:23
HENNEBE... 3:7
her 12:11 23:6,11,13 211:21 214:22 239:6
hereinbefore 249:11
hereunto 249:19
heroin 134:20 190:20
herpetic 104:20 105:14
heterogenei... 98:16
he'll 4:16
he/she 92:2
high 31:21 32:2 42:23 45:21 50:14 51:17 54:7 54:10 59:11 81:4,9 100:4 133:21,24 134:3 172:25 186:24 207:19
higher 13:15 28:4 38:10 38:11,16,17 38:18,20,23 40:3,6,24 46:22 119:22 135:15 136:3,12 202:8 208:2 210:5,10 242:21
highest 45:3
highly 190:18 202:10,11 202:14 231:7
him 8:15,16 8:16 14:19 17:10,16 22:17 81:8 81:10 87:22 88:2 104:4 104:7 109:4 109:8 111:25 112:11 146:15 226:24 231:11 238:20
hired 221:8
history 28:5 30:3 31:8 33:10 46:16 92:13 93:11 131:14,21 137:13 150:8 190:18 209:10 210:6 243:13,17 244:14
his/her 219:6
hit 219:11 221:24
hoarding 123:15 127:11 223:10
hoffman 3:11 25:10
honestly 16:23 158:6
hook 223:18
hop 102:4
hope 81:16 174:5
hoped 83:20
Hopkins 5:23 26:5,6,23 43:9,16
hospital 5:20 137:14,16 137:18,24 138:15 141:5 234:16
hospitalized 131:9 137:2 202:17
hospitals 131:19 134:3 137:3
hour 177:7 177:15 211:22 222:21
hours 24:25 71:24,24,25 71:25 171:20,21 176:13,14 181:24 216:2 220:5
house 8:15
housed 64:5
Houston 2:14
huge 49:18
human 3:16 41:11,12 42:8,9 150:17 154:5,18
hundred 133:16
hurt 125:2
hydro 238:19 239:10,20
hydrochlor... 118:15
hydrocodone 44:4,20,24 45:2,12,14 45:22,23,24 46:3,4,5,9 46:24 47:7 47:9,14,25 78:11,23 177:5
hydrocodo... 78:4
hydromorp... 41:4 46:23 53:3 131:18 190:20
hypodermic 31:18
hypothesis 82:14

I

IAAA 203:12
iatrogenic 123:21 128:6 130:4 133:12 135:2,4 139:20 144:5,23 146:7 203:25 209:7 242:2 242:9,13,15 243:7,9 244:5
ICAH 10:2
ICH 88:23,24
icons 132:25 133:2
idea 26:18 44:17 54:19 76:17 81:9 81:15 82:11 122:3 162:18 180:12 185:5 198:2 238:21
identical 112:13

122:14
identification 20:6 66:25 79:17 80:2 84:4 87:14 95:11 98:18 101:3 111:15 125:9 130:15 148:16 153:21 160:18 162:25 165:3 169:24 184:14 188:11 192:13 195:9 197:3 198:20 210:25 214:4 218:4 227:23 231:24 233:25 235:21 238:10,25 250:3,5,7,9 250:11,13 250:14,16 250:18,19 250:21,23 250:25 251:3,5,7,9 251:11,12 251:14,16 251:19,21 251:23,24 252:3,5,7 252:10,12 252:14,16 252:18
identify 103:17 121:6 241:5
II 35:4,7 46:3 46:9 77:24 108:18 109:2 113:12 154:15,17 193:17 244:11
III 45:17,19 46:5,6,10 77:25 78:10 193:17
imagined 49:24
immediate 39:6,8 52:25 53:8 53:14 54:21 63:3,7 83:13 85:25 86:3 105:7 121:6,9,13 122:11 157:6 159:14 167:11,19 174:2 175:5 175:15,22 176:3,17 178:4,23 179:6 183:7 183:11 184:2,4,10 186:25 187:13,24 215:21 224:5,11 225:7 232:22 233:5 245:2
implicated 131:16
implications 178:15
importance 88:5
important 4:19 14:13 18:21 28:24 103:21 112:24 117:3 158:12,15 165:24 166:2 192:10 198:2
impose 13:14
imposing 71:11
impossible 138:25 210:12
impressed 211:19
impression 174:9 187:8 229:13
improperly 29:6,8,11 29:15 31:3 32:12
improve 14:10 47:21 58:17 90:8 90:11
improved 232:18
inaccurate 217:17 222:6,7
inappropri... 72:21,23 94:3 100:12 221:19 231:21
INC 1:9,10 3:4
incidence 131:8 195:19 200:11,15 205:10
inclined 19:11
include 32:14 33:17 96:15 159:24 164:11 246:24
included 109:20 185:24 245:10,12
includes 181:13
including 25:25 47:20 95:20,24 125:15 171:4,9
incorporated 69:17 174:17 193:4,7
increase 47:22 117:20 171:20 187:25
increased 94:3 119:22 119:24 171:11 187:19,22 187:24 209:23
increasing 54:3 116:2
IND 65:13 69:3 70:19 100:2
indeed 68:16
independent 8:12
indicate 232:14
indicated 14:4 89:23 91:8,10,13 109:15 130:3 147:22 176:8,9,12 193:12 205:20
indicates 137:22
indication 72:18 91:12 225:23 231:19 237:25
indications 90:16 230:3
individual 15:13 30:9 33:3 40:19 40:22 57:2 57:3 61:5 68:16,16 70:4,4 179:24
individuali... 243:23
individualize 244:15
individually 22:4
individuals 27:6 56:11 57:17 62:14 65:12 88:7 130:2 135:14 141:7,10 142:24 208:13
individual's 58:20
industry 7:15 15:14 43:18 61:17 71:11 158:21 221:5
ineffective 180:8,15,22
infer 83:7 203:14 232:17 240:21
inference 236:10
inflammati... 106:15,19
influence 103:18
influential 210:18
information 19:5,6 67:13 110:3 110:12 126:21 145:21 157:22 165:14,15 166:21 191:18 195:19
informed 184:24,25 189:11
infrequently 46:15
ingest 37:2,10 37:10
ingrained 71:17
ingredient 190:16
inhaled 36:6 116:12 117:19
inherent 151:19
initial 19:4 70:22 161:13,14 161:20
initially 153:24 154:7 179:25
initiate 30:5
initiation 33:12 240:11
initiative 9:25 49:7
initiatives 14:10
inject 38:14
injected 52:8 120:15
injecting 46:20
injury 140:25
Innaurato 104:2,3,12 104:17,21 105:11 107:22
input 189:12 197:21
insert 17:24 18:6,8,10 18:17,20 62:25 97:2 109:21 125:12,15 126:22 127:13,17 151:19 152:7 160:23

161:11
174:6,7
197:8 223:8
227:12
237:9
241:25
242:6
243:10,15
243:19
244:9
245:10,13
245:15,19
246:3,7,21
inserted
162:16
230:4
insight
214:15
insofar
200:19
insomnia
171:10
inspect
102:14
instance
23:16
131:16,24
132:6
133:24
189:14
192:11
201:23
instances
25:22 84:17
209:8
235:15
236:12,16
instant
181:19
instead 54:2
58:13
115:17
152:2
182:13
201:9 236:9
239:14,24
Institutes
5:14 6:12
56:19 74:18
118:13
institutional
94:10
instructed
24:2
instructing
78:12
instructions
24:7 31:18
73:15,18
125:15
instruments
204:3
integrated
166:17,19
166:24
167:5
intemperate
191:11
intend 21:7
intended
123:4 230:7
230:9,15
intensities
107:15
intensity 91:6
105:16,22
231:18
intention
193:15
intentional
38:5
intentionally
38:4
interact
36:17
interacted
104:4
interacting
104:6
interchang...
122:25
123:3
interest 43:2
interested
48:20 71:10
77:11 89:8
249:18
interesting
110:18
141:22
interests
46:19
interface
15:13 238:4
interior
188:15
internal
101:7
internship
5:19
interpret
27:23
interpretati...
200:18
interpreted
60:24 81:7
interprets
214:19
interrupt
147:19
interval
182:9
intervals
30:14
interview
8:18 17:17
interviewed
8:19,21,22
8:23,25
intrinsic
36:15
158:11
investigatio...
42:21
investigator
41:15 42:2
42:4 43:14
44:14 105:9
investigators
51:13 57:11
59:21
100:18,23
103:12
139:7 202:9
involve 44:4
involved
40:19 44:14
97:18,19
138:11
161:18
184:3
237:25
245:25
involving
27:6 68:20
70:21 87:23
114:19
120:21
121:5
140:16
in-house
190:2
Iowa 141:21
IR 71:22 85:3
85:18 86:18
86:23,25
168:4
174:10
175:19,20
176:11
177:14
178:7 186:7
186:12
IRB 94:8
irritability
171:9
IR/CR 71:7
177:10
229:22
issue 72:13
82:4 92:10
108:13,17
108:23
118:9,19
132:16
133:15,15
134:8
140:19,24
146:7,18,21
157:21
158:21
159:3,5
224:15
issues 73:8
80:21 85:15
96:4 128:24
128:24
129:4
139:21
168:23
191:20
197:10
208:19
224:16
237:5,24
italicized
124:11,15
items 20:14
20:21,23
82:2
iterations
152:21
IV 1:16 4:1,2
5:1 6:1 7:1
8:1 9:1 10:1
11:1 12:1
13:1 14:1
15:1 16:1
17:1 18:1
19:1 20:1
21:1 22:1
23:1 24:1
25:1 26:1
27:1 28:1
29:1 30:1
31:1 32:1
33:1 34:1
35:1 36:1
37:1 38:1
39:1 40:1
41:1 42:1
43:1 44:1
45:1 46:1
47:1 48:1
49:1 50:1
51:1 52:1
53:1 54:1
55:1 56:1
57:1 58:1
59:1 60:1
61:1 62:1
63:1 64:1
65:1 66:1
67:1 68:1
69:1 70:1
71:1 72:1
73:1 74:1
75:1 76:1
77:1 78:1,8
79:1 80:1
81:1 82:1
83:1 84:1
85:1 86:1
87:1 88:1
89:1 90:1
91:1 92:1
93:1 94:1
95:1,5 96:1
97:1 98:1
99:1 100:1
101:1 102:1
103:1 104:1
105:1 106:1
107:1 108:1
109:1 110:1
111:1 112:1
113:1 114:1
115:1 116:1
117:1 118:1
119:1 120:1
121:1 122:1
123:1 124:1
125:1 126:1
127:1 128:1
129:1 130:1
131:1 132:1
133:1 134:1
135:1 136:1
137:1 138:1
139:1 140:1
141:1 142:1
143:1 144:1
145:1 146:1
147:1 148:1
149:1 150:1
151:1 152:1
153:1 154:1
155:1 156:1
157:1 158:1
159:1 160:1
161:1 162:1
163:1 164:1
165:1 166:1
167:1 168:1
169:1 170:1
171:1 172:1
173:1 174:1
175:1 176:1
177:1 178:1
179:1 180:1
181:1 182:1
183:1 184:1
185:1 186:1
187:1 188:1
189:1 190:1
191:1 192:1
193:1 194:1
195:1 196:1
197:1 198:1
199:1 200:1
201:1 202:1
203:1 204:1

205:1 206:1
207:1 208:1
209:1 210:1
211:1 212:1
213:1 214:1
215:1 216:1
217:1 218:1
219:1 220:1
221:1 222:1
223:1 224:1
225:1 226:1
227:1 228:1
229:1 230:1
231:1 232:1
233:1 234:1
235:1 236:1
237:1 238:1
239:1 240:1
241:1 242:1
243:1 244:1
245:1 246:1
247:1,6
248:1
249:10
i.e 88:8

J

J 2:6
Jack 162:3
jacket 166:25
James 67:17
January
110:25
111:21,24
Jasinski
43:12,23,25
44:2 80:15
JAY 3:7
Jick 128:16
129:19,22
130:15,17
130:24
131:3
133:10
134:17
136:12
137:10
145:12,14
145:19
195:6
250:24
Jim 109:17
job 5:14 6:20
7:15 8:10
10:7,19
23:6 191:12
joel 3:11
25:10
John 67:17
67:20,21
Johnson
211:10
John's 5:23
43:9
joined 5:18
188:24,25
joint 171:9
joints 90:12
Joyce 228:14
judgment
33:2 61:5
July 1:13
198:25
June 21:12
21:15 69:8
74:5 192:19
196:2 228:7
238:13
239:4
jurat 246:24
just 4:11,14
21:2,11
33:18 37:13
46:19 56:5
67:4 71:23
72:6 79:15
84:10,10
85:10,12
86:11 90:12
93:24
106:20
112:2,19
115:17,20
116:8,10
121:8
126:18
147:21
148:13
151:21
152:11
154:11
160:20,23
161:16
162:9,19,22
163:19
164:9,24
177:19
187:16
191:21
192:9 196:2
199:6 202:7
210:7 213:7
216:7 221:5
221:22
222:19
233:22
237:12,16
240:20
241:22
245:9
justification
126:24
164:19
justified 93:3
174:14
227:12
justify 206:15

K

keep 21:17,20
30:24 78:9
99:8 188:6
keeping
32:23
Kenzie's
79:21
kept 189:10
190:21
ketosis
171:23
keys 182:6
kid 51:5
kind 7:2
24:11 31:25
33:15 60:25
61:2,3
75:24 79:13
87:21
100:20
105:22
106:6 107:9
117:19
129:14
130:20
159:3,5
185:8,13
191:15
204:5
208:23
217:7
222:13,14
233:15
234:12
kinds 41:13
47:23 51:10
83:3 107:2
107:11,14
116:13
121:22
140:5
kineticist
66:2 164:3
164:8
kinetics 66:3
Klein 66:8
161:23,25
knew 28:14
43:17 83:9
103:16
121:10
147:25
158:7
178:12
207:25
knocked
121:12
know 4:11,16
4:21 8:24
13:17 14:7
18:15 19:13
19:16 20:2
20:5 23:4
24:15,20
28:13 35:21
38:25 39:2
39:4,17,20
39:21 40:12
40:16,23
41:7 42:3
48:16 50:7
50:10,12
51:5 53:6
54:23 55:13
55:15 56:15
56:17 59:3
60:3,6,7,9
61:14 62:21
63:2,4,5,13
63:16 66:23
67:20 69:3
73:6 76:9
76:10,11
81:16 82:9
83:11,23
87:7 88:15
88:16 92:16
99:18
100:10,23
103:6,7,8
104:11,24
106:6,24
108:9 112:6
112:9
114:18,21
117:10
120:22
122:9
125:16
130:6 132:2
138:10
139:3
142:23
145:6 147:5
147:24
150:4
151:10,13
151:14
152:16,23
153:2,5,18
156:6,6
157:14
158:7 160:2
161:17,19
162:16,22
164:2,9,15
164:25
169:3,6
173:5,7,12
175:20,23
176:2,4,6,7
182:12,21
182:24
185:20
186:15
187:10,17
187:18
188:2
191:23
192:7
194:15,17
194:23
195:4,7
197:24
199:2 201:6
201:12,14
201:17
203:6,14
204:16,21
204:21,22
204:25,25
205:5,6,10
205:17
206:20,22
207:19
208:16
209:12
211:10,12
213:3
215:20,23
215:23
216:6,14
217:25
219:6,10
221:3,4,6,9
221:16,25
222:2,21
223:21
225:11
226:7,8,19
226:20,22
227:17,20
233:7,23
235:15
236:18,19
237:2,21
238:5,7
239:19,21
239:22
240:22
241:7
244:13
knowledge
14:13 46:2
121:4
143:25
198:12
221:4
knowledge...
146:19,20
known 28:2
30:21,22
45:11,12

