IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

IN THE MATTER OF:)
)
Plaintiff,)
)
vs.)
)
WB: WILLIAM BIGLEY)
)
Defendant.)
)

Case No. 3AN-08-00493 PR CI

[redacted]

VOLUME II

TRANSCRIPT OF MOTION HEARING

BEFORE THE HONORABLE SHARON GLEASON
Superior Court Judge

Anchorage, Alaska
May 14, 2008
10:17 A.M.

APPEARANCES:

FOR THE STATE: Timothy M. Twomey, Esq.
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3AN6308-79
10:17:01
THE COURT: Okay. We are back on record in a case involving Mr. Bigley, who is present here in the courtroom. And we have Mr. Twomey and Mr. Gottstein.
And I received paperwork from you, Mr. Gottstein, yesterday. And in it, it indicated you had not yet received the chart. Has that been remedied, or what is the status there?
MR. GOTTSTEIN: Your Honor, I received -- it was there when I got back from my supreme court oral argument, so yesterday.
THE COURT: All right. And I see a rather lengthy witness list. And I am concerned about the timeframe. So -- and it looks like three are simply to have available for cross examination of the materials you submitted, which I have reviewed; is that correct?
MR. GOTTSTEIN: Yes, Your Honor. I really only have three witnesses I plan to call.
THE COURT: Dr. Jackson, Dr. Hopson, and Camry Altaffer (phonetic)?
MR. GOTTSTEIN: Altaffer.
THE COURT: Altaffer. All right.
Mr. Twomey, are you ready to proceed?

MR. TWOMEY: Yes, Your Honor.
THE COURT: All right. And who would you seek to call first, Mr. Gottstein?
MR. GOTTSTEIN: Dr. Jackson. And her number is area code 910/208-3278.
THE COURT: All right. Thank you.
So did I indicate until noon today we could go, or did I -- is that what I had indicated? Or did I make any indication?
I have to go to an event at noon or there about. So we'll see where we are time-wise. I know it's an important issue for your client, Mr. Gottstein. If we need to find more time in the next couple of days, we can do so. So let's see what progress we can make up until noon.
MR. GOTTSTEIN: You indicated noon.
THE COURT: I did. All right. That was my recollection, but I didn't see it in the log notes. All right.
We are a little late getting started, which was not really my fault, but my reality, anyway.
MR. GOTTSTEIN: Your Honor, I gave the clerk exhibits for this morning.
THE COURT: I have them right here. A through F; is that correct?

MR. GOTTSTEIN: Yes, ma'am. And I gave them to Mr. Twomey.
THE COURT: Mr. Twomey, you have a copy, as well?
MR. TWOMEY: Yes. I received them this morning, Your Honor.
THE COURT: Do I have Grace Jackson on the phone?
THE WITNESS: Yes.
THE COURT: All right. Good morning, Ms. Jackson. My name is Judge Gleason. We have you on a speakerphone here in a courtroom in Anchorage, Alaska.
You have been called as a witness on behalf of the respondent, William Bigley. It is a matter here where I have the lawyer from the state and Mr. Gottstein present.
I am going to be recording your testimony here in just a moment. I will administer an oath to you. But any questions first?
THE WITNESS: No.
THE COURT: All right. If you'd raise your right hand, please.
(Oath administered.)
THE COURT: If you would then please state

and spell your full name.
THE WITNESS: Grace Elizabeth Jackson. That's G-R-A-C-E, Elizabeth, E-L-I-Z-A-B-E-T-H, Jackson, J-A-C-K-S-O-N.
THE COURT: All right. Thank you.
Go ahead, please, Mr. Gottstein.