144:2
178:13
knows 18:23
42:16
Kramer
11:15,17
44:6,7,8
55:2 162:3
162:4

L

label 19:15
19:19 20:4
62:3,4
65:16,19,21
66:15 73:21
90:19,20
96:2,7,17
100:19
110:4,13,21
111:10,22
114:16,19
114:23
115:5,6
122:23
126:10
129:8
139:18
148:3,4
150:11
152:2,19,24
156:7,12,18
159:7,9,23
162:8 163:9
164:17
168:24
169:3,9,14
169:16,18
169:19,24
170:12,17
171:15
172:17
174:18,19
174:20
175:6,9
176:13,15
188:14,22
189:5,8,17
191:20
192:5
195:12,13
198:8,22,23
199:3
201:15
204:23,24
205:3
217:25
224:9
228:23
229:5 230:3
230:4,18,25
232:18
233:19,19
251:11
labeled 186:7
labeling
19:21,24
20:19 65:18
70:20 71:2
72:19 73:4
73:16 88:11
95:18 96:5
97:23 98:9
110:8
112:17
151:11
152:21
158:23
198:18,20
217:23
228:20
232:19
237:25
251:23
labels 73:10
97:17 98:2
98:11
158:16
204:18
205:4
laboratories
1:10,10
14:2
laboratory
51:14,14
lack 155:25
246:21
lacrimation
171:5,17
ladder
107:17,19
lag 216:4,19
224:15
lag/drug
216:14
language
110:14
114:23
129:8 151:5
151:18,23
151:25
157:18
159:24
168:25
169:5,8,10
172:5
174:23
175:2
189:16,20
190:16
191:10,15
192:10
193:6,7
194:16
196:23
197:24
198:8,11
201:4,6,8
201:11,16
201:18,19
222:13,15
222:15
224:8
229:22
246:6
large 31:17
100:4
134:14
146:4
203:25
204:7,9,12
larger 53:24
53:25
last 11:21
21:13 24:24
55:14 68:2
69:11 72:21
76:25
107:21
108:23
114:8 126:9
148:12
168:23
172:3,11
179:15
186:5
193:11
198:23,24
202:24
lasting
212:24
late 21:5
98:14
later 9:10,21
70:11 100:6
163:4,12,14
163:15
latest 197:8
launch 9:17
20:19 76:15
76:18
law 6:25
35:15 45:24
177:4
Lawrence
136:16
lawyer 24:12
24:16
lawyers
221:16
lay 222:15
lead 105:8
142:16,19
183:11
223:5
leader 13:4
14:14 55:17
65:9
leaders 8:22
leaked 31:24
learn 9:21
18:25 92:5
103:13
learning
115:5
least 131:11
138:3
176:19
210:4
239:12
240:4
leave 10:13
17:11
206:24
231:20
leaving 17:18
43:22
lectures
60:10
left 5:23 8:8
11:21 12:6
12:15 22:22
23:21,25
55:13 75:5
126:21
138:15
211:18
legal 27:25
31:13 34:22
35:11 40:11
109:24
113:15
227:10
legitimate
100:16,16
100:17
135:16
legitimately
40:14
123:22
242:2,9,16
length 172:13
less 37:24
50:23 62:11
63:2,6
74:23 77:2
77:14,17
118:8
142:21
146:11
147:7
158:10
195:20
205:20
206:2,11,15
207:5
215:21,24
224:4,10
225:6
232:12,12
232:15,20
233:4 236:4
236:11
244:25
245:16
246:17,18
246:18,19
let 4:11,16,20
22:23 27:12
49:4 60:21
61:14 79:12
111:9
135:23
141:24
156:19
169:19
173:23
177:19
231:9
237:20
242:14
244:21
letter 67:16
79:15,20,24
80:8 129:19
130:15,17
137:22
138:16
145:20
161:3,4,10
163:13
192:23
195:5
250:24
letters 195:25
let's 14:18
38:23 39:8
39:16 40:24
56:21 63:10
73:10,11,12
83:10 97:25
122:22
126:19
184:19
206:14
213:6 217:9
241:16
level 32:6
36:18 38:17
38:20,22,24
39:3,5 54:4
80:23 90:17
120:2 138:8
178:11,11
186:24
187:6
222:11
leveling 54:6
levels 54:7
81:24
100:17
118:21

119:22,24
levorphanol 41:5
liability 27:25 34:10 34:13,19,19 35:4,5,7,19 35:20 36:5 36:25 37:12 38:18 39:25 40:7,11,12 43:20 45:20 45:21 46:19 47:22 50:22 55:21,22 63:13 64:23 65:15 81:22 86:24 113:11,13 113:15,16 113:25 114:2,10,15 115:16,19 116:4,6 117:21 118:2,8,11 118:12,24 119:13,23 119:25 150:22 151:2,9 152:4,18 156:4,10,14 159:25 162:15 163:22 164:14 174:24 193:8 223:13 246:8,10
licensed 33:24
lies 43:7
life 12:3 231:9,9
light 70:11 204:7
lighting 77:17
like 4:16 5:7 21:2,17 32:14 50:11 50:13 51:17 54:8,9 62:5 62:12 69:15 79:8,20 80:5 81:5 85:6 89:15 91:16 97:7 98:25 101:21 104:22 107:17,22 111:6 125:22 129:5 138:20 139:24 140:23 149:19 155:16 159:18 160:24 163:3,18 164:16 166:16 177:11 184:20 188:13,15 189:15 195:11,16 197:10 199:6 205:11 210:11 213:7 218:19 219:15,23 232:24 235:18 241:17,23
likelihood 32:13 135:5
likely 125:2 135:9 158:10 165:19
liking 53:11 119:4 120:4 120:17 246:12,18
limited 49:21
limits 68:15 70:3
line 112:7,7 115:10 116:17 170:16 171:15 248:7 250:2 251:2 252:2
lined 192:25
lines 145:14 170:3
link 81:23
list 20:13 41:5 51:23 58:12 171:22
listed 76:25 154:15
listen 145:15
listened 232:10
listener 219:6 223:25
listing 21:3
lists 171:3
litany 215:19
literally 57:18 139:11 201:17
literature 129:16 157:15,19
litigation 68:20
little 34:8 36:22 41:24 55:20 64:11 105:19 110:15 142:22 149:13 202:2 213:4 213:5,5 222:24 234:21
live 146:7 201:16,19 201:20
lively 144:4
lives 59:19
LLP 3:9
local 26:25
located 112:17 170:5
locations 203:13
long 6:15 7:6 7:9,23 8:4 12:8,13 13:15 24:18 24:22 52:2 116:10 118:10 122:7 137:22 143:21 148:5 171:22 181:20 190:17 212:24 234:13
longer 177:12 182:7
Longmeyer 162:3
long-acting 234:14 235:5,6,12 235:17 239:8,14,17 239:18,24 240:16,20
long-term 9:16 30:10 88:8 150:5
look 19:12,19 23:9 32:24 32:25 52:5 62:25 67:4 67:7 83:24 91:16 102:18 111:21 116:17 120:11 122:22 124:14 125:5,13,22 126:9,19,25 129:6 133:13,17 133:19 134:9 140:25 142:16,18 145:3 150:10 155:11 157:25 158:15 159:7 169:20 177:6 182:5 184:18,19 192:4 198:22,24 199:18 213:6,9 227:11 228:3 234:11 237:23 240:25 241:17
looked 18:5,8 75:13 96:10 128:15 137:8,9 139:25 162:8,9 174:8,19 190:13 196:2 202:24 203:19 234:25 236:21
looking 17:11 21:12 50:21 68:6 69:6,7 69:10 70:16 73:23 76:24 76:24 80:8 84:7,11,22 85:16 88:4 91:20 102:16,21 103:22,23 112:14 113:8 114:4 118:19 119:11,13 120:15 124:20 128:11 131:22 133:14 139:18 148:22 154:8 160:23 161:22 162:11 163:16 166:13 167:6,21 168:18 172:9 173:17 177:17 178:18 179:15 183:4,13,14 186:5 189:21 192:22 193:24 195:13 196:13,22 199:12 203:10 204:3 219:5 223:3 225:12
looks 69:15 79:20 80:5 85:6 88:10 98:25 112:12 160:24 163:3,18 166:16 184:19 188:13,15 189:14 195:11,16 218:19 237:3
loop 205:15
lose 59:10 60:15
loss 56:25 216:4,14
lost 164:25 237:18

lot 49:14 96:24 135:19,25 140:5 144:2 144:14 178:16 182:2 187:9 203:24 244:8
lots 94:2 210:16
low 54:7 90:15 104:20 105:14 107:11 109:5,10,13 118:11 134:2 217:10
lower 51:6 53:12 118:7 119:14,19 119:20 132:23 135:4,8 141:19 155:2,9 156:24 157:6,21 167:12 173:3 232:25
LP 3:15
lunch 94:14
Luncheon 94:15
lynn 1:6 4:9 11:15 44:7 44:8
L.P 1:9 3:3 7:7 228:5

M

made 10:11 19:2 20:3 71:3 72:22 75:25 102:10,10 112:9 115:18 176:25 193:3 209:19 235:4
magnitude 39:21 118:22,23 173:13
main 127:19
maintaining 22:8
maintenance 205:3 212:19,20 216:24
major 131:15 131:23 132:3,10,21 134:25 141:18
majority 225:9
make 23:21 30:14,19 37:22 50:22 57:20 58:11 58:12 70:4 70:8 75:10 75:23 79:9 88:11 90:17 91:12 109:16 110:6 116:12 129:7 133:5 143:22 152:14 177:10,14 186:11,17 186:18 192:9 209:17 210:21 221:11 248:5
makes 130:13 159:9
making 33:2 59:20 74:4 74:22 78:13 81:2 101:25 115:15 175:8
malignant 89:6
man 37:23
manage 15:14,14 29:19 93:15 135:7 169:12 180:21,22 209:24
managed 29:6,9,12 31:3,4 32:12 90:23 133:18 141:20 194:9,25 196:9,18 197:14 200:9
management 9:12 59:13 60:13 64:5 64:7 73:9 91:14 92:2 93:6 107:16 123:22 133:22 135:22 136:2,20,21 142:7 145:8 146:19,21 149:24 150:3 190:12 194:12 196:15 200:4 202:19 205:16 207:18 242:3,10,16 244:7
manageme... 133:4
managing 146:22 189:13
manifest 56:17 57:19
manifestati... 56:22,24 127:20
manifestati... 56:23
manner 190:19
manual 58:8
manufactu... 176:25
manufactu... 176:19,20
many 14:15 14:21 15:5 18:9 33:23 34:15,15,16 35:22 39:15 42:3 44:17 44:23,24 58:15,21 82:21,22 87:2 97:18 107:8 125:20 137:11 145:9 173:5 173:7 187:13 204:5 212:5
March 111:10,11 111:23 169:20 189:22
marginalizi... 210:20
mark 2:15 111:8
marked 20:9 103:23 170:4
market 9:10 10:16 18:24 19:6 46:2 74:21 146:5 176:25 187:23 215:8 231:2
marketed 109:17 176:5
marketing 7:4,4 76:14 76:17 99:10 99:19 104:14,21 107:22 108:10 109:22,25 206:23 231:16,20
marketplace 187:17
marriage 249:17
Martin 154:19 232:7 239:5
Mary 11:18
master's 5:24 25:25 26:4
material 19:20,22 20:24 96:6 104:17
materials 23:22 110:12 205:16 227:18
matter 4:19 32:21 123:7 183:14 249:18
mattered 116:3 117:14,17
matters 225:3,4
MATTHE... 2:13
matured 48:22
may 18:25 23:23 28:20 30:12,18 38:17 48:15 52:14 72:10 86:7 88:16 102:2 117:25 142:3,4,5 147:19 155:24 171:2,8,21 172:3 184:16 185:18 193:4,13 194:20 198:18 200:13 202:14 210:5,9 214:15 218:6 220:13 226:19 231:2 232:2 233:20 234:3 235:14 240:13 241:8 245:16 246:2,7
maybe 15:2 50:7 160:12 191:14
McCormick 12:7,9 192:17 228:20 229:25
mcnamara 2:6 4:6,8 16:17 21:11 41:20,23 52:19,21 94:13 95:8 136:7 140:10 142:12 144:17,20 146:15 150:13 188:6 199:10 213:12,23 228:2 237:11,15 245:7
McNeal 22:21,24 23:9,17
MD 1:16 4:1 4:2 5:1 6:1 7:1 8:1 9:1

10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1 67:1 68:1 69:1 70:1 71:1 72:1 73:1 74:1 75:1 76:1 77:1 78:1 79:1 80:1 81:1 82:1 83:1 84:1 85:1 86:1 87:1 88:1 89:1 90:1 91:1 92:1 93:1 94:1 95:1,5 96:1 97:1 98:1 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1 121:1 122:1 123:1 124:1 125:1 126:1 127:1 128:1 129:1 130:1 131:1 132:1 133:1 134:1 135:1 136:1 137:1 138:1 139:1 140:1 141:1 142:1 143:1 144:1 145:1 146:1 147:1 148:1 149:1 150:1 151:1 152:1 153:1 154:1 155:1 156:1 157:1 158:1 159:1 160:1 161:1 162:1 163:1 164:1 165:1 166:1 167:1 168:1 169:1 170:1 171:1 172:1 173:1 174:1 175:1 176:1 177:1 178:1 179:1 180:1 181:1 182:1 183:1 184:1 185:1 186:1 187:1 188:1 189:1 190:1 191:1 192:1 193:1 194:1 195:1 196:1 197:1 198:1 199:1 200:1 201:1 202:1 203:1 204:1 205:1 206:1 207:1 208:1 209:1 210:1 211:1 212:1 213:1 214:1 215:1 216:1 217:1 218:1 219:1 220:1 221:1 222:1 223:1 224:1 225:1 226:1 227:1 228:1 229:1 230:1 231:1 232:1 233:1 234:1 235:1 236:1 237:1 238:1 239:1 240:1 241:1 242:1 243:1 244:1 245:1 246:1 247:1 247:6 248:1 249:10

mean 32:19 34:16,19,23 54:14 62:7 64:17 86:21 87:9 119:19 125:20 132:11 150:15 160:10 164:6,21 165:12 166:20,23 168:6,10 172:14,20 191:2,14 202:15 203:16 217:10 221:5 233:7 233:11 240:13

meaning 62:17 110:19 234:24

meaningful 102:14

means 34:10 85:21 87:7 87:8,9 132:13 152:11 154:5 161:20,21 200:19 201:7 221:25 239:20,21

meant 40:13 69:20 81:17 95:21 99:18 100:13 169:7 172:4 185:20 186:15

measure 43:4 82:16,17 118:18

measured 83:6 200:22

measureme... 50:10 81:22 82:8

measures 83:5

measuring 43:3 82:20

mechanism 100:3 133:8 237:21 238:6

med 239:7,18

media 19:3

medical 4:22 5:21 8:24 9:3 11:6,8 11:17 16:22 26:19 30:23 34:5,18 35:13,19,20 36:24 38:11 39:25 40:6 40:10 41:6 45:20 55:7 65:10 113:15 131:9,20 153:7,14 162:10 165:3,4,8 165:10,17 166:6,17 172:6,9 177:17 179:16 190:11 203:10 226:5 227:10 237:2,4 251:10

medically 38:8 222:6

medication 31:19 101:14 102:7 121:20 134:16 180:17,18 180:19,25 181:15 205:22 207:7 212:15 217:3,6 244:17

medications 4:25 61:4 71:18 136:4 146:12 147:9 209:22 230:21

medicinally 36:19

medicine 5:11,17,22 5:25 6:2 29:23 32:24 34:3 90:10 133:16 139:8 213:16

meds 231:11

meeting 66:20,23 68:4 69:4,4 69:5,8 76:21 78:16 78:17,19 79:3 101:6 101:8 193:12,14 228:4,6,12

meetings 64:9

membership 97:15

memo 218:9 220:10 227:4 240:17

memoranda 24:3

memorand... 95:13 101:5

memorialize 22:2

memorializ... 22:25 234:18

memory 4:23 5:2 128:16

Memphis 214:8

ment 234:13 235:5 236:5 239:10

mental 5:14 134:3

mention 17:10 88:13 240:5

mentioned 6:4 15:4 25:21 33:18 36:22 38:20 41:25 43:21 45:11 49:12 50:3 51:7 60:2,18 117:17 120:6 121:4 138:5 139:15 144:22 145:12 146:6 149:22 155:24 160:4 185:3 187:12 201:21 223:19 224:25 226:4

mentioning 74:9

Merlo 226:22

merperidine

131:16
message 109:9 219:10 220:12 221:23 230:22
messages 226:12 227:11
met 17:16 21:24 22:4 43:16 78:6 226:24
metabolic 137:17
methadone 212:19,20 212:22 215:2,16
methodolo... 42:25
methodology 159:4 200:22,23 200:24
methods 42:11
METHVIN 2:8
MICHAEL 3:16
mid 8:8 54:9
middle 170:17,20
midway 91:21
mid-year 194:21
might 35:3 36:9 37:23 37:24,24 48:24,25 60:7,15 71:7 75:2 78:2,19 81:14,19 90:11,20,22 93:7 96:16 106:11 110:22 132:16,17 142:2 152:12,12 156:9 164:7 164:8 177:21 186:12 198:15 206:14 207:16 210:21 214:16 216:8 217:11 237:22
Mike 66:8 103:25 104:2,12,17 104:21 107:22 161:23,25
MILES 2:8
milligram 40:25,25 85:22,22 87:10
milligrams 82:21,22 85:23,25 86:13 87:2 172:15,15
million 209:15
MILSTEIN 2:3
mind 92:11 103:18 108:24 190:21 214:13,18
mine 111:8 170:3
minimum 13:6 30:25 219:24
minor 132:3 132:10,18
minute 39:21 240:6
minutes 57:13 68:3 69:9 74:7 77:9 78:17 78:18 185:13 228:5,17 232:10
misleading 195:19 230:22 231:3
misses 208:23
missing 158:19
MISSISSIP... 1:3
misuse 191:21 193:25 195:14 197:11 199:13,20 199:24
mixed 53:18 53:23 83:2 121:20
mobility 90:8
modal 172:18 172:20 173:3
model 88:3 231:6,12
models 89:18 89:19,20,21 89:22,23 90:15 181:22,24 228:23 229:9
moderate 225:25 230:11 231:10 236:22
modern 31:22
modification 33:13
modified 51:2 83:12 84:23
modify 50:21
modifying 90:9 91:10
money 81:5 100:4,24
monitored 131:10
monitoring 32:15
Montgomery 2:9
month 8:9 122:2 173:8
months 12:10 21:8 137:16 140:2 172:3
mood 58:24
moonlighting 26:23
MOR 173:17
more 10:20 29:11 35:14 35:14 46:24 54:8 57:17 64:18,19 65:5,22 74:23 75:2 77:20 86:15 100:20 115:19 119:15 121:23 125:2 132:5 133:13 135:9 137:6 139:8,13 142:3,21 146:20,22 152:13 173:8 181:17,18 184:9 187:14 191:17 195:22 196:11 202:20 206:20 212:16 213:10,15 213:19,24 215:14 218:25 220:22,22 225:24 226:2 229:22 230:12 235:16 236:14,17 236:23 244:5 246:11
morning 4:7 41:19 56:12
morphed 97:15
morphine 38:7,22,24 39:2,5,14 39:24 46:12 46:17,25 65:2,6 113:11,14 116:12,13 121:2 150:23 154:20 190:20 211:20 222:14
Morphine's 47:2
mortality 94:4
most 18:21 27:9 30:8 45:5 51:11 51:12 55:8 65:24 66:2 80:24,25 81:2 82:4 89:22 97:10 97:16 116:4 117:6 120:12,25 121:19,21 134:5 139:21 141:3,6,7 171:24 172:22 176:11 177:10 180:9 186:25 188:2 192:10 193:3,5 202:21 212:18 219:16
mostly 26:2 83:18 96:11
move 77:24 78:7 141:10 160:5
moving 223:21
MPH 1:16 4:1,2 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1,6 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1 67:1 68:1 69:1 70:1 71:1 72:1 73:1 74:1 75:1 76:1 77:1 78:1 79:1 80:1 81:1 82:1 83:1 84:1