DR. GRACE JACKSON

called on behalf of the respondent, testified telephonically as follows on:

DIRECT EXAMINATION

BY MR. GOTTSTEIN

Q Thank you, Dr. Jackson. First off, did you send me a copy of your curriculum vitae?
A Yes, I did.
Q And it's 11 pages?
A I believe that is correct, yes.
MR. GOTTSTEIN: I'd move to -- it's Exhibit A. I would move to admit.
THE COURT: Any objection there?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. A will be admitted.
(Exhibit A admitted.)
MR. GOTTSTEIN: Should I give this to the clerk at this point?
THE COURT: That's fine. You can hold on to

it, and we'll get it later, if that's easier for you.
BY MR. GOTTSTEIN
Q Okay. And if I might just take care of the other part of it, too. Did you also send me essentially an analysis of the neuroleptics, neurotoxicity of -- oops, I didn't number it -- 19 pages.
A Yes, that's correct.
Q And is that your work?
A Yes, that is my work.
Q And this analysis is true to the best of your knowledge?
A That's correct.
MR. GOTTSTEIN: I would move to admit that, Your Honor.
THE COURT: That is Exhibit E?
MR. GOTTSTEIN: E.
THE COURT: All right. Any objection to E, Mr. Twomey?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. E will be admitted.
(Exhibit E admitted.)
BY MR. GOTTSTEIN
Q Thank you, Dr. Jackson. Could you briefly describe to the court your experience, training --

training, education and experience?
A Certainly. I attended medical school at the University of Colorado between 1992 and 1996.
Following that, I entered and successfully completed residency in psychiatry, which was performed actually within the U.S. Navy. And that residency was performed -- well, the internship was in 1996 through '97, the residency 1997 through 2000.
Subsequent to completing that residency program, I served as an active duty psychiatrist in the U.S. military. I actually transitioned out of the military in the spring of 2002, and I have been actually in self-employed status since 2002 working at a variety of different positions in order to have some flexibility for research, lecturing, writing, and clinical work, and also forensic consultation.
Q Could you describe -- so have you published papers?
A Yes. I have published papers in peer-review journals. I have contributed chapters to other books which have been edited by other mental health professionals, both in this country and overseas.
And I am also the author of my own book, which I published in the year 2005.
Q And what was the name of that book?

A That book is called Rethinking Psychiatric Drugs, a Guide for Informed Consent.
Q And have you testified as an expert -- testified or consulted as an expert in psychopharmacology cases?
A Yes. I have served as a consultant in a number of cases involving psychiatric rights similar to this case.
Also involving disputes over the use of medications versus alternative treatments in regards to child treatments. I've served as a consultant to families or their doctors in other states in order to assist in the preparation of different treatment plans.
And I've also been involved as an expert witness in consulting on product liability cases.
Q Were you qualified as an expert in psychiatric and psychopharmacology in what's known as the Myers case in Alaska here in 2003?
A Yes, I was.
Q And did Dr. Moser testify I think something like that you -- that you knew more about the actions of these drugs on the brain than any clinician he knew in the United States?
MR. TWOMEY: Objection, hearsay, Your Honor.

THE WITNESS: I'm sorry. I'm getting a lot of beeps on my phone. Can you hear me all right?
THE COURT: Yes.
But, Mr. Gottstein, your response to the hearsay objection?
MR. GOTTSTEIN: It's actually in the testimony that was filed, I believe.
THE COURT: Well, then the testimony speaks for itself.
MR. GOTTSTEIN: Okay.
THE COURT: So you can go forward.
MR. GOTTSTEIN: I would move Dr. Jackson as an expert in psychiatry and psychopharmacology.
THE COURT: Any objection there, Mr. Twomey, or voir dire?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. Then I will find the doctor so qualified in those two fields.
Go ahead, please, Mr. Gottstein.
BY MR. GOTTSTEIN
Q Dr. Jackson, in preparation for this case, have you reviewed the -- what's known as the -- well, the affidavit of Robert Whitaker?
A Yes, I have.
Q And what is your opinion on that affidavit?

A I believed it was very truthful. I thought it was a very accurate presentation of the history of this specific class of medications which we are discussing in this case, the antipsychotic medications.

And also a very succinct but accurate description of some of the problems that have emerged, not only in the conduct of the research, but also in terms of the actual lived experience of patients. So I felt it was a very accurate and very clear presentation of the information as I understand it myself.