87:1 88:1
89:1 90:1
91:1 92:1
93:1 94:1
95:1,5 96:1
97:1 98:1
99:1 100:1
101:1 102:1
103:1 104:1
105:1 106:1
107:1 108:1
109:1 110:1
111:1 112:1
113:1 114:1
115:1 116:1
117:1 118:1
119:1 120:1
121:1 122:1
123:1 124:1
125:1 126:1
127:1 128:1
129:1 130:1
131:1 132:1
133:1 134:1
135:1 136:1
137:1 138:1
139:1 140:1
141:1 142:1
143:1 144:1
145:1 146:1
147:1 148:1
149:1 150:1
151:1 152:1
153:1 154:1
155:1 156:1
157:1 158:1
159:1 160:1
161:1 162:1
163:1 164:1
165:1 166:1
167:1 168:1
169:1 170:1
171:1 172:1
173:1 174:1
175:1 176:1
177:1 178:1
179:1 180:1
181:1 182:1
183:1 184:1
185:1 186:1
187:1 188:1
189:1 190:1
191:1 192:1
193:1 194:1
195:1 196:1
197:1 198:1
199:1 200:1
201:1 202:1
203:1 204:1
205:1 206:1
207:1 208:1
209:1 210:1
211:1 212:1
213:1 214:1
215:1 216:1
217:1 218:1
219:1 220:1
221:1 222:1
223:1 224:1
225:1 226:1
227:1 228:1
229:1 230:1
231:1 232:1
233:1 234:1
235:1 236:1
237:1 238:1
239:1 240:1
241:1 242:1
243:1 244:1
245:1 246:1
247:1,6
248:1
249:10
much 32:16 33:8 37:10 49:16 51:17 51:18,20,24 54:19,21 57:17 62:17 64:13 71:20 71:21 72:13 76:22 82:24 92:10 110:19 115:13 117:9 122:25 135:4,8,15 136:12 138:5 139:12 146:22 178:14,17 179:4,10 189:10 191:6,7 202:8 209:5 212:23 213:4 215:11 216:20,23 221:16 246:12,12
mucositis 222:17
Mulligan 228:14
multidimen... 58:14
multidiscip... 66:16 123:17 128:3 136:2 202:19 207:18
multiple 12:2 62:7 90:16 101:20 104:18 122:19 129:15 136:10 177:12 201:15 228:10
multiples 122:17
MURRAY 2:15
must 60:24 77:9 130:10 185:16 190:21 223:24
muzzy 51:22
mu-agonist 113:10
mu-opioid 82:18,18,18 82:19,19 160:7,10 162:13 163:20 164:5
mu-opioids 82:13
myalgia 171:6
mydriasis 171:6,19
myself 66:8 81:2 95:15

N

N 2:2 95:2,2,2
Nalmefene 79:5
Naloxone 47:24 48:8 73:25 74:10 75:9,17 79:5
Naltrexone 44:4,20 48:3 75:9 75:21 79:5
name 4:7 12:2 17:13 55:6 99:6 162:3 234:12,25
named 55:10 211:12 232:6,7
names 25:7
narcotic 31:18 131:8 131:12,19 138:3
narcotics 28:2 31:14 107:4 193:18
narrator 207:5
nasal 36:6 116:13
National 5:14 6:12 56:18 74:18 118:13
natural 35:5
nature 35:22 36:2 75:7 76:21
nausea 171:11
Naval 5:19
navy 5:18,23
NDA 65:13 68:9 69:18 70:12,22,24 76:3 127:2 153:6 154:22 155:6 157:15 176:21
nearly 97:20
neat 190:24
necessarily 124:10 128:9 137:8 227:8
necessary 30:24 71:12
need 4:20 29:25,25 30:3,4,5,5,6 35:14 42:12 59:12 70:22 70:23 73:21 89:3 93:13 143:6 165:16 185:23 186:11 214:21 216:17 217:13 218:25 219:10 244:17
needed 10:18 31:19 72:16 96:25 107:6 177:2 212:16 215:14
needs 46:9,9 107:4 109:2 165:16
needs/wants 219:7
negative 134:13
negotiate 212:22,23 215:15
negotiating 164:22,23 189:12 215:16
neither 189:12 229:2
nervous 119:3
neuralgia 104:21 105:14 109:14
neurobiolo... 56:22
neuropathic 89:21 109:14
never 14:23 19:18 22:4 27:8 38:21 41:15 43:13 64:21 75:17 92:12 98:10 158:18 164:6,20 176:20
nevertheless 175:3
new 1:19,19 1:21 2:4 3:5 3:5 8:14 9:4 9:9,25 11:10,12 14:13 15:19 32:6 48:19 72:3 125:18 125:21,23 153:13,24 157:12,22 165:14 166:10 177:2 196:16 209:6 248:2 248:4 249:3 249:5,9
next 74:3 79:12 87:12 91:20 95:10 101:2 108:15 110:20

112:25 114:4 122:22 125:5 127:25 145:6 149:12 171:21 188:5 191:3 199:25 200:7 230:5
NICHOLS 2:12
nicotine 119:4,6,7 155:16
NIDA 51:13 194:13,18 194:22,23 216:15
NIDA's 207:14
night 5:15 224:3 244:25
nine 8:5
nod 81:16
nominal 182:11
nonaddictive 217:15,19 218:2
nonmalign... 89:19 108:19 109:3,12,19
nonmedical 56:10 220:2
nonmedici... 123:16 127:12 223:11
non-cancer 87:18
non-GNP 104:17
non-opioid 138:22 209:21 217:12 230:21 236:17
Nope 138:9
normal 49:9 49:10 82:6 178:24
normally 164:7 217:4
NORTHE... 1:3
notably 193:6
Notary 1:20 4:3 249:8
note 21:3 67:9 87:3 183:6 195:16,18 196:10 199:6 213:7 235:14
notebook 21:18
NOTED 247:4
notes 21:18 23:10,13,17 24:3 87:15 87:20,20 168:20 235:24 239:6 241:18 250:13
notes/memo 214:9,11 234:10
notes/memos 211:15
nothing 137:21 203:16 217:25
notice 1:17 20:7,9 21:4 102:21 250:4
noticed 102:25
notion 225:2
noun 145:6
novel 73:13 116:5
November 66:21
218:13
NSAID 92:3
number 14:9 26:10,25 27:19 43:19 67:2 68:6 70:17,18 79:18 80:3 84:5 98:19 100:2 111:16 113:5 115:7 116:11 118:19 125:10 129:2 146:9 153:22 160:19 163:2 165:6 169:22 174:5,7 176:18,20 178:9 179:12 183:13,16 184:15 188:12 192:14 195:10 197:4 199:23 202:25 204:2,10 205:24 206:2,3,12 206:14,15 206:16 207:11 211:2 213:19,22 214:5 218:5 219:5 223:3 225:12 227:24 231:25 234:2 235:22 238:11 239:2 241:7 250:6,8,10 250:12,17 250:20,22
251:4,6,8 251:13,15 251:17,20 251:22 252:4,6,8 252:11,13 252:15,17 252:19
numbered 170:2,3,3
numbers 26:18 68:2 84:19,20 85:18 170:7 180:10 181:13 208:17
numerals 199:7
nurse 141:21
Nx 75:4
N.W 2:4 3:10

O

O 95:2,2,2 234:10,22 236:2 238:15 239:6
OA 225:14 236:2
object 13:9 17:25 31:6 37:3 61:23 68:10 96:18 105:24 113:17 142:9 204:19 207:22 224:18 233:6 237:7 237:12,16
objection 83:15 205:13 237:19
objective 223:6,24
observable 171:25
observation 112:2
observations 85:10
observed 168:21
observing 33:4
obtain 31:15
obvious 75:16 113:2
OC 99:5,16 104:25 241:2
occasion 138:13
occupational 5:25
occur 28:21 30:18 34:25 60:8 100:21 149:8 171:2
occurred 10:18 99:14 157:20
occurrence 61:18
occurs 62:21
Ochu 232:7 234:7,17,22 235:4 236:7 238:12 239:3
Ochu's 235:24
October 79:14
odor 101:14 101:20 102:2,8 103:4,14
off 18:13 52:17 54:4 54:6 62:24 64:6 120:18 199:3,11
offer 10:12 189:16
offered 189:20 190:15
offering 106:9
office 22:16 207:4
officer 5:21 11:17 15:11 22:3,6,7,14 22:16,20 26:20 65:10 165:3,4,8 165:10,17 166:6,17 172:6,10 177:17 179:16 190:11 251:10
officers 15:10 15:12
offices 1:18
off-label 113:4
often 27:23 29:4 37:8 43:4 57:23 70:8 102:17 171:20 182:21 208:20 216:13
Oftentimes 46:12
oh 11:2 26:14 41:2 44:16 85:6 109:6 181:2
okay 13:18 14:8 29:2 29:18 31:9 34:17 42:14 43:15 54:13 60:22 68:14 73:10 79:20 85:20 86:9 95:16 100:25 105:10 141:6 167:21 181:16 190:15 191:24 206:6 221:9 221:23

222:2
226:10
227:14
236:5
240:12
old 177:24
178:13
204:4
older 209:16
omitted
195:22
196:11
once 17:16
56:12
165:21
235:3 236:8
237:15
239:13,23
240:24
once-a-week
215:25
one 4:10 7:21
8:22 14:17
14:20 17:20
18:5 22:5
25:11 32:17
37:2 38:10
38:11 40:6
40:17,21
44:19 48:21
50:8 52:4
58:19 66:13
67:24 72:15
73:8 80:21
82:21,22
83:7,24
86:18 96:4
97:12 99:6
99:25
102:20
103:5
108:22
112:21
118:8 120:2
121:4 122:8
122:13
124:7,8,14
125:6
131:11,15
131:17,18
131:24
132:25,25
138:3
140:19
141:18
143:17
144:9
147:10,11
150:14
157:7,9
158:20
159:5
160:24
161:21
162:9,10
170:4,6,8
172:14
176:14
179:3,18
181:21
182:3,6
183:15
186:12
191:5 197:7
198:17
203:14
208:24
210:23
213:6
214:12
216:7 217:3
228:13
231:15
232:6,17
234:3
235:23,25
238:15
ones 16:7
41:3,12
52:12
one's 38:18
48:9 144:6
239:22
ongoing
103:5
only 6:19
7:21 12:17
17:15 18:8
47:7,10
67:5 72:25
77:22 86:4
89:7 100:23
102:19
125:6
131:12,15
131:24
151:15
160:13
166:3
174:22
192:2
198:17
200:19
203:19
210:23
218:20
225:22
241:19
op 105:8
107:6
231:12
open 95:19
99:5,15
100:19
148:3,4
172:17
opened
101:16
102:22
operational...
58:11
operatively
231:10
opiate 95:18
opiates 30:10
opinion 72:15
106:23
152:13
opinions
130:2
opioid 29:20
45:2,15
47:20 50:15
50:17,19
54:21 57:19
59:11 80:23
80:25 81:21
81:22 82:8
83:6,18
90:16 93:12
96:17 97:17
98:8 107:6
107:12
108:18
109:2
113:10
114:20,23
119:12
120:19
121:6
122:11
138:21
146:12
147:8 150:5
181:14,20
191:5,7,16
194:24
195:14
196:17
197:12,13
200:8 217:5
219:14,22
220:4,8
222:5,10,11
225:7
235:17,17
236:14,23
239:25
240:11
opioids 28:7
28:20,24
34:7 40:23
53:24 54:12
57:9,11,14
60:17 63:3
63:7 82:21
88:21 97:6
97:10,14,21
97:23 98:3
119:10
120:7,14,24
123:21
127:9
128:19,25
146:8
156:24,25
157:7 158:4
159:22
174:2 175:5
178:23
184:3,4,11
188:2
191:22
194:2,5,9
194:25
196:8
199:14
201:24
204:18
205:9,21
207:6
209:20
215:10,22
220:7 224:5
224:11
226:2
230:12
232:22,24
240:15
242:2,9,16
245:3,17
opportunity
4:17
opposed 31:4
35:13 40:11
56:22 91:5
103:14
105:16
115:20
182:22
231:17
optional 26:5
oral 36:7
46:22,25
65:3,4
78:22
150:25
151:8 156:8
156:9
orally 38:15
38:23 39:4
order 67:11
67:11 79:9
173:13
190:5 217:5
229:11
orderly 18:22
ordinary
77:13 166:5
166:8
organizatio...
62:15
original
117:11
153:24
166:16
orphanizing
210:7
orphans
209:18
osteoarthritis
87:24 88:8
88:12
105:21
106:11
109:2,10,13
225:19
229:2
236:13,17
other 7:14,21
16:4 17:17
19:6 23:13
26:10 37:21
45:25 47:11
49:2 54:11
65:12 74:13
79:5 83:3
90:8 92:19
97:6,7
109:5
114:18
117:19
118:11
120:13
137:9
144:10
156:25
158:2,3,8
159:22
161:18,21
171:8 177:6
179:3
180:23
185:2
188:21
191:22
202:8,9
204:17
221:18
230:21
245:5
others 41:5
43:7 44:22
44:23
107:12
ought 117:14
139:13
out 15:8
17:15 28:16
31:24 32:23
33:16 34:24
35:13 43:6

49:23 56:9
62:8 77:12
77:24 92:23
93:19 97:7
121:17
130:11
137:14
143:25
146:25
151:13
156:12
163:20
173:14
179:23
182:8
206:21,25
210:11
215:6,12
220:10
221:22
224:13
240:7 244:4
244:10
outcome
249:18
outpatients
202:18
outstanding
197:9
over 12:23
14:20 21:7
24:11 52:8
57:2 67:5
97:16 104:4
104:7
110:17
131:22
133:16
146:7
151:10
167:17
171:21
177:3
189:13
204:10
216:3,3,4
220:5
237:23
241:11
246:13
overdosage
112:25
170:18
overdose
51:4,6 94:3
154:9
overrepres...
203:12
overruled
70:12
oversight
11:11 65:10
221:20
overtly
215:17
overwhelm...
127:10
own 13:20
14:6 24:12
53:21,25
112:23
245:21
oxycodone
38:7,16,23
39:4,23,24
40:5,25
46:24 47:12
47:13,24
48:3,8
64:25 65:2
65:5 74:10
75:17 85:3
85:4,18,18
85:25 105:7
114:5
115:17,21
150:21
154:11,15
154:16,20
159:14
167:11
172:16
175:19,20
175:24
176:11,17
177:5,15
178:4 179:7
179:25
183:7,8,11
183:12,17
185:2
186:23,25
187:14,19
187:21,24
190:16,18
233:3
oxycodone's
40:3 153:10
153:17
oxycodone/...
48:6
oxycodone/...
48:7
OxyContin
16:3,21,23
20:4,18
22:13,20
23:22 39:16
39:19 61:8
61:11 62:22
63:2,6
64:12,15,18
66:22 79:8
80:20,21
85:24 87:17
87:23 96:2
101:19,22
104:7,13
105:6
107:25
111:3
113:10
114:9,14,24
115:6 118:5
120:22
145:22
147:13
148:3 152:3
152:17,19
153:9,16,25
156:3,19
157:5,8,10
159:14,17
159:18,19
159:23
160:7
161:19
162:8,14
163:21
164:13
165:5 169:3
169:9,14,18
170:4,17,19
170:24
173:8,25
175:4,13,14
177:18,23
178:2,19,22
182:13,17
182:21
183:21
184:2,9
187:22
188:22
189:5,8
190:17,22
191:8,20,22
192:5,18
198:3,22
199:3 212:4
213:18,19
215:3,4,8
215:20
217:4,8,11
223:8,12
224:2,8,9
225:15,17
225:18
226:13
227:16
229:21
230:18
232:10,15
232:20,24
233:4,5,13
235:18
236:4,9,14
239:24
243:10,12
244:23
245:11,13
245:15,16
OxyContin's
20:18,19
65:8 217:15
217:18
OxyContin...
75:18
Oz 218:23

P

P 2:2,2
pack 105:14
package
17:23 18:6
18:8,10,17
18:20 62:25
97:2 109:21
125:12,14
126:22
127:13,16
151:19
152:7
161:11
174:5,7
197:7 223:8
227:12
237:9
241:25
242:6
243:10,15
243:19
244:8
245:10,13
245:14,18
246:3,6,20
packaged
101:19
page 20:13
21:13 67:25
69:6,10
70:16 73:23
74:3 76:13
76:24 80:10
91:20
101:12,13
103:22
111:9,18
125:13
126:9 127:3
150:16
154:8
160:21,21
163:16
166:14
167:7
168:18
170:2,5,7
172:10
173:18
177:21
179:15,16
179:18,18
183:4
184:19
193:11,24
195:15
198:21,23
198:24
199:5,8,12
199:16,22
200:2 228:3
246:24
248:7 250:2
251:2 252:2
pages 170:2
paid 100:24
pain 26:15
27:6,8,14
28:8,11
29:10,12,20
30:2 31:3,4
32:12 33:22
33:23 40:14
58:2,3 59:7
59:13,18,18
59:21,22
60:4,11,13
60:17,25
85:4 87:18
88:3,11,25
89:4,6,7,16
89:19,20,21
89:24 90:6
90:7,10,15
90:15,21
91:5,6,14
92:3,6
104:20,20
104:21
105:13,14
105:14,15
105:16,22
105:23
106:5,10,14
106:20
107:2,6,11
107:16
108:19
109:4,5,10
109:13,14
109:20
115:7
123:22,25
124:5,21,25
125:2
133:21
134:4 135:9
135:16,17
135:21,22
136:2,19,19
136:21

137:7
138:21
139:24
140:12
141:16,18
142:4,6,7
142:24,25
143:3,7
144:3,3
145:8
146:11,19
146:21
147:2,6
148:18
149:9,15,24
150:2,24
171:10
176:9,14
178:20
180:21
181:19,22
181:23,25
194:9,12
195:2 196:9
196:15,18
197:14
200:5,9,12
200:16
201:24
202:17,19
205:21
207:6,18
210:10
211:19
212:10,21
214:17,24
215:3,5,6
219:13,16
219:21,24
220:3,6
222:9,15,17
222:22
224:2
225:25
228:23
229:3,9,14
229:15
230:11,20
231:6,10,11
231:12,17
231:18
233:17,18
234:11,24
236:4,11,22
239:7 240:5
242:3,10,12
242:17,18
242:22
243:2,21
244:23
painful
106:13
Paolo 189:24
paper 24:4
papers
202:21
paradigm
32:11
233:15
paragraph
69:12 103:4
108:15
154:9 161:9
167:9,23
172:11
173:19
184:23,25
186:6
192:23
193:11
194:6 197:6
199:17
228:20
parenteral
65:3 122:16
150:21,22
Parenterally
38:13
parke 1:18
3:3 25:9
parlance
61:17
parochial
203:4
part 14:10
17:22 21:4
32:11 34:3
34:4 50:20
65:14,15,17
68:9 78:7
97:9 103:21
113:18
125:17,21
138:17
145:20
146:18
150:4 154:2
154:22
162:7
165:22
166:8 167:2
186:22
199:8 216:3
219:25
partial 83:2
Partially
208:21
participant
63:23
participants
9:19
participate
229:11
participated
41:13
participating
89:8,9
198:7
particular
6:11 23:18
72:5 100:8
103:14
105:22
115:9
130:20
137:22
139:23
152:10
155:12
161:2
189:14
192:11
210:4
220:10
225:5 227:4
particularly
34:7 77:11
113:21
179:13
particulars
100:9
particulates
36:7
parties 123:4
249:16
parts 32:10
65:19,21
233:13
party 101:10
passed 24:11
past 21:8
50:13 93:11
209:10
210:6
pastor 1:19
4:4 249:7
249:23
patches 36:8
patient 19:11
27:14 29:19
29:25 30:11
31:3,5
32:13,15,20
32:23 33:2
33:3,4,4,7
34:19 36:10
37:17 40:13
58:2,3
60:25 81:8
91:25 93:11
106:7,10
108:25
125:3,15
135:9 139:8
140:12
142:6
170:25
206:19
212:18,20
214:12
219:21,25
220:6
222:17,20
231:9 236:3
246:9,14
patients
26:12,15,21
28:3,11,15
28:20,24
29:7,10,12
31:15,21
36:5 37:15
40:8 59:7
59:17 60:5
60:17 62:23
63:9,11
70:21 81:8
82:7 83:18
83:20 85:4
86:3 87:18
87:24 89:6
89:10 90:2
90:22 92:12
92:13,13,14
92:21
102:18,25
105:8 106:9
106:25
107:18
108:18
109:19
113:25
123:7,25
124:5,25
131:9,11,14
131:17,21
132:9
133:18,23
135:16,18
135:22,25
136:18,19
136:24
137:2,7,13
137:16,17
137:18,23
138:14,21
141:2
142:25
143:14
144:3
146:11
147:2,7
148:19
149:9 150:6
150:7,24
158:11
168:21
172:10,12
173:5,7,11
174:13
177:16
179:8,21,23
179:24,25
180:7
181:13
182:10
187:5 194:9
194:25
196:9,18
197:14
200:9,12,16
201:24
202:17,25
205:21
206:25
207:6,20
208:14
209:10,14
210:10
211:23
212:8,10,19
214:17,25
215:3
219:13,16
222:10
224:3
225:14,20
229:10,14
230:16,19
231:21
232:12
233:11,17
233:18
240:16
242:11,18
242:22,25
243:3,4,6
243:13,17
243:22,24
244:3,14,16
244:24
patient's
27:24 29:3
29:4 30:2
37:20 57:8
197:15
244:16
patient/pha...
101:18
patient/pha...
102:24
Patricia
189:24
198:10
pattern 78:23
Patty 190:10
190:11
pay 51:18
81:5
paying 24:15
100:3
pays 94:6

peach 222:21
peak 39:3,4 39:10,18 72:6 119:21 167:12 216:25
pending 61:22
Pennsylvania 3:10 7:20
people 18:5 18:10 32:2 34:15,23 40:20 46:21 50:10,12 51:23 57:18 57:22 64:7 66:8 73:19 77:19,22 102:3,14 110:16 116:4,12 117:4 122:2 123:8,9,11 123:12 134:8,22 139:5 141:3 143:2,7 144:13 145:22 146:20 161:21 190:8 192:8 203:11 204:4,5,6 210:14 216:10,12 222:16
per 40:25 85:22 86:5 86:6
perceived 32:5,7 34:6 53:11 124:24
percent 61:18 62:12,22 146:11 147:7 149:5 149:5 179:21 180:7,8 182:5,7,24 200:19,20 200:20 203:8 205:21 206:2,11,16 207:5,20 208:6 209:16
percentage 149:9
percentages 149:3 202:7
perception 48:15 77:15 82:14
Percocet 97:7 97:11 104:13 105:6
Percodan 131:17
perennial 231:6
perfect 166:3
perfectly 51:14 106:23
perform 70:19 71:22
performance 72:17
performs 68:22
perhaps 56:8 89:16 109:24 240:3
period 46:16 55:8 73:7 74:19 88:22 98:9,13 107:7 112:23 118:14 124:20 132:13 137:13 143:21 146:3 157:12 158:5,8 179:5 186:4
periodic 30:13 33:12 143:21
periodically 33:24 89:14
permitted 180:16
persists 92:11
person 18:7,8 18:12 21:24 77:19 155:25 190:9 221:14 226:5
personal 21:17 24:12 28:14 245:22
personally 21:23 42:4
personnel 115:3 136:23 217:21
persons 15:5 210:5 237:22
person's 72:15 222:3
perspective 71:13 129:25 143:24 145:18 179:9
perspiration 171:5,18
pertain 34:6
pertaining 24:5 43:19 49:18 73:9 82:5 128:24 174:17
Pg 248:2
Pgs 248:2
pharma 1:9,9 3:3,4,15 7:7 7:8,10 8:11 10:23 16:4 16:12 17:2 17:3,4 20:2 55:11 67:17 68:8 147:13 228:5
pharmaceu... 7:4,15 13:6 13:23,25 15:24 22:5 121:11 158:21 167:2 193:16 211:7 221:5
Pharmaceu... 7:19
pharmaco 72:16
pharmacod... 81:24
pharmacod... 80:22 118:17
pharmacoe... 134:15
pharmacoe... 133:3
pharmacog... 40:19
pharmacok... 38:21 64:24 72:6,17 81:23 83:19 183:25
pharmacok... 64:16 179:10
pharmacok... 35:24 64:23 84:9 118:17 183:24
pharmacol... 36:11 64:12
pharmacol... 64:15
pharmacol... 164:4
pharmacol... 66:10
pharmacol... 6:3,5,6,9,10 6:21 14:4 34:5 122:5 177:7
pharmacov... 200:23
phase 69:4 147:16 172:2
phenomenon 56:6
phone 96:4 238:15
phrase 34:12 55:21,23,25 164:6,12 239:16
physical 30:4 33:10 57:5 57:8,21,23 60:19 123:24 124:4,23 128:7,10 168:24 169:4,7,9 172:5 243:24 244:2
physically 5:5 50:25 57:25 170:25
physician 26:24,24 27:4 29:6 30:16 32:16 93:10 219:13,21 220:21 222:9 241:12 244:13,18
physicians 18:22 27:20 31:17 73:11 89:7 96:22 106:6 133:14,17 151:20,22 161:18 182:22 220:13 222:11 243:11
physician's 59:12
physiologic 43:4
PI 161:12
pick 37:22 107:18 186:20
picked 204:2
picture 236:2 236:18
piece 206:21 227:7
pieces 189:17 205:8,19
pill 38:5 86:21,25,25 103:6
pills 46:20 211:24 212:6,9,16 213:11,15 214:13,18 215:14
pilot 67:21
PK 82:6 216:25
place 54:6 68:19 144:12 225:16 228:6
placebo 43:2 50:18 89:4 89:8,14 102:10,11 102:15 103:17 105:6 185:24 230:7
placebos 103:4
placed 58:10 96:7 154:17
places 134:5 142:20 193:5
Plaintiff 1:7
plaintiffs 1:17 2:3 4:8 21:9

plan 30:4 33:11 219:2 220:20 229:24
planned 229:21
planning 218:16
plasma 38:22 39:5,18
play 9:13
played 207:17,24
Plaza 1:19
please 4:14 4:20 23:24 68:14 88:19 106:3 115:25 153:12 161:10 169:21 219:18 223:2 229:23
PLLC 2:3
ploy 99:10,19
point 41:19 48:18 76:25 82:2 83:10 92:3 134:19 140:6,8,12 161:17 169:6 170:14 173:21 176:6 180:12 182:8 186:2 220:19 225:5 232:9 241:10
pointed 224:13
policies 217:25
policy 72:10 145:5
poorer 143:2
population 62:19 92:17 107:20 149:15 185:4 195:21 196:20 201:5 202:12,14 203:8,10,15 208:14 209:16,21 209:22 230:8,9,15
populations 133:20 202:10
population-... 204:3
populized 203:13
Porter 128:12,16 128:16 129:19,22 130:15,17 130:23 131:2 133:10 134:17 136:12 137:9 145:12,14 195:5 250:24
portfolio 51:12 92:16
portion 68:3 160:14 168:19 169:14
PORTIS 2:8
Portnoy 141:18 149:23 150:4
Portsmouth 5:19,20
posed 9:8,19 9:23 33:5 36:9 89:17
position 9:2 11:5,7,13 11:21 12:25 76:14 89:14 104:22 107:23,25 108:11 109:13 116:21 118:14 134:24 135:3 158:25 176:22 229:2
positive 195:22 196:11 227:15
possibility 169:11 183:7
possible 31:15 45:8 156:5 168:3 173:16 174:22 186:16 219:24
possibly 202:18
post 9:16 104:19 105:7,13 107:6 231:10,12
poston 1:6 4:9
post-operat... 229:3
potency 65:2 82:20
potent 65:5
potential 9:9 38:8,12 40:24 41:7 41:9,11,25 42:23 44:15 46:13 47:15 47:17 49:22 50:2 54:20 74:22 76:17 77:2,3 78:24 79:10 80:16 82:17 100:20 103:9,24 120:7 150:17 153:10,17 154:10 155:3,9,20 156:24 157:6,22 183:6 232:16,21 232:25 233:4 245:23 246:17
potentially 49:3 224:4 224:10 225:6 244:25 245:16,24 245:25
potentiate 216:8
power 190:10
powered 63:14
PPLP 193:12 193:18
PPLP's 192:24
practice 29:24 30:14 31:20,23 33:20 41:6 135:13
practiced 30:9
practicing 27:8
practitioner 27:10 37:19 135:5 141:21
practitioners 33:20 139:12,17 139:23
precaution 189:17
precautions 112:19,22
preceded 189:22
precipitate 54:14
precisely 39:21 46:11 65:22 91:7
preclinical 154:18
predictable 46:25
predictive 231:7,8
predictively 64:19
predilection 197:16,25
preeminent 149:24
preexisting 243:5
preliminary 74:25
premiere 56:24
preoccupat... 123:14 127:10 223:10
preparation 131:12 138:3
prepare 24:19 219:9
prepared 194:21
preparing 193:23
prescribe 117:5 220:22 235:11,16 240:16
prescribed 37:18 65:25 181:7
prescriber 231:21
prescribers 33:16 100:4 210:9 219:16
prescribing 30:16 31:14 32:15 190:21 240:14
prescription 59:12 128:19 225:16 235:8
prescriptive 74:24
present 3:13 22:6,11 25:9,10,12 154:17 220:25
presentation 218:17 219:5 220:20,23 220:25 221:10,12 226:17 227:16 244:16
presentatio... 60:11 80:5 198:6 219:2
preserve 45:8
president 10:5
pressure 171:12
prestigious 134:16
presumably 40:14 136:19 137:6
presume 108:7
presumed 246:11
pretend 177:3
Prettiman 16:19
pretty 5:4 45:21 49:20 82:8,24 99:23 114:3 119:16

124:22 134:16 141:3,4 178:14 215:11
prevalence 60:4 149:2
prevalent 136:21 144:11
prevent 169:12 194:11 196:14 200:4
preventative 6:2
previously 25:14,18 37:16 95:6 104:15
pre-IND 69:4
price 119:11
prices 120:16
primary 65:10,12 161:19 162:21 180:3,20
primitive 49:20 114:3
principal 43:14
principle 45:7 59:24 119:17 168:9
principles 34:4
printed 151:11
prior 7:14 31:11 73:10 92:13 108:13 219:8
prisoner 150:20
private 43:18
PRN 176:14 236:13
pro 40:20
probability 79:2
probably 31:21 35:8 38:9,13,14 72:21 83:6 91:17 93:12 98:16 115:13 124:7 141:19 147:10 167:18 173:12 178:7 206:2 209:5 227:2
problem 19:24,25 27:15,22 40:9 45:4 59:4 69:24 72:6,10 88:21 89:17 103:9,11 123:7 132:12 134:25 135:6,12 138:17,18 140:19 149:16 155:21 175:6,9,10 200:22 208:22 231:6
problems 27:12,18 32:7 34:24 133:19 135:15 139:16 142:3,7 181:22 191:5 211:23 212:8,12,21 215:2,4 219:25 222:8
procedure 24:2
process 9:10 9:11 10:3 66:21 130:8 141:10 158:25 216:3 226:15 227:19
procurement 123:15 127:11 223:10
produce 119:24
produced 21:8 119:21 166:25
product 11:10 14:3 19:15 20:19 20:19 44:4 44:7,9,10 44:20,25 45:25 47:25 48:4 53:4 55:16 72:3 72:20 73:15 73:17 74:2 74:10,20,23 75:7,17,18 75:21,23 76:4,6 78:4 79:6 100:24 100:25 109:17 110:4,7 112:17 115:5,5,17 116:7,23,25 117:5,19,25 122:23 159:25 169:24 175:20,22 176:3,8,9 176:25 181:4 216:17,18 220:22,22 228:25 236:9 251:11
production 67:2 79:18 80:3 84:5 98:19 111:15 125:9 153:21 160:18 162:25 184:14 188:11 192:13 195:9 197:3 211:2 214:5 218:4 227:23 231:25 234:2 235:22 238:11 239:2 250:5 250:7,9,11 250:16,20 250:22 251:4,6,8 251:13,15 251:17,19 251:21 252:4,6,8 252:11,13 252:15,17 252:19
products 9:4 9:9 11:12 13:20 48:21 48:22 49:4 49:9,15,17 49:19,19 74:14,16 78:23 98:16 114:5 116:14 117:7,19 119:7 154:12,13 154:15 176:11,12 176:16,24 179:12 187:2,14,19 191:16
product's 17:23
professional 30:19
profile 167:14,18 168:2,3,9 174:10 175:4 216:25
profiles 173:25 178:13
progenitor 155:25
prognosis 133:25 140:23,25 141:2 143:2
program 5:17 6:11 6:12 63:21 64:3 69:17 132:25 134:11,11 134:17 136:25 137:3 185:2 185:3 221:21
programs 14:9 133:5 133:6 221:20
progressively 89:2,5
project 8:22 95:12 145:13 250:15
projects 10:10
promising 219:9
promo 206:20 227:7
promotion 19:16,22 226:21 227:8
promotional 19:9,20 100:12 110:12 189:17 205:8,16,19
proof 45:7 133:11
propensity 34:23 35:12
proper 28:17 94:12 194:11 196:15 200:4 243:16
properly 28:15 29:9 29:15,19 31:4 32:12 133:18 135:17 143:12 194:9,25 196:9,18 197:14 200:9 220:6 241:5
proposed 72:19 76:15 76:23 77:7 78:4 109:22 129:9
prospective 15:19 73:3
prospectively 73:4
protect 71:14 71:17
protective 67:10,11
protocol 93:14 99:5 99:16 100:2 103:8 148:4 148:5
protocols 88:9
prototype 45:2
prototypica... 121:2
proud 122:21
proved 122:6