Q Now, would it be fair to say that this information is not generally shared by most clinicians in the United States?

A Oh, I think that would be a very fair -- very fair statement.

Q And why would you say that is?

A Well, I think we have a short time here. It's really a broad subject. But quite succinctly what has happened is that the educational process throughout medicine, not just psychiatry, and also the continuing medical education process, even when physicians have completed the first steps of their training, have actually presented a very biased

depiction of the history, or actually omitting the history of many medications.

So a lot of this is a reflection of the educational process, both in the first stages of medical school and residency, and then what is occurring in the medical literature even now.

Q Let me stop you right there just for a minute. So were you trained in this way?

A Yeah. I was -- absolutely. I was trained in the traditional sense that basically serious -- especially severe -- quote, severe mental illness or mental illnesses are diseases of the brain which require chemical treatments, i.e., medication treatments, and that in most cases, these medications must be used on a very chronic or even permanent basis.

Q And did something happen to cause you to change your mind or question that information?

A Lots of things happened. Probably one of the most important things is that I was fortunate enough to be trained -- or be training in a location that exposed me to some additional information.

In other words, some of the history, and also some of the alternative work which could be done that might be effective. So that was one part, is I did

begin to have an exposure to a different perspective.

But the most -- probably the most important thing for me was the lived reality of my patients, just opening my eyes and really paying attention to see whether or not people were improving.

Q I'm sorry; I missed that a little bit. Could you go into that a little bit further, what you found?

A Sure. Well, what really happened is that internship -- I should probably just back up and say that I regard -- in retrospect, I look at the educational process as really an indoctrination.

And I think it's rather unique or heroic when people can begin to examine things more critically. And I was just lucky enough to have an exposure to some individuals who allowed me to do that.

But more specifically, I began to see that in clinic after clinic, whatever setting I was moving through, I was seeing the patients were in fact not improving, that in most cases, in fact, patients were getting sicker and sicker.

And there are two ways to react to that. One could either blame that on the underlying illness and say that we just don't have treatments yet that are effective, or one could even begin to pay attention and ask a broader question or more pointed question,

gee, is it possible that there's something about the way we are approaching these phenomena that is in fact getting in the way of recovery?

And once I began to ask that question, I basically had a 180-degree turnabout in terms of how I had to practice ethically and according to science.

Q And did that result in a -- I think you kind of testified to this -- in a change in direction more towards researching this issue?

A Oh, absolutely. Well, basically, it resulted in two things. It resulted in a great deal of conflict between myself and most conventional settings. It's why I'm an independent practitioner and not a person enjoying an academic appointment or an appointment in a facility.

So it really made -- I had to make a firm decision, was I going to be truthful to science or was I going to go after a $200,000 a year job with nice perks and the respect of my colleagues?

So it was very clear to me that in order to honor the dictum first do no harm, I had to really stay truthful to the science. And that's really what necessitated my breakaway. So that's why I'm really an independent person who does my own research and tried to just help where -- you know, where the help

is actually needed or asked for.
Q Thank you. And so then, just to kind of fill in then this, it's Exhibit C, your neurotoxicity analysis, that would be some of your, you know, more recent work, is that correct, or current state of your research into this issue?
A Yeah. Fairly current.
I am trying to finish a second book this year. And what has really happened over the past two years is that I try to do clinical work to keep myself current with that.
But I also step aside. And probably every single day, I am working on the most current research in the field in order to, you know, lecture and to also write this second book.
What really happened about four years ago is I began to appreciate the fact that most physicians -- and this isn't just a criticism of psychiatry, by any means. But most of us ignore something which is called target organ toxicity. We don't pay attention to how the treatments we're using might actually be adversely affecting the very target we are trying to fix or help improve or repair.
So in my case, about two years ago, I started to just begin focusing on the most current research

that looked at the brain-damaging effects of different kinds of interventions. And that is really what I've been focusing on.
So the document that you have there is a reflection of some of that research. I should say that it's not completely up to date, because some of the research I've been doing more recently even demonstrates that these drugs are more toxic than what I have written in this report.
Q Okay. Thank you. I want to get to that -- get to that also a little bit more. But I'm also -- are there other reasons why clinicians are not really understanding this -- this state of affairs?
A Sure. Well, I think there are so many things that happened.
I'll just take my example. I went to medical school in 1992, graduated in '96, and did my residency until 2000. This was a very pivotal time in what was occurring within the mental health field and also within the United States culturally. And if I just picked, like, maybe four key things.
One is the government decided to name this decade the decade of the brain. In doing so, it sort of attached a governmental license or the (indiscernible) of sanctioning regarding these

phenomena as brain diseases.
The second thing that happened was the birth of something called evidence-based medicine. This was -- actually sort of became official through the Journal of the American Medical Association and other major journals to really elevate an importance, not the actual day-to-day observations that a doctor would be making and not the actual science of what causes illness, but clinical trials that are aimed at just improving or changing symptoms.
The third thing that happened was something that is called direct consumer advertising in 1997, which again was trying to market these drugs and make them more popular or appealing to the public.
And the fourth big thing that has really changed is something called the preemption doctrine. And also, the Daubert litigation.
Daubert was a supreme court decision in 1993 that has really made it quite difficult for toxic tort litigation to occur, so that the implications of that for doctors -- and they don't realize this. It's very much behind the scenes -- is that the pharmaceutical industry began publishing as many papers that they could as fast as possible in the journals in order to meet the Daubert standard of something called weight

of evidence or preponderance of the evidence.
So essentially what happened in the 1990s is that the journals, more than ever before in history, became a tool of marketing, a marketing arm for the drug companies. And drug companies shifted in terms of previous research in the United States.
Most of the research had previously been funded by the government and conducted in academic centers. In the 1990s, that was pretty much over, and most of the funding is now coming from the pharmaceutical industry. So that's really in a nutshell what happened in the 1990s when I was training.
Now, where are we now? What that means is that the journals that most doctors are relying upon for their continuing information continued to be dominated by pharmaceutical industry funded studies and by papers which are being written, if not entirely by the drug companies, then by authors who have part of their finances paid for by the drug companies.
And while I don't believe that it's necessarily going to buy us the information in an article, I think trials have to be funded by someone. Unfortunately what has happened is that there have been too many episodes of the suppressed information,

so that doctors cannot get the whole truth.
Q Well, I want to follow up on that. What do you mean by suppressed information?
A Well, one of the things that has happened repeatedly, and again, most doctors don't realize this, is that the pharmaceutical industry has not been forthcoming in terms of surrendering all of the information to the Food and Drug Administration that they were by law I believe, or at least under ethics, required to do.
For instance, in January of this year, the New England Journal of Medicine published a very important article that had been done. Actually, one of the key authors was a former reviewer at the Food and Drug Administration, who is now back in private practice, or somewhere.
And he and his co-authors had actually had access and reviewed the clinical trial database on the antidepressant medications. And they found that 31 percent of the trials were never published. So 31 percent of that information was never reported in the journals so that doctors could see it.
Okay. Well, you might say who cares. The point of it is that within that 31 percent, had they been published, the overall risk benefit understanding

of this category of medications would have been changed. Instead of favoring these drug treatments, it would have altered the whole face of the journals, and potentially the use of these medications would have become more limited.
Because that 31 percent of the information was showing that the medications were, A, not terribly effective or not more effective than placebo at all, and, B, it really began to reveal the full scope of the hazard. So by not publishing all this information, there is a false view of efficacy and safety.
I should say the same thing has happened with Vioxx. The same thing has happened with the cholesterol-lowering drugs. This is an epidemic right now, which is a real crisis in the integrity of medicine. It's not just psychiatry.
Q Does the same thing happen with respect to the neuroleptics?
A Absolutely, the same thing has happened with respect to the neuroleptics. I think you're a perfect example of someone who has tried to work to bring some of this hidden material to the forefront, because I still think there are concerns among professionals, and I hope among the public, that the Food and Drug