151:21 152:10
proven 233:3 233:8 246:4
provide 14:11 31:17 115:4 117:4 224:2 226:11 238:18 244:23
provided 33:25 114:9 114:14 152:3,17 153:8,16 156:2 162:14 163:20 164:12 177:18 178:3 223:12 229:4
providers 33:25
providing 45:8 71:11
Prue 192:17
pseudoaddi... 59:23 60:4
Psychiatric 143:7 214:8
psychologic... 122:24 123:2,9,13 123:25 127:5,7,9 127:25 128:8,8
psychologist 221:7
public 1:20 4:3 5:24 9:21 10:17 19:3 25:25 26:4 71:14 71:18 145:17 249:8
publication 194:19
publications 62:14 182:20
published 33:21 104:15 147:22,23
purchase 220:21
purdue 1:9,9 1:9 3:3,4,4 3:15 7:7,8,9 8:11,12,14 8:17 10:23 16:4,4,11 16:11,12,12 16:14 17:2 17:3,4,18 20:2 21:8 24:17 25:11 43:23,24 44:3,12,13 48:17 50:3 50:6 52:15 55:11 63:21 66:20 67:17 68:8 74:9 75:12,16 76:6,9,11 77:3 78:3 79:8 81:18 82:3 83:12 84:25 88:10 91:16 95:24 96:21 101:8 107:25 115:13 147:13 152:21,23 153:6,14 156:16,21 157:4,11,16 161:7 162:17 163:8 164:11 167:4 173:24 174:15 175:3,22 176:3 185:10 188:25 191:19 198:14 199:11 201:19 204:22 205:7,20,23 207:11 217:21 218:11 228:5,5,11 237:22
Purdue's 84:19 108:10 162:22 228:9
pure 54:8
purity 14:3
purple 75:10
purported 165:15
purpose 100:16 126:20
purposes 56:10 68:9 83:11 104:14 123:16 127:12 223:11
pursuant 1:17 21:9
pusher 57:20
put 18:24 19:5 35:16 75:9,9 96:8 96:25 112:24 139:3 152:2 152:24 191:17 197:19 214:20 221:10 223:16 226:17,19
putting 110:2 210:3
p.m 94:15 95:3 247:4

Q

QDP4 139:24
QID 167:14 175:17 177:24 178:5 184:5 184:11 186:20 214:12 215:24
qualificatio... 135:20
quality 141:14 143:5 165:19 202:3
question 4:13 13:10 18:2 22:13 28:14 28:25 31:7 37:4,6 56:7 58:25 61:21 61:22,24 62:2 63:15 63:17 64:22 68:11,12 69:20 82:10 83:16 84:21 84:22 96:19 105:25 106:17 112:2,3 113:18,19 142:10 146:16,18 147:19 153:11 157:13 160:9 165:9 191:13 204:20 205:14 207:8,23 210:2 212:17 213:21,25 219:17 222:25 224:19,23 233:7,21 237:8,18 241:4 242:14,21
questioning 4:17
questionnai... 51:8 84:24
questionnai... 51:11 80:19
questions 4:10,18 5:8 43:19 64:24 75:6 81:12 85:10,11,12 93:16 179:2 191:6 240:24 241:9,18,23 241:24 245:6 247:2
quickly 67:5
quite 27:20 89:12 106:2 106:4
quote 128:15
quotes 99:10 219:12 223:7 225:13
Q12H 175:14 182:14,18 182:22 183:22 213:20
Q4 176:12,14 177:7,8,15 186:7,12 215:25
Q4H 176:9 178:21
Q6 177:8
Q6H 175:15 176:8 178:22 186:7,12,13
Q8 211:22 213:14 214:2
Q8H 182:13 182:15,18 182:22 212:3,4,7 213:12,17 213:18

R

R 2:2 3:7 58:8 95:2 249:2
RADARS 63:20 64:3 64:4,9,9,10
radiation 222:18
ran 14:10 121:16 202:25
randomizat... 174:12
randomize 138:21
range 54:8,9 54:10 149:4 182:23 217:7
ranged 172:13,16
ranges 101:13
rapidly 119:15 137:14
rare 62:6,6 62:11,11,16 123:23 128:6 130:4 131:20 133:12 137:19 139:20 182:6 194:10 195:2,21 196:6,9,10 197:14 200:10,21 200:25 201:2,9,10 204:9 205:10 206:10,10 242:3,10,17
rarely 201:10
rate 31:21

45:3,3 119:2 120:19 133:25 134:2 135:13,15 136:3 142:17 144:5,8 171:12,12 180:14 182:11 201:23 202:4 203:6 203:24 205:9 208:6
rates 62:19 62:20 207:25,25 242:21
rather 89:24 131:5,6 165:24 183:12 230:20
rating 85:14
ratings 53:11
ratio 50:25 65:2 211:20
reach 41:18 110:8 139:19 140:7 144:10 221:13
reached 168:8
reaches 39:4
read 61:22 115:11 130:12 131:5 149:11 151:20,22 154:11 163:19 197:12 209:13 211:4,15 214:9 230:6 244:21 245:9
readable 18:23
readily 103:20 118:23
Reading 107:21
reads 167:25
ready 116:15
real 59:25 81:15 144:5 146:7 188:7 192:9 201:22 210:19,20 231:8,9
realistic 29:5
really 30:21 82:20 102:16 141:9 183:14 209:17 221:21 232:10 233:21 235:13
reason 24:9 59:9 74:6 95:16 99:4 99:13 124:25 141:14 180:23 185:12 226:8 248:9 248:11,13 248:15,17 248:19,21 248:23,25
reasonable 57:3 236:10
reasonably 131:13
reasoned 61:4
reasons 30:2 56:11 113:2 121:18 159:5 180:3 227:6 248:6
recall 12:21 15:6 23:12 44:22 66:20 71:2 75:12 77:3 78:12 79:7 87:16 96:14 99:11 104:6 109:4 109:8 111:4 114:13,17 114:22 153:6,13 156:21 165:4 167:15 174:20 178:2 184:8 208:9,12,12 212:14 214:25 241:24 242:20
receive 36:19
received 5:12 5:21 129:5 131:11 138:2
receives 57:10
recent 101:17 102:23
recently 72:25 131:7
Recess 41:22 52:20 94:15 144:19 188:9 227:21 241:20
recidivism 128:3
recipients 228:10,14
recognize 166:14
recognized 42:22
recollection 105:3 164:10
recommen... 74:5
recommen... 69:21,23 70:13 192:25 193:3 216:22
recommen... 73:25
record 4:18 21:3,11 52:18 249:13
records 22:8
recovering 92:6
recruiter 8:12 10:21 17:2,14
recruitment 122:5
red 192:25
Reder 8:23 16:21,23 17:6,8 22:12,17 23:8,19 55:4 79:21 80:9,18 87:17 88:13 92:8 95:14 95:23 98:23 99:12 100:13 101:16 102:22 108:16,20 109:15,18 109:21 185:9 188:14,21 189:23 190:5,15 198:10
reduce 47:22 114:10,15 117:25 120:3 152:4 152:18 153:9,17 156:3,13 162:15 163:21 164:13 223:13
reduced 78:24 79:9 233:20
reducing 78:25 159:25
reevaluate 30:6
refer 16:11 35:11 132:9
reference 103:3 126:23 127:15 148:23 154:21 173:6
referenced 129:20
references 128:14 129:7,12,17 155:12,14 155:18 157:16 236:21
referred 155:15 242:25
referring 49:14 104:25 113:14,22 113:23 195:25 202:22 227:3 230:16 235:4 243:3 243:4
reflect 123:5
refractory 142:4
refresh 105:3
regard 228:24 242:11
regarding 145:21 155:15 193:8 204:18 230:22
regards 16:20 19:15 23:22 44:3 79:8 108:6 109:10 120:7 124:6 146:25 148:3 155:19 159:14 198:9 201:22 233:17,18 234:7 237:5 239:5 240:3 240:25
regimen 181:13
registry 147:12,14 147:21,23 148:2 159:6 206:5,7 241:3,6
regulated 116:22
regulation 215:7
regulatory 6:18,25 10:6 15:15 16:24 18:15 31:13 71:12 81:20 109:24 110:16 175:7,9 192:16,18 228:8
rehabs 26:25
reimburse... 100:17
reinforces 223:23
rejected 201:4,8
relapse 28:4 28:11 93:19 93:23 244:19

relapsed 28:12,16
relate 20:17 118:23 223:24
related 53:3 57:7 82:11 120:4 121:19,21 135:25 140:11 148:4 249:16
relating 104:19 105:13
relation 64:2
relationship 80:23 82:9
relative 43:7 47:17 53:13 64:22 82:20 113:25 114:2 116:9 150:6 216:21
relatively 9:25 31:16 46:15 72:25 115:11 118:11 122:2,18 133:18,23 157:24 187:5 205:25 215:18
release 39:6,9 39:12,13,15 52:25 53:2 53:7,8,13 53:14,16 54:21 63:3 63:7 77:13 77:16 83:14 83:14 85:25 86:3 88:21 105:7 107:6 114:19,23 115:20 117:6,25 121:6,8,9 121:13 122:11,12 150:25 151:8 154:16,25 155:8 156:9 156:24 157:7 158:4 158:9 159:15,17 159:22 167:11,19 174:2 175:5 175:15,22 176:3,17 178:4,23 179:7 181:4 183:8,12 184:3,4,10 186:25 187:13,24 191:7,15 215:9,22 216:16 224:5,11,15 225:6,7 232:21,22 232:23 233:3,5 245:2
released 104:17
relevant 26:11 110:12 129:4 186:2
reliable 139:16,22
relied 195:4
relief 104:19 105:13 106:21 176:10 219:13,21 219:24 220:3 222:9 222:12 224:2 244:24
relieve 222:22
relieving 178:19
reluctant 209:17
rely 13:22,24
remedicated 182:10
remedication 182:9,11
remember 8:6,9,19 12:20,25 14:15 16:10 16:13,24 17:13 22:19 24:22 25:3 25:5 55:24 66:9,11,24 74:4,8,12 74:12 75:14 75:15 76:8 76:16,20 77:5,6,7,10 78:16 79:3 79:11,14 80:18 82:3 83:21 84:17 85:13 87:19 87:22,25 88:2 92:7,9 94:9 95:23 96:3,4,20 99:15 108:20 111:5 112:23 115:10,15 116:9 120:10,24 121:16 125:23 128:20 140:21 144:25 148:11 151:4 160:2 172:23 174:6 180:10 185:8,11 193:19 196:22,24 198:3 228:16 242:4
reminded 211:20
reminder 234:16
remission 28:16 93:20
rep 214:20 232:6 233:21 235:4
repeat 153:11 219:17 224:21 237:18 242:14
rephrase 4:12 27:12 141:24 173:23 219:19 237:20
replacement 119:7
replete 158:17
replicated 237:9
replied 190:4
report 11:14 12:5,11 84:12 95:12 98:22 136:11 148:8 184:18,20 210:25 211:8 212:2 213:4 214:4 214:7 228:8 231:24 232:4 233:25 234:5 235:21 238:10,25 240:4 241:14 250:15 251:25 252:4,10,12 252:14,16 252:18
reported 60:10 136:4 200:10 201:9,10 205:9 208:5
Reporter 1:20 249:8
reporting 207:19 208:16
reports 11:16 101:19 136:10 137:10 139:7 145:17 148:7 209:13 236:21 237:3,10,23 240:25
represent 227:13
representat... 78:20
representat... 22:4
representat... 211:8
representing 4:8
represents 72:15 179:24
reps 214:23 237:4
request 73:13 100:2 115:15,18 237:16
requested 193:18
require 68:17 98:12 107:9 107:12
required 14:25 15:2 33:13 236:23 237:16
requirement 81:20
requirements 13:6 22:5 70:14 73:3
requiring 230:11
rescue 180:16 180:17,18 180:24 181:15 182:2,5,8 216:17,21 216:23,23 217:3,6,12 217:13
research 5:15 6:13 56:20 58:10 75:23 81:12 100:2 118:25 119:4 122:5 134:13 138:18,19 145:5 238:3
residency 5:25
residential 121:24
resistance 47:23 222:14
resistant 48:17
resolution 197:9 229:19
respect 16:15 16:22 19:21 20:24 44:25 65:7 116:11 157:10 174:23 194:22 198:3,5 242:17
respectable 216:11
respiratory 171:12
respond 21:6 21:7 32:22

37:5
response 9:25 27:24 32:25 180:22 190:23 192:24 242:20
responsibili... 15:24 97:20
responsible 14:16,22
rest 161:15 202:2
restless 171:19
restlessness 171:4,17
restrictions 198:5,13 226:21
result 36:18 94:8 181:19 181:19
results 52:10 53:6,10 80:24 83:22 86:16 103:19 106:8 122:21
resume 20:15
resumed 95:6
review 11:22 11:24,24 62:4,4 66:16 68:24 69:2 70:7 70:12 71:20 84:13,15,19 93:4 97:10 97:20 128:21 145:20 148:16,17 157:12,25 158:25 161:19 165:3,5,8 165:10,21 166:17 167:3 172:7 172:10 177:18 179:16 205:15 208:7 251:10
reviewed 18:10 25:17 65:11 66:16 78:17,18 98:10 109:23,25 197:6,7 205:6
reviewer 65:12 68:16 70:4,8 161:13,14 162:21
reviewers 66:4
reviewing 83:21 86:15
reviews 65:10 161:12 162:10 166:10
revised 70:11 160:22 161:11 193:2 197:7
revising 189:4
revision 161:12 163:9 188:21 189:8
revisions 192:5
rhinorrhea 171:5,18
RICHARD 3:14
Richards 189:25 190:10 198:10
right 4:25 10:15 21:12 41:21 45:3 61:15 62:2 70:10 76:2 83:10 85:7 93:25 94:14 97:4 99:22 101:8 102:4 103:10 105:10 106:2,4 109:8 111:6 112:14 115:22 116:8 117:13 120:23 122:14,16 123:2,19,20 124:19 126:3,6,8 126:22 127:12,21 128:11 135:19 137:5 138:3 140:4 142:2 143:23 144:21 149:21 154:6 166:4 167:23 168:16,17 170:13 173:10,12 178:9,11,11 180:4 182:24 186:8 196:7 198:24 208:13 214:24 221:2 225:15,17 229:17 232:11 235:8 240:5 241:10 246:15
rightly 220:11
Ripa 55:19
rise 119:2
risk 9:4,6,12 10:3 11:18 30:24 36:10 36:18,20 49:6 51:4,6 64:5,6,6 73:9,9,17 78:25 92:5 92:16 93:6 93:14,15,18 94:2,4 133:3 134:15 145:22 158:11 178:13 183:6,17 190:12 204:11 205:16 208:24 209:2,4,6 209:23 210:5,10 219:24 222:12 233:20 246:20
risks 9:8,19 9:21,23 33:5 133:7 133:7 141:19 204:14 227:13
Robert 12:12 88:16 101:16 102:22 108:16,20 109:15,18 109:21 188:14 189:23 190:13,24 191:11
Robins 136:16 140:16 202:6 208:10
robust 71:8
robustly 78:22
Rockefeller 1:18 3:5
role 9:13 17:23 65:7 71:14,15,17 80:22 189:7
roles 9:18
rolling 158:4
room 25:10
roughly 39:20 126:23 154:20
round 123:5
routinely 64:8
rule 237:17
rules 13:13 13:15,16 15:17
run 6:23 48:5 55:9 221:21
running 103:7 241:13
rural 141:21
rushed 137:14
Russ 141:17
Russell 211:10
Rx 234:13 235:5,7 239:7,17

S

S 2:2 95:2,2,2 250:2 251:2 252:2
safe 72:20 73:12
safely 93:7,11 108:7
safety 13:20 15:9,11,12 20:3 22:3,6 22:7,14,15 22:16,20 47:21 51:3 75:6 139:21 166:18,19 166:21,24 167:5 168:3 168:9 174:9 205:4,17 221:20
salary 10:23 11:3 12:15
sales 211:8 214:20,23 218:10 220:24 221:11 232:6 235:4 237:3,23 238:4
same 11:5 22:10 37:25 38:8,14,15 39:11,20,25 49:6 71:23 72:7,9 82:12 86:18 102:10 107:5,10 111:9 112:8 119:23 123:10 127:23 129:14 140:6 151:2 151:9 162:4 168:12 176:13 193:17 203:18 221:15 227:18 229:12 231:4 239:10,21 239:22
sampling 144:11
Santa 189:24
sat 139:12
satisfactory 92:2
saw 49:3 120:17 129:15 203:5 206:6
saying 52:11 86:2 92:7,9 96:15