Administration still may not have seen all of the actual data that has been generated in the actual trials. So it is a continuing problem and a continuing concern.
And yes, I believe that most people -- I'll give you an example. When I was working in the VA clinic a couple summers ago in Oregon, I attended a dinner lecture where a speaker for a specific antipsychotic medication slipped out some information that I thought was extremely important. He said that the FDA and the public still has not seen information on Abilify, Aripiprazole, another antipsychotic.
And he alluded to the fact that there was a severe problem with cardiac toxicity, but he would not go any further. He was speaking on behalf of another company. But he said that it would be possible to contact him and perhaps he could share that information.
Well, my point is, why are the rest of the doctors not getting this information that Abilify is eight times more toxic to the heart than the other antipsychotics? I sort of filed that away in the background of my head and said, boy, you know, I'd like to have this information.
But the point is, doctors are not getting the

information. And that's a real problem both for them and it's a problem for their patients.
Q Is it fair to say that you've really devoted your life to -- or your work at this point to ferreting out this sort of information and making it available?
A Right. As best I can. And you know, it's -- it's really sort of a Catch 22. I would love to have the respect of my peers. I would love to be at Harvard teaching. You know, I would love to be an academic able to teach medical students.
But unfortunately, the system is so skewed still in the direction of the pharmaceutical companies and their products that I can't, you know, even get a foot in the door.
So yes, I am full-time researcher trying to do my best to understand this material accurately, and fairly, and objectively, and then to actually act responsibly in response to that knowledge.
Q So in reviewing this information, is it important to carefully look at the data and analyze what's actually presented?
A It's extremely important to look at the methodology. I don't think -- unless a person is actually working at the Food and Drug Administration

or one of the actual clinical trial researchers, you know, actually producing the data that you would actually -- that a person like myself would have access to the raw data.

But what I can analyze and ask questions about is to go to people who have either performed these studies, or when I read the published studies, which is usually what I have access to, to really use good critical thinking in terms of analyzing the methods that have been used.

And you might -- I'm not sure if we're going to have time to discuss methodology, but this is one of the key things that any physician really has to pay attention to.

It's not just the fact that there might be 10 or 20 studies that say a particular medication is either good, bad, or indifferent. It's actually important to -- you know, before even looking at that conclusion, to address how the study was performed so that one can make a well-informed and an appropriate judgment as to whether or not the conclusion should even be considered.

Q And so without going too much into it, could you describe a couple of methodological concerns that you have with respect to the second generation of

neuroleptic studies of which Risperdal is a member?

A Certainly. One of the things that has happened is that the database or the research (indiscernible), which is actually used to approve medications in this country, psychiatric medications, and then used to continue to argue in their favor, especially in product liability litigation or in a lot of cases. That data set is very limited in terms of generalizability.

What most people don't realize is that when a drug is being approved, the people performing the research want to pick the healthiest or the least sick or the least damaged patients, so that they can try and produce good outcomes. So that is one of the main concerns that all of us doctors have about clinical trials is that we recognize the fact that the generalizability is limited.

What do I mean by that? Well, they usually want to pick people who don't have additional illnesses, such as diabetes, heart disease, lung problems, liver disease.

Well, that's going to rule out a large number of people who are actually existing in the real world, because once they've been on many of these medications, they are guaranteed to have some of these

problems.

Number two is they eliminate the use of additional drugs, meaning additional medication. Well, that eliminates another huge portion of the United States population, because most of the people who are being seen in mental health settings are actually receiving more than one, and in some cases, you know, as many as 10 or even 20 medications for various conditions.

So it makes it very difficult to extrapolate to the real-world setting the information that they get or they find in a clinical trial.

Another problem is the length of a clinical trial. A clinical trial usually is cut off at six weeks. That's it. And the drug companies understand and actually choose the six-week cut off for a very good reason. They know that generally speaking, they can't continue to produce favorable results after six weeks.