112:10
134:7 135:8
139:24
141:23
143:5
158:22
164:18
168:14
194:23,24
202:24
210:8,12,12
217:22
240:14,19
242:20
245:20,21
245:23
says 62:10
68:12 69:12
70:19 73:24
76:14,25
87:4 91:21
95:16,19
99:4,6,7
102:21
107:22
109:3 113:9
114:5,8
125:14
126:11
127:4,8,13
127:25
128:5
131:23
138:2
148:23
149:2
150:17,20
161:10
162:13
163:12
167:22
168:19,23
170:18,23
171:16
172:11,16
175:19
179:19
183:10
184:23
189:22,25
191:14
192:24
193:11
194:8
195:18
196:10
200:2 212:3
212:7
213:12
217:23
218:2,16,24
219:4,6,12
220:3 223:4
223:7,21
230:6,14
232:9
233:19,19
234:10
235:25
241:25
scale 134:14
scales 51:15
scandalous
99:24
scattered
243:18
schedule 35:4
35:7,16
45:17,19
46:3,5,6
77:24,25
78:8,10
108:18
109:2
113:12
154:15,17
186:21
193:17
244:11
scheduled
40:12
116:23
154:13
schedules
244:7
scheduling
35:9 77:22
78:15
218:24
schizophre...
134:2
140:23
141:2,4,9
schizophre...
134:3
school 5:16
34:5
science 45:6
48:17,19
49:18,23
71:21 72:11
119:11,13
155:19
sciences 46:8
scientific
26:10 42:11
58:6 71:8
71:13 72:10
140:18
153:7,15
scientifically
19:11 41:8
222:6
scientist
55:10
scientists
6:13 15:16
216:15
score 85:13
scores 85:16
86:24 87:9
scoring 58:12
58:14
screens 204:8
second 52:15
80:10 161:9
173:18,19
180:2
184:19,24
192:23
195:23
196:12,16
197:20
219:25
secondary
172:2
secretary
11:19
section 66:3,6
90:22 95:18
95:25 96:9
96:16
103:23
109:21
110:4,5,7
110:10
111:17,18
112:16,19
112:20,22
112:25
113:9 125:7
126:23
127:4
150:17
153:23
154:3 155:6
155:12
162:11
163:17
170:4,11,14
173:19
186:6
193:25
195:13,14
197:12
199:13,15
199:18,20
199:21
211:16
212:2
214:10
228:22
230:18
234:10
239:6
sections
65:25 66:5
66:15 67:6
91:13
see 22:24
23:8,17
45:7 50:16
50:16,21,25
51:3,5
72:16 73:11
73:12,14
83:19 85:16
86:23 87:3
91:21
100:15
101:14
102:12
103:3
126:10
130:20
131:22
138:23
143:18
148:23
150:16
154:10
155:14,18
163:23
165:18
167:8
170:20,23
171:15
172:11
174:16,25
179:18
193:9 194:2
194:4
195:16
199:5,12
200:2
205:19
219:2 223:3
223:15
224:6 230:4
234:12,25
236:20
237:4
seeing 23:12
74:11 77:7
113:4
114:22
151:4
174:20
193:19
228:16
seek 30:13
34:24 35:12
132:5
143:21
173:24
244:4
seeking 90:16
seem 83:21
152:8
234:23
237:8
seems 105:15
128:12
seen 20:10
38:21 61:14
64:25
130:21
148:6,7,8
190:20
196:19
211:5,7
218:7
222:19
select 231:21
244:16
selected
50:11
106:25
202:10,14
202:16,16
206:18
208:13
236:25
selecting
208:15
selection
243:24
selective
202:11
Self 56:9
sell 227:9
selling 72:20
226:12,18
send 192:8
230:21
senior 27:3
49:2
Senokot
234:16
sense 130:13
sensitive
198:14
sent 79:21
80:9 190:5
190:6
220:10
228:9
sentence
69:11 88:5
102:22
107:21
112:14
113:13
114:4,8,13
122:22
127:25
128:5,12
149:12
151:7
152:16,24
162:17,19
163:19

167:7,21,25
168:23
177:22
186:5
190:25
191:16
194:4
195:23
196:12,16
196:16
197:10,20
197:22
200:2,7
220:2,3
223:5
225:14
230:5
244:21
sentences 223:15
sentiment 176:24
separate 57:22 65:19 92:24 112:19,22 210:4
separately 65:20
September 68:4 69:10 79:24 80:9 184:20
series 4:9 6:23 50:15 79:21 134:21 171:4 202:23 203:5,15 208:16,18
serious 73:2 88:20 204:12,15
seriously 99:23
serve 217:6
served 5:20 21:5
service 130:11 203:2
Services 3:16
sessions 24:21,22 25:4,6,11
set 139:17,22 140:11 172:23 178:11 249:11,20
sets 13:5,13
setting 181:21 246:15
settings 138:24 173:20 228:24
seven 15:9 18:9 148:24 168:21 172:18,21 172:23
several 9:18 18:20 42:25 43:2 51:10 66:8 193:5 220:5
severe 118:12 137:17 141:8 175:9 222:17 225:25 230:11 231:10 236:22
severity 171:20
SHANE 3:16
share 146:5
sheets 205:4
short 95:20 131:6 167:23 188:5,7 239:10 241:19
shorter 177:13
shorthand 1:20 235:7 249:7
short-acting 234:14 235:6,11,17 236:3,9,13 238:19 239:7,14,17 239:25 240:15,20
shoved 162:21
show 78:22 79:12,15 84:15 87:12 95:10 101:2 125:4 148:13 160:11,12 185:19,22 207:4 236:2
showed 119:2 156:18 236:19 238:20
showing 108:5 184:9
shown 38:18 146:10 159:19
shows 147:6
sick 32:3 81:6
side 35:11 61:13,16
sign 18:13
signed 165:21
significance 18:16 110:2
significant 15:2 71:19 75:6 84:18 85:17 115:23 116:4 149:8 172:24 181:12 185:25
significantly 40:18
signs 123:25 128:7
SILBERT 3:14
silly 237:14
similar 109:9 112:12 113:11,14 127:18 168:4 190:19
simple 90:10 99:9
simply 85:14 162:19 187:16 244:22
since 10:25 37:23 44:13 73:8 74:20 83:17 93:5 120:20 131:6 187:19,22 229:20
single 45:24 86:5,6 92:18,19 104:16,25 105:5,6 147:5 154:12 173:2 181:23 186:23,25 187:13,18 187:21,23 203:19 223:5 229:3 230:5
single-hand... 141:20
sir 5:12 8:3 25:24 35:6 69:6 84:21 85:8 100:22 111:20 117:22 144:24 150:16 175:16 180:5 184:21 192:21 197:17 232:2 234:9
site 199:11
Sitler 211:13 214:7
sitting 142:19 240:14
situation 91:3 189:19
six 12:10 18:9 71:24 172:3 181:24
size 37:20 86:21 185:21
skip 218:23
slanted 146:22
sleep 171:19 224:3 244:24
slightly 65:5 165:12 167:12
sloppy 233:22
slowed 119:25 158:9
slower 118:8 119:14,20
small 7:18 160:13 180:18 204:14
smaller 180:18 216:23
smoked 118:16 120:14
soap-boxing 81:14
social 36:15 40:9 246:15
society 32:8 33:23 40:9 124:21 139:24 243:21
soft 119:11 155:19
solely 230:19
solid 36:7
some 4:18 5:8 8:14 10:10 16:8 22:2 23:9 27:17 32:9,21,22 32:22,23 33:17 37:8 40:20 42:2 43:8,24,25 44:22 45:9 47:10 49:5 51:2 53:24 56:10,15,23 57:11 58:23 59:7,21 60:14,15 65:11,13 68:3,7,12 72:2,3,18 72:18 74:25 76:17 78:13 78:14 79:5 80:14 81:12 83:21,25 84:23 89:11 92:3 95:24 97:6,19 98:9,12,13 99:23 100:8 100:11 106:5 109:5 115:22 117:4 118:10 119:6,9,12 120:20 121:4 124:5 125:11 132:9 134:12,12 137:9 139:15 141:24 151:20,21 152:14 168:22 171:3 173:6 173:21 174:11 175:23 176:16 177:5,16 179:13 182:19

188:21
189:4,15,20
202:9
203:17
204:14
211:23
212:8 216:2
216:15
218:22
223:19
224:14,24
224:25
231:11
233:12,13
240:23
241:8
somebody
37:22 50:23
51:4,16
65:23 83:7
122:13
132:15,16
143:11
181:25
208:25
209:2,4,6
216:13
221:7
somebody's
57:25 65:22
93:22
217:10
somehow
63:24
115:16
someone
27:22 28:4
36:18 38:3
42:16,18
56:18 57:11
58:5,19
59:3,9 61:6
86:10,12
121:11,24
135:6
139:17
177:14
185:21
226:20
someone's
59:11 243:8
someplace
191:17
something
4:15 52:16
59:23 92:7
94:9,10
96:9 103:2
107:17
117:15
129:5
134:18
145:14,15
158:15
160:11
166:4
175:11
207:10
something's
61:16
sometime 8:9
sometimes
18:9 27:25
57:7,24
71:15
137:18
164:21
177:8,8
203:4,4
208:14
215:17,18
somewhat
32:10 35:3
47:2 53:22
111:12
176:16
206:18
somewhere
12:18 76:12
164:25
203:8
sophisticati...
113:24
SORRELS
2:12
sorry 29:8
147:18,25
160:16
179:17
191:10,10
194:24
sort 9:16 32:9
47:11 62:8
127:17
176:13
177:20
206:21
215:13
235:7
sought
130:11
173:22
190:18
sound 126:2
126:5
173:10
219:15
sounds 111:6
126:7
sources 19:6
Spalding
99:7
speak 71:15
speaking
49:25 61:8
67:16
special 82:15
82:16 93:14
124:16
185:3
specialist
11:18 27:9
60:12
192:18
221:7
specialists
15:15 59:22
149:24
specific 9:22
41:9,10
44:23,25
60:13 69:16
87:25 91:8
105:15
125:7
154:24
155:7
157:21
164:10
166:25
174:23
191:8 198:5
209:10
210:8
225:13
specifically
63:15 67:6
108:9
233:14
specificity
58:17
208:20
specified
225:23
speed 37:9
118:22
speeding
120:14
spend 65:24
66:2 86:15
122:3
232:10
spoke 8:15
sponsor
15:24 92:19
94:10 99:24
110:6
185:16
195:16,18
196:10
230:25
sponsors
71:21 113:3
159:21
spray 116:13
sprays 36:6
spring 189:3
189:8 192:6
ss 248:3
249:4
stable 10:19
72:16
staff 13:4
14:15 15:4
15:5,10
66:4 67:22
68:24 97:14
117:3
157:25
237:23
stage 10:20
117:8
stamp 68:2
stamped
67:10
stand 145:4
standard
19:8 45:14
46:17 51:14
81:10 115:4
176:15
177:6 186:3
standards
178:6,7,18
182:3
193:17
standpoint
45:21 64:13
175:7
Staples
214:11,19
start 32:20
63:10
124:20
158:22
170:16
190:2,6
204:4
started 8:7,8
48:16 58:25
121:15
188:16,18
starting
81:25
170:13,17
171:15
173:18
228:19
starts 56:9
57:10 80:10
167:7
199:25
startup 7:18
10:14,15
state 1:21
29:22 30:22
34:2 37:21
143:4 180:2
180:13
186:6
230:19
234:13
235:2 248:2
249:3,9
stated 104:18
104:21
108:16
126:23
205:8
211:16
223:8
229:25
statement
115:12
129:10,13
129:14
152:15
159:10,20
160:5
162:13
170:18
183:10
195:21
196:5,10
200:17
217:18
222:4
241:25
242:5,8,15
245:9,12,15
245:18
statements
70:5,8
209:20
statement's
246:20
states 1:2
13:14 30:8
33:23,23
88:4 101:16
103:25
107:22
108:15
145:7 149:7
200:7 224:2
239:6
Stating 75:16
statistically
185:25
statistics 26:9
status 230:20
statutory
98:11
stay 202:7
step 32:5
107:19
177:19
steps 30:17
30:22
Steve 55:19
Steven 232:7
235:24

238:12
239:3
still 45:20
55:11 71:16
78:3 93:16
103:7 108:7
144:4 146:6
159:11,13
197:11
198:4
200:25
216:5
231:13
233:2
stock 10:15
stop 52:14
strategy
42:15
strauber 3:6
13:9 14:19
16:15 17:25
21:2,14
31:6 37:3
41:18 52:17
61:20,23
63:8 67:9
68:10 83:15
96:18 104:8
105:24
108:3
111:25
112:4,10
113:17
136:5 140:7
142:9,14
146:13
149:11,18
150:12
160:15
169:22
188:4,8
199:6,22
204:19
205:13
207:22
213:7,14,21
224:18,21
233:6 237:7
237:13
241:4,16,21
245:5 247:3
street 2:9,13
57:18
119:11
strength
83:22
203:23
strengths
16:8
stress 58:10
stressed
141:20
strict 24:2
strike 226:5
strike-out
192:25
195:15
strong 83:6
89:14 97:14
97:21,23
98:2 116:21
118:14
strongly
119:5 143:3
216:11,12
studied 32:4
60:3 144:7
150:24
151:3,10,18
152:9 156:8
158:18
167:19
207:25
studies 9:24
11:11 14:6
14:12 15:18
15:21 41:9
41:10,14,25
42:7,8,9,16
44:15 45:5
45:6,13
46:14 47:3
47:4,5,6,8
47:11,13,16
50:2 51:3
52:2,5 63:5
63:10,14,16
65:11,13
68:22 76:12
78:14 80:6
80:16 81:2
82:23 83:11
89:4,9,10
89:11 102:7
103:24
105:12,15
109:23
110:6,8
117:23
118:19
120:7,19,25
121:22
122:6 129:2
134:20,21
134:22
135:25
136:9,11,13
139:11
140:15
146:24,25
147:16,22
147:25
148:24
149:14
154:19,24
155:7,15
156:16,21
157:3,8,9
157:11,12
159:8
162:10
167:8,10
168:22
172:13,18
172:25
173:2
174:13
175:14,23
178:21
180:4,13
183:21,24
184:2,7,8
185:4,6,18
202:5,9
207:19
208:10
229:20,21
230:2,7,15
230:17,17
230:25
study 50:21
52:8 54:20
54:24 55:9
55:9 70:20
70:20,22
71:2,21
72:7 84:21
85:23 86:13
86:17,24
89:25 92:12
92:24 93:2
99:8,9
100:7,15,16
100:19
101:18
102:24
103:5,13,21
104:13,15
104:16,18
104:24,25
105:3,4,5
106:8 109:6
109:19,20
110:3,3,5,7
121:15,17
121:20
132:19,24
138:20,25
144:8,10
147:5,12,14
147:20,20
147:21,23
147:23
148:2
151:23
159:6
185:23
203:11,20
206:5,7
208:4 229:3
241:10,13
stuff 192:8
207:14
stunk 103:2
subject 41:16
66:15 67:10
77:2,14
200:18
218:16
223:22,24
224:14
subjective
42:17,19
43:3 50:9
51:7 120:3
subjects
83:19 154:6
subjunctive
222:8
submission
69:18 70:23
77:10 84:20
126:16,17
126:18
192:17,23
193:20
submissions
15:15
submitted
125:17,21
125:24
153:7,14,24
155:5 156:7
156:22
165:19
167:2,4
176:21
205:5
Subscribed
247:7
subsection
111:22
subsequent
18:25 43:17
43:21
subsequently
193:13
subset 56:5
210:9
substance
5:22 25:23
26:3,8
27:15 28:5
92:4 113:12
116:24
150:7
154:21
212:11
substances
31:12 33:17
35:9 116:22
154:14
178:12
substantial
180:14
substantially
53:12 116:6
succeed
91:17
successfully
144:7
suggest 152:8
154:19
167:11
suggested
84:24 91:25
108:16
119:5 150:6
153:2 192:5
193:5,7
196:23
197:18
198:11
suggesting
75:2 236:8
237:8
suggestion
70:25 78:13
108:21
239:13,24
suggestions
30:12 68:7
107:16
161:12
169:11
174:16
243:18,20
suggests
105:11
Suite 2:4
sulfate 38:24
39:5
summaries
157:14
summarize
166:21
summarizing
220:12
summary
19:4 84:8
125:14
166:17,19
166:24
167:5,9
174:8
179:17
183:5
summer
122:4 192:6
sums 100:4
sundry
116:13