And then another big problem with these methodologies is the fact that they really are enrolling people who have previously been receiving medications.

So what does that mean and why does that alter or bias the results? Well, one of the problems

in the antipsychotic medication literature, as in the antidepressant literature, is the fact that patients are brought into the study and they have previously been taking a medication, in some cases right up to the day that they enter the study.

And then the first seven to ten days in most of these trials involve taking the patients off of those previous or pre-existing medications. So seven to ten days, the person is abruptly cut off from their previous drug.

Now the real stage of the trial begins. So that first seven- to ten-day window is something that is called a washout. And sometimes what they'll do is they'll give everybody a sugar pill in those first seven to ten days and call it a placebo washout.

Now, the use of the term washout has two meanings. Washout meaning whatever other drugs the person may have been taking before, those are supposed to wash out of the system. And the second part -- and the second meaning of washout is that if someone begins to improve too much in those seven to ten days, they are removed from the study.

Q So may I interrupt you?

A Sure.

Q Are you saying that when people are withdrawn

from the drugs they were taking previously and they improve when they get taken off the drugs, then they are eliminated from the study?

A That's right. They take them out of the study. Because they only want to have people remaining in the study who are going to continue to look -- you know, either continue to look bad on the placebo if they continue to stay -- if they are randomized to the placebo part of the trial.

Or if they are then switched back on to an active medication, something chemically active instead of a sugar pill, their withdrawal symptoms, having been cut off of a previous drug, will hopefully respond to having another drug that was similar to the previous drug, you know, put back into their system.

So you understand completely, they remove people -- and this is important in terms of this case. Because for instance, in the Zyprexa trials, a full 20 percent of the people improved so much in the first seven to ten days when they were taken off their previous drugs that they kicked all those people out of the trial.

If they had retained them in the trial, they could not have gotten results that made Zyprexa look like it was any better than a sugar pill. It would

have biased the results in favor of the sugar pill.

Q So now, did you -- did you analyze the studies that the FDA used in --

THE COURT: And I am going to cut off here and say what would be helpful to me, Mr. Gottstein, is as I understand it, API is proposing Risperdal here, correct?

MR. GOTTSTEIN: Yes.

THE COURT: And so if we focused exclusively on that, I think given our time constraint and the proposal, I think that would be the most helpful for me.

MR. GOTTSTEIN: Well, Your Honor, one of the problems is that we didn't know until Monday that -- you know, that it was Risperdal.

THE COURT: But now that we do, if we could focus on that, I think that would help.

BY MR. GOTTSTEIN

Q Well, are all these -- are all these things that you mentioned also applicable to the Risperdal studies?

A As far as I know. And I have no reason to believe from what I've read in the literature -- I haven't had time to read the FDA review on Risperidone as I have done with olanzapine. But based on the

trials that I have seen in the regular journals, I have no reason to believe that anything other than this procedure has been used repeatedly.

In other words, the placebo washout and actually switching people or removing people who improve too much, it's sort of a standard protocol that you have a certain score in terms of symptoms. And if people don't meet that cutoff, in other words, they begin to improve too quickly, they don't get to stay in the study.

So I have no reason to believe that Risperidone was any different than Zyprexa in terms of this method of eliminating people who -- and you know, favoring or biasing the result of the study.

Q In the interest of moving forward, is it fair to say there are other methodological problems with these studies?

A Oh, absolutely. What many of these studies will do is to allow certain concomitant treatments. In other words, certain additional medicines during the study so that you can't really be sure that the results they are claiming are the result of the actual interventional drug. For instance, Risperdal instead of a benzodiazepine or an antihistamine.

Another thing is the way that the data

themselves get reported. And one of the things that is frequently done is to use something called LOCF, or last observation carried forward. So what that means is if you were to enter a study for instance, and they started you on Risperdal, and you start to have a severe side effect, let's say Parkinsonian symptoms, and you dropped out of the study at two weeks, but the study is supposed to end at six weeks, they will carry forward your score to the six-week mark.

Now, this will sometimes -- people will actually drop out when they have a higher score and they'll carry that forward, as well. But the use of LOCF statistics, especially when they carry forward people who are dropping out on placebo, those are people who are dropping out because they are in withdrawal. They have been cut off from a previous drug.

And so they carry forward an end result, which is not a reflection of the underlying illness, let's say, but a reflection of this introductory bias, the placebo washout.

So the fact they report all of these LOCF data, meaning the fact that they are just carrying forward the results or the statistics from people who drop out of the study early, biases the results in

favor of the drug, when in fact it's not an accurate reflection of what's really going on in the study.

And that happens quite often, and that certainly happened in the Risperdal/Risperidone literature.

Q So just to kind of finish up this part, would it just generally be fair to say that it would be pretty difficult for a practicing psychiatrist in clinical practice to have this information that you are providing to the court?

A Oh, it would be almost impossible. It's -- it would be something you would really have to devote your study to.

And actually, you know, not only would it be difficult for the ordinary doctor to know this is going on, but he or she would read what is published in the regular journals and see that the results are promising, like 70 to 80 percent response rates, meaning a good response with patient satisfaction, et cetera.

And then he or she would be in the real-world setting, and maybe be lucky see 30 or 40 percent of the patients able to even tolerate the drug. So it not only is something that would be hard for doctors to know, but what they're actually being exposed to is

so far removed from reality that they are very unlikely to understand what is going on in the real world.

Q Okay. So what is going on in the real world? What is the impact of drug -- well, specifically Risperdal on patients?

A Well, the real effects in the real world are -- are really in two categories. And as a doctor, you know, I am sort of thinking in terms of safety first. I sort of think of, boy, what do I really have to look out for here if somebody comes into my office and they are receiving this medication or I am asked to begin it?

So one of the things that, you know, we are really talking about is safety. Are people dying on these drugs? Do people die from taking Risperidone? Yes. People are actually experiencing shorter life spans.

Initially it was felt that the life spans for people on medications like Risperidone were perhaps shortened maybe ten or 15 years. And I think that's even been elevated in the most recent government studies to more like 20- or 25-year shorter life spans. So instead of a male -- and we're usually talking about, you know, males with mental illness,

would probably be living, you know, if they were lucky, 72, 74 years of age for men in the United States these days. And we are really talking about something which drops the lifespan down into the 60s.

So at the worst what is going on is that we are actually contributing to morbidity, actually shortening people's life spans. And that's -- and that is either through an acute event like a stroke or a heart attack or something called a pulmonary embolism, or we are talking about more chronic illnesses that eventually take their tolls, things like diabetes and heart failure.

So at the very worst, what is going on in the United States is an epidemic of early suffering or mortality that was not present before these medications were being used, you know, by such a prevalence -- in such high numbers.

The second thing that is going on is that we are arguably worsening the long-term prognosis of people, and in directions that were not previously seen or talked about. And I think my affidavit speaks to this. And also Mr. Whitaker's affidavit speaks to the history and the actual historical outcomes when individuals were being offered something other than just the medication or the priority on medication.

And so that is the other big thing in terms of what's going on.

What's going on is that people are suffering in great numbers, and that people are dying early, and that people are having what might have previously been a transient, that is a limited episode, converted into a chronic and more disabling form of experience.

Q Is -- are these drugs brain damaging?

A Well, I try and not sound like I am, you know, really off -- off my rocker. Because people probably wouldn't like it if I actually used a term for what's happening.

But I sort of say we have unfortunately contributed to a population of CBI patients, meaning chemically brain injured.

I was in the military, so I am very used to TBI patients, traumatic brain injury from, you know, concussions and explosions and what's going on in Iraq and Afghanistan.

But what is the elephant in the room that people aren't addressing in psychiatry and neurology is this population of CBI, chemically brain injured.

So yes, I actually would say that what we have created, and I think Mr. Bigley is an example of this, is that we are creating dementia on a very large