Sunshine 105:8,10
superior 12:13
superiority 173:22,24 174:14,21 185:7,17 186:2,3
supervising 44:15 64:10
supervisory 97:20
supplements 157:15
supplied 65:25
supply 55:7
support 12:4 14:12 78:15 104:19 105:12 127:15 129:8 153:7 153:15 156:23 157:17 225:2
supportable 183:16 246:4
supported 26:23
supporting 20:4 108:17 109:23
Suppose 207:17
supposed 143:17
sure 18:2 30:14,19 31:10 37:8 59:20 62:8 73:6 76:22 77:19 84:12 105:2,18 107:14 108:12 110:19,24 111:11 129:7 140:10 142:14 143:22 146:3 153:13 164:18 178:10 187:16 188:3 192:7 205:11,23 206:12 207:11,14 237:20 246:5
surgeries 107:8
surgical 5:19 104:20 105:13
surrogate 246:11
surveillance 77:18 134:11,15 136:25
survey 119:10 128:17 200:23 204:3
surveys 129:2 155:19 204:9
suspect 187:25
SUTHERL... 3:9
suzanne 1:19 4:4 249:7 249:23
swallow 222:21
Sweating 171:22
swelling 90:7
switch 71:22 93:22 177:11 178:7 229:22
switches 71:7
switching 93:24
swollen 90:12
sworn 4:3 95:6 247:7 249:12
symptom 57:24 58:3
symptomatic 127:20
symptoms 50:24 168:20,20 169:15,16 171:4,8,20 171:25 172:6 215:19
syndrome 132:22 171:2
syndromes 105:16 142:4 231:17 244:6
synonymous 91:4
syringe 31:18
syrup 46:6
syrups 45:25
system 31:25 58:12 119:3 141:11 142:16 143:12 210:15
systems 58:14 77:18

T

T 2:15 95:2 249:2,2 250:2 251:2 252:2
table 62:10 84:7,20,22
tables 174:8,8
tablets 101:19 102:2 114:10,15 127:13 152:3,17 153:9,16 154:16 156:3 162:14 163:21 164:13 176:14 183:8,11 190:17 213:19,22 213:24 223:12 225:16 232:12
tabs 236:4,11
tag 234:12,25
take 22:22 24:3,18 30:3,17 31:19 32:9 41:19 42:18 52:3 59:9 81:25 90:13 122:19 125:5 138:20 140:8 144:17 166:20 181:9,18 188:5 211:24 212:5,9,16 213:17,18 213:19,24 214:13 216:17 217:4 241:16 244:14
taken 1:17 23:17 41:22 52:20 121:11 135:3 144:19 151:13 158:25 188:9 227:21 241:20
takes 54:6 57:2 86:12 222:20
taking 28:20 28:24 32:17 33:8 46:20 51:24 59:3 59:6 60:17 86:11,12 89:13 118:14 145:22 146:11 181:3,6 201:24 204:11 205:21 207:6 213:10,20 216:16,21 217:10,12 246:9,14
talk 22:18 25:13 38:23 39:16 56:19 62:18,20 115:16,18 125:6 141:13 149:18 155:23 158:22 160:13 196:4 206:14 214:21,22 220:24 221:11 232:11 243:22
talked 34:8 41:24 90:14 93:18 96:5 109:9 124:3 128:4 130:23 131:2 135:20 143:15 174:4 177:22 230:17 231:14,15 240:25
talking 37:14 37:15 38:3 55:20 60:14 60:16 63:8 75:8 79:25 87:22 88:2 103:9 108:8 109:4,7 123:6 128:23 134:4 141:9 141:15 173:18 198:9 210:7 217:8 221:22 240:9,10,10
talks 69:7 223:18
Talwin 75:4
tamper 47:22 48:17
tampering 116:18
target 219:8 221:24
targeted 233:14,16
targets 114:5
tasked 22:7 193:22
teach 6:24 221:14
teacher 221:14
team 13:3 14:14 65:9 65:14,15,17 65:18 95:12 97:10 101:6 101:7 161:15 162:7 193:22 250:15
technical 15:10 42:12 50:4 121:18 140:21
technically

45:7
technologies 46:18
technology 42:20 48:23 48:24,25 49:12 75:4 75:5
teleconfere... 228:11
telegraphic 234:21 235:13
telephone 22:9 95:14 100:14 198:7
tell 5:10 10:22 22:17 28:19 50:14 50:17,18 53:15 55:6 93:10 102:12,19 103:20 158:12,15 162:20 208:2 240:17 244:22
telling 186:10
tells 33:5 213:4
ten 44:18 47:3,4,4,5,6 57:13 85:6 97:16,24 105:2 138:22
tend 102:15 141:11 173:3
tens 21:8
term 35:8 59:23 60:2 93:19 140:21 148:5 155:25
terminology 96:23
terms 28:3 32:16 35:18 35:20 39:3 40:8 41:12 62:17 93:3 93:4,21 95:25 96:5 98:6,8 109:4 116:3 120:14 122:25 124:4 127:19 138:6 167:4 173:25 174:21
terri 1:6 4:8
terribly 231:8
tertiary 133:21
test 14:2 42:25 73:10 75:25 229:10
tested 62:23 73:5 87:17 89:23 159:13 229:13
testified 4:4 95:7
testimony 246:23 249:13
testing 13:19 14:2,4 98:12
tests 13:23
Texas 2:14
text 131:22 193:2
Thank 79:16 241:15 247:3
Thanks 190:24
their 6:24 13:20 25:7 25:14 34:2 36:14 39:10 46:22 51:6 53:25 56:19 59:10,11,13 59:19,21 61:2 68:9 76:17,18,22 89:7 95:25 96:2 100:24 100:25 106:9,10 109:22 115:16 122:4 133:7 136:3 137:11 144:16 146:12 147:8 155:6 155:6 159:25 167:3,4 181:14,14 181:25 204:18 205:21,22 207:4,6,7 207:25,25 208:14,14 209:22 210:6,9 212:22 222:22 225:17 230:19,20 230:20 233:22 237:5 244:14
themselves 56:17
theoretically 168:2
theories 216:2
therapeutic 35:23 209:17
therapeutic... 40:15
therapy 14:11 30:5 30:7 32:21 32:25 33:12 33:13 150:6 222:18 236:18 238:20 239:9,19 240:11
thermometer 51:16
they'd 51:8 125:22
thing 22:10 32:17 94:12 143:23 221:15
things 22:8 32:14 33:17 34:16 36:17 37:21 51:23 58:22 60:14 68:12 91:15 115:7 122:20 140:22 142:21 143:5,17 145:9 164:7 165:13 171:22 206:22 208:24 221:19 231:16 237:14
think 4:19,21 10:24 11:4 12:18 16:18 19:25 22:21 23:20 28:19 28:23 29:4 33:19 40:16 42:12 46:3 47:8 48:5,9 49:22 58:6 59:8,24 60:17 62:2 62:15,16 67:6 75:7 76:5 78:18 79:13,24 82:7 84:8 84:14,14 85:12,13 86:7 94:6 94:11 100:13 104:4 108:7 108:23 110:21,22 111:2,21,22 113:21 114:25 116:14 117:9,18 119:16 120:23 122:21 124:3,7 127:18 128:4,22 133:10 139:3,13,14 140:4 143:6 144:9,9 145:13 146:17 148:10 158:18,23 159:2,3 162:9 163:12 164:2 165:6 174:16,24 177:15,20 182:15 184:6,12 186:14 187:8 188:23 189:10,19 194:20 196:24 198:23 200:24,24 200:25 202:2 209:23 210:2 220:15,17 220:19 222:24 225:11,14 225:18,23 226:15 228:18 229:6 230:9 233:9,12 241:18 246:20
thinking 10:20 58:24 59:4 72:14 82:24,25 91:2 113:24 117:2,8,9 190:9
thinks 70:9 214:22
thinly 100:3
thinner 37:23
third 88:5 161:24 182:9 197:6
though 45:19 75:16 104:14 140:12 149:17 155:21 188:7 231:16
thought 9:16 37:13 58:16 64:22 92:22 92:23 96:23 132:16,20 139:9 147:24 185:4 191:11 197:15 201:25 203:3 206:13 214:21 215:14 223:5 228:11
thousand 70:21
thousands 21:9
three 6:16 12:14 14:25 24:21,24 60:19 68:2 121:25 161:18,21

206:22 236:24
three-quart... 52:9
three-year 241:3,6
threshold 110:9
through 19:3 22:14 67:3 79:19 80:4 84:6 90:18 96:11,11 97:11 101:4 111:16 116:8,11 125:10 131:5 139:25 141:10 153:22 154:11 158:16 160:19 184:15 192:14 197:4 203:2 215:18 216:14 218:5 224:3 226:14 227:9,18,24 227:25 228:9 240:4 243:19 244:25 250:6,8,10 250:12,18 250:20,22 251:4,6,13 251:17,22 252:6,8,9
throughout 92:22 237:14
Thursday 189:22
TID 213:25 214:12
tighter 218:25
time 8:24 10:15,18 11:10 12:4 13:3 14:17 14:20,24 15:3 18:24 21:6 26:19 28:11 37:2 38:22 39:3 39:10,18 43:16,17 48:19 49:6 55:8 62:22 65:24 66:2 67:12 70:12 71:5,15 72:12,22,24 73:7,8,13 77:19 78:10 81:19 82:25 86:15 88:17 88:22 90:17 91:2 92:11 92:18 93:5 96:10 97:25 99:22 104:9 107:7 108:4 115:6,22 116:9,10,20 117:13 118:4,10 119:2 120:8 120:20,20 121:10 126:14,15 129:23 130:10 133:17 143:21 145:7 146:4 157:16 161:17 163:24 164:17 169:6 176:6 176:19 178:17 180:2 182:5 182:25 185:14 186:15,24 187:12 191:3,4 206:8 208:13 224:15 225:23 228:18 229:12 234:20 247:4
times 12:2 25:12 86:19 174:3 201:15
timewise 24:18
timing 116:10
title 218:19
titrating 214:16
titration 180:15 211:22
tobacco 116:14
today 4:9 5:5 20:22 24:13 24:19 45:5 59:2 83:23 93:8,16 143:15 169:8 178:6 187:15
today's 75:5 178:18
together 65:21 139:3 221:10 223:16 226:18,20
told 78:19,20 107:24 134:18 145:15 185:15 210:19
tolerance 57:13 60:18 123:24 124:4,24 128:6,9 132:15 170:4 244:2
tolerant 59:14
TOLL 2:3
tools 83:18
top 62:24 120:18 183:14 200:2
topic 60:13 63:6 74:14 74:16 93:6
total 86:2,17 87:8,10 172:14 178:25 179:21,23 179:23
touched 229:6
tough 93:16 93:21 143:8 143:9,11,14 240:7
toughy 40:21
toward 146:22
towards 26:2 83:10 170:20 172:11 199:13 220:21
Tower 2:4
toxicity 47:21
traded 31:25
Traditional 185:18
train 42:19
training 5:11 5:21 6:11 6:17 7:3 18:16 25:22 26:7,9,10 34:3,4 137:20 140:22 218:9 220:10 221:7,18 227:8,17
Tramadol 39:24 79:22 132:19
transcripts 25:18
transdermal 36:8
transference 128:18
transmucos... 36:8
treat 26:12 26:15 90:7 90:7 141:8 142:23,25 143:8,9,11 143:14,18 144:12,13 144:14 193:15 220:6 236:2 242:23 243:2
treatable 123:17
treated 26:20 27:2 28:7 28:15 34:20 72:2,4,5 90:24 128:2 135:16,17 141:17 144:15 210:15 212:10 242:11,18
treating 27:14,20 30:9,10 91:4 143:6 143:13,19 143:20 144:3 214:24
treatment 5:22 26:20 27:24 28:17 30:4 33:11 33:22 58:21 59:20 61:2 62:18 91:9 91:14 102:20 105:21 113:6,6 115:8 121:23,24 124:18 132:8 137:12 138:22 141:4 142:5 143:12,16 171:24 180:8,15,20 210:17,21 215:5,6 222:16 243:16
treatments 92:20
tremendous 62:3
tremendou... 14:24
trial 33:12 75:24 93:10 93:12 102:18 167:20 177:10
trials 6:25 9:14,20,22 20:18 87:23 89:15 90:22 92:16 133:8 150:18 177:9,11 179:22 182:13 228:22,22
trickier 49:23
tricky 58:5 106:13
tried 122:13 134:9 139:5 174:25
trigger 246:15
trouble 32:24 46:10 70:3 133:22 181:11 199:16 210:16
troubling

72:8 207:10
207:15
trough
167:12
troughs
179:9,10
true 50:16
107:10
139:10
151:21
159:11,12
165:19
200:11,15
200:19
242:6,11,17
244:23
245:3,4,8
245:20,21
245:23
246:5
249:13
truly 40:16
96:3 112:8
152:25
153:18
221:8
227:20
trumped
129:25
trust 206:9
try 4:12 8:13
10:2 18:21
19:19 29:17
32:9 47:18
60:21 62:8
62:18 81:23
92:5,15
113:2 117:4
123:5 133:5
134:8 139:2
141:24
156:19
177:11
221:12,24
237:20
trying 9:8
40:10 43:4
43:6 45:6
47:17 52:5
62:20
103:19
106:7
115:14
127:23
134:22
135:11,21
142:15
164:24
220:19
221:14,22
turn 76:13
127:3 188:4
241:11
turned 49:23
121:17
turning 20:13
67:25
135:13
twelve 18:10
71:25
twice 86:19
86:22
175:14
178:20
181:9
185:25
216:17
two 10:16
25:10,11
47:18 52:8
58:22 64:24
66:9 86:25
103:19
113:23
121:25
128:13
131:17
132:14
139:11
149:23
163:3,11,14
169:17
172:3
176:14
179:2 180:3
184:18
208:23
211:20
223:15
225:14
two-thirds
182:9
two-week
172:25
Tylenol 46:5
type 44:11
108:21
typed 69:10
types 243:2
typewritten
21:14
typical 96:16

U

Uh-huh 68:5
127:6
188:23
194:14
196:21
ultimate
15:23 18:12
unbalanced
174:11
227:15
uncertain
27:23
uncertainty
203:16
unclear 64:17
uncomfort...
27:21
uncommon
29:7,10
62:6 122:18
133:7 187:5
196:19
200:25
201:2,5
220:8
under 9:5
57:3 65:13
73:24 75:25
95:18 99:7
103:23
106:17
112:17,18
154:13
167:22
172:5
173:15
177:22
183:5
197:11
199:19
225:12
237:17
underlined
124:15,17
162:12,20
underlying
240:5
underneath
112:15
113:9 127:7
154:9 167:9
172:10
199:14,18
199:24
undersea
5:22
understand
4:11 18:2,4
28:25 37:4
37:6,7
70:15 85:22
86:13,16
135:21
141:23,25
160:9,12
193:15
220:9
224:20
238:22
understand...
8:13 61:15
175:21
understands
37:5
understood
75:11
100:25
162:23
167:6
unethical
89:11,17
unfair 79:13
unfortunat...
51:13
Uniphyl
236:6
unit 122:5
134:21
united 1:2
145:7
University
5:16,24
unpleasant
43:5
unresponsive
82:6
unsafe 71:18
unsolved
231:13
until 17:8
121:16
208:20
untreatable
143:9
unusual
102:3
unwarranted
88:9
use 16:11
19:15 36:16
45:11 46:21
46:23 57:2
67:25 72:20
73:19 74:24
78:22 80:15
80:19 84:25
87:17 88:3
88:8 90:14
93:19 94:3
99:6 100:24
107:17
108:17
113:3,4,5
116:18
128:25
131:19
133:5 159:4
180:24
186:24
187:3,18,21
187:23,25
191:14
209:21
215:24
221:13
226:12
228:25
230:20,23
236:9 238:2
239:8,14,17
239:18,24
240:19,20
243:20
246:2
used 19:7
34:14 36:14
37:8 42:11
44:24,25
46:13 47:7
47:14 51:12
53:16 55:21
81:11,23
83:12 99:9
100:3
101:25
120:25
122:25
123:3,22
167:13
173:5,7,11
175:20,24
176:4
178:21
181:23
227:7 242:2
242:10,16
243:12
246:6
useful 34:7
104:14
using 29:20
42:24 47:12
50:9 75:4
87:23
100:24
104:17
200:22
204:5
209:20
usual 168:24
169:4,7
172:4
181:17,18
182:3 186:3
216:22
usually 43:2
61:17 84:18
122:19
152:14
165:17
178:15
235:9
utilizing
123:17
128:2
utterly 81:13

V

232:7 239:5
validated 89:18
validation 70:20 71:2
value 59:10 60:16,20,24 124:6
variability 62:3
variable 47:2 52:4
variants 100:7
varied 14:24 15:7
variety 42:24 121:18 158:24
various 19:3 25:12 116:13 119:12 139:4 174:3
vary 39:22
varying 176:15
vascular 137:17
veiled 100:3
version 110:25 125:11,16 125:17 126:20 160:22 161:3 162:20 163:12 164:16,25 174:18 188:14 193:2 195:15 196:2,4,7 196:13 199:2
versions 125:19,20 160:24 163:3,11,14 163:15 174:5,7 195:12
versus 38:22 104:13 120:14 121:8 174:10 175:15,17
very 10:11 21:5 23:25 24:8 30:10 38:2 41:10 49:21 52:4 58:23 59:19 60:12 62:6 62:6,11 66:9 71:13 71:16 73:5 74:11,11,15 74:21 91:7 92:10 94:6 98:7,13,14 112:12 116:20 118:12,14 118:20,22 122:6,7 123:23,23 124:18 128:6 129:15,18 129:21 130:4 132:17 137:14 139:6,20 141:8,8,20 141:22 142:22 146:23 151:18,24 158:10 160:4,13 162:18 173:9 174:23,25 185:6 187:5 198:14,24 203:4,4,12 204:14,15 206:10 209:19 210:15 219:9 226:19 231:7 242:3 242:10,17
vice 10:5
videotape 207:3,17
violation 217:24
Virginia 5:20
virtually 217:15,18 218:2
visual 51:15 85:14
volume 37:9 100:4
volunteers 82:6,6 150:21
vomiting 171:11
vulnerability 36:15 116:18 142:6
vulnerable 142:3 246:14

W

wahoo 190:23
Wait 240:6
waiting 57:20
walking 236:5
want 52:15 82:13 84:15 93:19 94:9 94:10 106:6 106:24 108:24 112:11 115:23 118:3 124:23 147:4 151:23 170:14 212:25 219:11,20 219:23 220:3,13 221:9,23,24 222:11,23 229:12
wanted 8:17 22:12,17 23:8 48:20 81:18 83:19 91:11,13 96:15 100:14,15 107:25 108:11 116:5,12 148:13 185:22 187:7 222:12 238:18
wants 219:13 222:9 230:6
want/suggest 81:19
warning 189:16 193:7 199:15,19 204:23 209:10 210:4,8
warnings 199:19 204:17 243:11 244:3
warns 169:10 244:13,18
Washington 2:5 3:10 5:16 208:6
wasn't 13:2 75:4 145:24 186:24 210:2
WATKINS 2:12
way 9:24 14:23 18:23 22:2 32:5 50:5,22 82:12 88:9 88:15 139:6 144:7 191:10 198:13 203:18 208:21 216:7 231:20 249:17
ways 50:4 127:24 134:9 158:20 202:12 231:2
weak 115:12 159:9 160:4 246:20
weakness 171:10
week 121:25
weeks 121:25 121:25 140:2 172:14,17 173:6,6,11
weight 37:20 132:23
well 5:4 13:13 21:17 22:23 23:2 24:8 32:19,22 39:2 43:6 45:10 46:20 47:3 48:18 53:22 56:21 58:18,19 61:13 66:12 67:16 68:6 69:6 74:11 74:12 75:8 78:13 90:5 93:21 94:6 107:21 111:8 112:18 118:4 119:3 125:16 128:7 132:17 133:21 136:7,23 139:15 141:5 143:20 144:15 146:23 151:25 154:10 173:23 178:18,19 178:23 179:25 189:21 190:7,8 199:5 206:17 207:9 208:4 209:24,25 211:4 214:20 220:4 226:19 234:22 235:15 237:24 238:5 239:16 240:3,21
well-contro... 231:7
well-docum... 131:13
well-formu... 223:4
Well-recog... 150:2
went 5:23 6:11 28:16 97:12 130:9 152:7 160:25 201:14 239:8,19
were 6:15 7:17,25 8:4 10:11 11:9 11:20 13:19 14:9,14,16 14:22 15:5 15:10 16:5 17:10,18,20 17:22 18:9

21:16 24:8
24:9,23
25:8,12
26:12,16
27:12,19,20
27:23,24
28:15 34:4
36:5 45:6
47:16 48:20
49:14 52:5
52:12,22
53:6,10,12
59:5 60:14
62:23 63:14
65:11 66:10
66:15 68:18
68:19 69:9
69:9,21
71:12,13,19
71:22,23
72:3,12
73:18,20
74:21 76:18
76:23 77:16
77:17 78:3
80:6,6,19
81:16 82:5
84:18 85:12
86:14 87:10
89:7,12,16
89:18,19,20
89:21,21,23
89:23 90:21
90:24 91:8
91:10,15
96:8 97:25
98:4,10,12
98:14
100:11,15
103:13,15
103:18
104:10
107:18,24
108:6,8
109:6,7
112:9 113:4
113:5 115:7
115:8
116:23
117:5
118:20
119:16,22
120:10,25
121:2,19,21
122:17,20
124:19
125:20,20
129:15,23
131:9,10,12
131:16
137:3,13,23
138:14
145:10
149:4 158:3
158:10
159:6,21
160:23
161:18,21
164:21
165:25
168:20
173:15
174:8,17
175:24
176:24
178:13,14
179:8,10
180:2,6,16
184:3,4,7
184:25
185:4
186:10,17
189:15
190:8
207:24
208:15
213:20
217:21
221:19
224:25
228:13
229:20,21
230:2
232:24
243:3,18,19
weren't 32:2
44:23 63:17
90:18 98:17
100:10
101:10
178:10
187:13
West 2:4
we'll 63:11
111:8 159:7
we're 37:15
67:5,7
116:17
125:6
160:13
164:17,18
199:3 220:7
222:24
we've 33:7
48:5 55:20
55:21
139:25,25
140:2 220:4
whatnot
224:16
Wheeler
234:8,19
235:11
236:8
238:18
WHEREOF
249:19
while 16:5
24:8 45:8
57:19 78:3
205:8 224:4
224:13,24
244:25
whole 9:24
41:5 51:22
192:2
233:15
widely
172:13
widespread
131:19
wife 8:15
wife's 10:17
willing
229:11
winding
57:10
wise 70:9
227:14
wish 30:13
112:7
151:15
248:5
wished 124:8
withdraw
156:19
224:23
withdrawal
50:24 54:14
57:19 59:15
60:18
168:19,20
169:11,15
169:16
172:6 180:3
244:6
witness 3:9
28:10 37:5
249:11,14
249:19
Wizard
218:23
wonder
207:16
WOODSON
2:10
woozy 51:22
word 45:4
69:25 70:2
71:8 246:2
246:7
words 62:5
work 7:23
16:3 24:5
33:10 43:8
43:11,22,24
48:20,24,25
58:18,19
64:8 75:2
76:6,8,11
83:20 97:3
100:5 119:9
120:12
162:4
178:23
201:13,13
205:2,3
221:20
worked 7:18
12:8 19:18
42:2 43:18
48:11,23,24
65:16,17,19
65:20 66:5
66:6,11
78:3 97:10
178:12,19
working 44:6
44:8 48:13
50:2 65:14
66:10
143:12
181:20
198:13
199:3
works 106:24
177:7
221:20
worry 179:11
179:12
208:24
worse 168:4
168:12,15
worth 33:5
wouldn't
14:5 81:14
90:11 91:17
103:7
117:12
129:16
140:15
191:3 227:2
227:4
wrestle 82:4
113:3
134:22
140:20
191:4
wrestled
97:16
wrestling
72:12 179:2
wright 1:16
4:1,2,7 5:1
5:10 6:1 7:1
8:1 9:1 10:1
11:1 12:1
13:1 14:1
15:1 16:1
17:1 18:1
19:1 20:1,6
20:8 21:1,5
21:16 22:1
23:1 24:1
25:1 26:1
27:1 28:1
29:1 30:1
31:1 32:1
33:1 34:1
35:1 36:1
37:1 38:1
39:1 40:1
41:1,24
42:1 43:1
44:1 45:1
46:1 47:1
48:1 49:1
50:1 51:1
52:1 53:1
54:1 55:1
56:1 57:1
58:1 59:1
60:1 61:1
62:1 63:1
64:1 65:1
66:1,25
67:1,15
68:1 69:1
69:16 70:1
71:1 72:1
73:1,24
74:1 75:1
75:13 76:1
77:1 78:1
79:1,17
80:1,2 81:1
82:1 83:1
84:1,4 85:1
86:1 87:1
87:14 88:1
88:6 89:1
90:1 91:1
91:24 92:1
93:1 94:1
95:1,5,9,11
95:19 96:1
97:1 98:1
98:18 99:1
99:8 100:1
101:1,3
102:1 103:1
104:1,9
105:1 106:1
107:1 108:1
108:4 109:1
110:1 111:1
111:14
112:1 113:1
114:1 115:1
116:1 117:1
118:1 119:1
120:1 121:1

122:1 123:1 124:1 125:1 125:8 126:1 127:1 128:1 129:1 130:1 130:14 131:1 132:1 133:1 134:1 135:1 136:1 137:1 138:1 139:1 140:1 141:1 142:1 143:1 144:1 145:1 146:1 147:1 148:1 148:15 149:1 150:1 151:1 152:1 153:1,20 154:1 155:1 156:1 157:1 158:1 159:1 160:1,17 161:1 162:1 162:24 163:1 164:1 165:1,2 166:1 167:1 168:1 169:1 169:23 170:1 171:1 172:1 173:1 174:1 175:1 176:1 177:1 178:1 179:1 180:1 181:1 182:1 183:1 184:1,13,23 185:1 186:1 187:1 188:1 188:10 189:1 190:1 191:1 192:1 192:12 193:1 194:1 195:1,8 196:1 197:1 197:2 198:1 198:19 199:1 200:1 201:1 202:1 203:1 204:1 205:1 206:1 207:1 208:1 209:1 210:1 210:24 211:1,3 212:1 213:1 214:1,3 215:1,20 216:1 217:1 218:1,3 219:1 220:1 221:1 222:1 223:1 224:1 225:1 226:1 227:1,22 228:1 229:1 230:1 231:1 231:23 232:1 233:1 233:24 234:1 235:1 235:20 236:1 237:1 238:1,9,24 239:1 240:1 241:1,22 242:1 243:1 244:1 245:1 246:1 247:1 247:6 248:1 249:10 250:3,5,7,9 250:11,13 250:14,16 250:18,19 250:21,23 250:25 251:3,5,7,9 251:11,12 251:14,16 251:19,21 251:23,24 252:3,5,7 252:10,12 252:14,16 252:18

write 52:10 64:9 167:17 241:13

writers 59:21

written 88:9 124:19 139:7 199:23 200:18 221:18 226:5,11 235:14

wrong 68:13 70:10 71:8 92:23 107:2 222:11

wrongly 220:12

wrote 145:8,9 221:3 226:8 226:8

X

x 1:5,12 151:17 203:5 250:2 251:2 252:2

Y

yawning 171:5,18

year 7:24 10:24 11:4 12:18 15:7 15:7 52:9 55:14 111:6 148:12

years 6:16 7:11 8:5 12:14 26:7 26:22 44:11 52:8 97:16 97:24 105:2 116:16 133:17 137:19,20 137:20 138:23 210:14 222:13

york 1:19,19 1:21 2:4 3:5 3:5 248:2,4 249:3,5,9

Yup 190:3

y'all 65:18

Z

Zellman 11:18

$

$158,000 12:18

$185,000 11:4

$200,000 10:24

0

006 163:13

011 163:12

012 195:15

031 69:6

032 69:11

033 68:3 70:16

079 76:13

080 76:24

1

1 20:6,9 61:18 62:11 62:11,12,22 64:25 67:7 69:4 146:11 147:7 183:16 200:20 205:20 206:2,11,16 207:5,15,15 250:3

1.6 101:14

1.8 64:25

10 111:14 169:22 172:15 198:22 199:12,16 209:15 250:15,19

10th 200:20

10,000 138:21 207:15

10/22/92 95:12 250:15

100 12:23 27:5

100,000 200:20 207:16

101 250:18

10112 3:5

11 125:8 150:12,14 173:10 250:21 251:18

11,882 131:11 137:23

11.8 180:7

11/2/92 76:16

1100 2:4

111 250:20

12 130:14 250:23 251:13

12.8 180:8

12:15 94:15

12:50 95:3

124 154:8

125 250:22

1275 3:10

13 148:15 173:11 250:13,20 250:24,25

130 250:24

14 153:20 228:7 251:3

140 12:18

15 160:16,17 164:25 203:8 251:5

150 202:25

153 251:4

157 179:21

158 12:19

16 162:24 163:13 182:24 183:2 250:8 251:6,7

16th 126:11 161:4

160 251:6

162 251:8

164 251:10

169 251:11

17 165:2 166:13,15 250:17 251:9

18 169:23 251:11,23

18th 198:25

18.9 149:5

180 105:7

184 251:13

188 251:15

19 184:13 251:4,12

1910s 134:20

192 251:18

1940s 46:16

195 251:20

1957 154:18

196 251:22

1966 154:19

198 251:23

1980 128:12 129:19 130:19 195:5

1989 8:8

1990 96:11

1992 66:21 68:4 69:9 79:14 80:9 128:13 148:20 178:7 184:20 187:20

1992/1993 229:20

1993 87:17 99:2 101:6

1994 126:2,7 126:11 156:17

1995 12:21 13:2 110:21 118:4 119:17 126:5 156:18 161:4 163:6

1996 110:25 111:22,24 218:14

1998 7:13 10:25 11:3

206:6
1999 232:19

2

2 20:13 27:2 65:2 66:25 67:9 168:18 219:6 250:5 250:18 252:4,6
2,000 26:21
20 188:10 202:24 210:13 250:4 251:14 252:15
200 2:9
2000 111:10 111:11,23 169:20 238:13 239:4
20004-2415 3:10
20005-3964 2:5
2001 121:16 189:3,9 192:6,19 193:4,13 198:25 228:7
2002 121:16
2003 1:13 247:7 249:20
21 192:12 251:16 252:9
214 252:4
218 252:6
22 160:12,15 172:14 173:6,11 195:8 238:13 251:11,19 252:11
22nd 239:4
227 252:9
23 98:25 193:4 197:2 251:8,21 252:13,19
23rd 110:25 193:13
231 252:11
233 252:13
235 252:15
238 252:17,19
24 171:19 198:19 250:6 251:23
24-hour 179:4
25 1:13 209:15 210:24 250:10 251:10,22 251:24
26 214:3 252:3
26-M-B 1:8
27 208:6 218:3 244:22 252:5
28 207:20 227:22 252:7
28th 80:9
29 173:15 231:23 252:10
29th 79:24 189:22

3

3 58:8 69:9 79:17 172:10 223:3 250:7 250:12
3.2 149:5
30 1:18 3:5 202:24 233:24 252:12
30th 21:12,15 101:6
300 27:2
308 84:8
31 235:20 252:14
31st 163:5 193:13
316 101:13,13
319 103:22
32 172:17 173:6 179:21 238:9 252:16
323 170:5
325 111:19,19
33 238:24 252:18
36101-4160 2:9
3802 228:3,19
39,946 131:9

4

4 67:8 68:6 70:17,18 80:2 147:16 173:18 218:13 250:9
4:02 1:8
40 85:24 86:4 202:24
400 217:12
434 173:14
440 170:13,15 170:16
445 173:14 179:24
454 171:15
46 179:25
487 127:4
488 150:16
491 179:23,23

5

5 61:18 62:11 62:22 84:4 171:25 203:8 250:4 250:11
5th 110:21
50 27:5 182:5 182:7
50s 46:17
500 2:4
505 178:15
58 180:6

6

6 79:14 87:14 176:12,14 177:7 183:13 215:25 225:12 250:13
6H 186:8
6/22/2000 238:14
6:04 247:4
60s 46:17
63 180:8
66 250:6

7

7 84:7,22 95:11 171:25 200:19 250:14,22 251:20
7th 196:2
7041 160:21 162:11
7076 163:16
72 171:21 202:25
720 172:15
722 193:24
7501020320 111:16 250:20
7501020327 111:16 250:20
77002-1665 2:14
79 250:8,10
7911443057 231:25 252:11
7911450215 234:2 252:13
7911450927 235:22 252:15
7911452549 239:2 252:19
7911452553 238:11 252:17
7912511060 211:2
7912533279 214:5 252:4

8

8 98:18 179:18 200:20 250:16 252:17
8th 68:4
80 85:23 86:13 87:10
80-milligram 87:5
800 2:13 217:12
8001000296 84:6 250:12
8001000313 84:6 250:12
8001039123 153:22 251:4
8001039135 153:22 251:4
8002017468 125:10 250:22
8002017497 125:10 250:22
8002065027 67:3 250:6
8002065089 67:3 250:6
8003007024 160:19 251:6
8003007048 160:19 251:6
8003007060 163:2 251:8
8003007076 163:2 251:8
8113900019 80:4 250:10
8113900024 80:4 250:10
8113900032 79:19 250:8
8113900043 79:19 250:8
8113900101 184:15 251:13
8113900102 184:15 251:13
8113900235 98:20 250:17
8113900315 101:4 250:18
8113900323 101:4 250:18
84 250:12
87 250:13
88-105 105:4
88-1105 104:25
8810119940 188:12 251:15

9

9 101:3 179:16 183:4 199:23 250:18 251:15
9:38 1:14
90 96:11
90s 108:6
9100939555 218:5 252:6
9100939557 218:5 252:6
9101803708 192:14

251:17
9101803709 192:14 251:17
9101803722 192:15 251:18
9101803798 227:24 252:8
9101803799 227:24 252:8
9101803800 227:25 252:9
9101803808 227:25 252:9
9101804000 195:10 251:20
9101804012 195:10 251:20
9101804075 197:4 251:22
9101804076 197:4 251:22
92 69:10 74:5 77:4,8,13 82:15 84:25 95:14 178:9
92-1101 99:5 99:16
93 74:8 88:14
94 74:8,15 82:15 96:12 155:7 156:22 157:4,20
95 14:18,20 14:20,21 74:15 96:11 111:4,5 156:23 157:5,21 178:8,9 250:15
96 124:14
97 8:9 11:21 12:6 17:8 76:12 78:2 96:11
970302 241:2
98 11:5,7 76:12 121:15 188:24 250:17
99 121:15