IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

WENDY B. DOLIN, Individually and as Independent Executor of the Estate of STEWART DOLIN, Deceased, Plaintiff,	)	
-vs-	)	Case No. 12 CV 6403
SMITHKLINE BEECHAM CORPORATION, d/b/a GLAXOSMITHKLINE, a Pennsylvania corporation, Defendant.	)	Chicago, Illinois March 14, 2017 1:10 p.m.

VOLUME 1-B
TRANSCRIPT OF PROCEEDINGS - Trial
BEFORE THE HONORABLE WILLIAM T. HART, and a Jury

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(Proceedings heard in open court, jury not present:)

[redacted]

(Jury enters courtroom.)

THE COURT: You may sit wherever you want now. You're not bound by any particular seat, whatever makes you the most comfortable.

All right. Ladies and gentlemen, you have now been selected as the jury, and the clerk will swear the jury.

THE CLERK: Would you please rise and raise your right hand.

(Jury sworn.)

THE COURT: Thank you. Be seated, ladies and gentlemen.

All right. At this time, counsel for the plaintiff may make an opening statement.

MR. RAPOPORT: Thank you very much, your Honor. If it pleases the Court, I'll do exactly that, and counsel for the defense.

Ladies and gentlemen, welcome to your jury service. Let me be the first person to do that. And I'm going to be using, for my comments this afternoon, some help from some technology. So, you have televisions before you, and there's

a great big one behind me, although it's a little bit hard to see.

The evidence will show a lot of things in this case, and what I'm about to talk about is what the evidence is going to show in the case. And it's my habit to try to start very carefully with something that no one should agree with. The evidence --

MR. BAYMAN: Your Honor, excuse me. I don't mean to interrupt, but I think this is argument.

MR. RAPOPORT: I'm about to describe the central point of what the evidence in this case is going to show.

THE COURT: Proceed.

MR. RAPOPORT: The evidence in this case is going to show that prescription drug companies are required to tell doctors what they know about the side effects of the drugs they bring to market. When a prescription drug company does not tell doctors what they know and someone is harmed as a result, the drug company has to pay for the harm that they cause.

Every witness that is knowledgeable about what the duties of a pharmaceutical company is -- are in this case will agree that prescription drug companies are required to tell doctors what they know about the dangers of those drugs. That's the whole purpose for having clinical trials.

Now, let me tell you the story of what GSK, sometimes

called SmithKline Beecham, what this pharmaceutical company did in this case.

Now, first of all, we're talking about a drug, Paxil. Paxil was first marketed in 1992, but for several years before it was first marketed, there were clinical trials involving Paxil. And you'll hear much more about what a clinical trial is in this case, but for simple -- to start in a simple way, it is using the chemical that's been developed and comparing it with either something or a sugar pill, nothing, to see what effect it's having on people.

And the document that I have in front of you here shows that by 1989, from the clinical trials, the defendant in this case knew about six suicides that happened. And here are details. What I'm showing you here is an exhibit that the Court has already admitted into evidence and which shows some details about these suicides.

Now, I'm going to zoom this in so we can see it a little bit better. And I'm going to use my highlighter to show some of these. There's five of them right there called up, and the other one is down a little bit further, right here (indicating). You can see it there.

Now, I'm going to go back and forth between this image and this one, which summarizes these -- five of these deaths; and the reason I chose five of them is one of those deaths happened a few days after the person stopped taking the

Paxil. I'm getting rid of that one for now. We'll talk more about that one later.

Here are the five deaths that this defendant knew all about. These documents come from their records. This is what we have here.

There is a 58-year-old female who was on Paxil for eight days who violently committed suicide by hanging herself.

There was a 42-year-old female on Paxil for 10 days who committed suicide by overdose of a different drug.

There was a 56-year-old female on Paxil for seven weeks who committed violent suicide by drowning.

There is a 50-year-old male in the third month on Paxil who committed violent suicide by hanging.

There is a 58-year-old female in the fifth month on Paxil who committed violent suicide by hanging.

Now, we're going to get into much more detail about what else this defendant knew, but this defendant knew all of that.

And certain things jump off the page. You'll hear testimony in this case about suicide. Most people that consciously choose to commit suicide do it in a way that they perceive as painless. There is an 80 percent factor of violence here.

Also, you'll here evidence that more men, by about four times, commit suicide than women. Here, we have a lot of

women. Okay. The question arose in the clinical trials, what is the connection between this drug and these suicides?

Let's go on. Oh, I want to -- before going on, I want to come back to the first screen for a minute and talk to you for a second about the one that happened after. You'll see that -- let me see if I can just point it out to you here. I don't draw such good circles, but you see there's an 18-year-old female who was on Paxil during the clinical trial, but then who was six days off the Paxil when she committed suicide. So, there actually were six suicides, but the sixth one happened after she was off the Paxil.

And as you'll learn in clinical trials, you want to compare apples to apples, and that's what we're going to be doing in this case. And so I want to illustrate for you what it means, exactly, to compare apples to apples.

So, first of all, more facts. GSK knew by 1989 that in addition to the five suicides while people were on Paxil that happened in the clinical trial, they had 40 human beings who attempted to kill themselves while they were being treated with Paxil in those clinical trials.

Now, a clinical trial has a go point. It's almost like a horse race where you're picking people, so it doesn't just start where it's you, you, you, and you, and you start either taking a drug or getting a sugar pill in the blind. That's not how it starts. They start by designing who they

want to study.

Then they have to collect people and make sure they qualify. They have to make sure they're not on any other drugs. And you come to a go point where -- it's called randomization or baseline, where everybody is being compared apples to apples.

Now, that's a very important concept. So, what happened in these clinical trials? They didn't want the people that were so depressed that they were ready to kill themselves or on the verge of killing themselves. They were studying people with depression and eliminating the ones that were really close to killing themselves before they reach baseline. That's what it's about.

So, what this is saying is these folks, after they reached the baseline, they split them into groups; and one of those groups got Paxil, and one of those groups got a sugar pill. And neither knew which they were getting. That's how that works.

So, more details on that later. Here's the statistic that I want to get at, which is they knew about 40 suicides on the Paxil, so the question comes up: How many happened for the people that were on the placebo after the baseline randomization occurred? And the answer there is one, which is a little bit different than the answer for this group of suicides. In the completed suicides, how many did they have

on the placebo? None.

So, between the suicides and the suicide attempts, they had a total of 45, five suicides and 40 attempts, on the drug, and one attempt on the sugar pill. That's what they had.

So, this was a signal that this defendant knew about of danger; and statistically speaking, comparing apples to apples, which are the same people that were selected for the study, they got to the start of the horse race, and then some were given the sugar pill and some were given the Paxil, and then they compared the group. A 760 percent increased risk of suicidal behavior.

Now, there's another term that I'm introducing for the first time. What is suicidal behavior? So, this means that you try to kill yourself. It's either trying to kill yourself or actually killing yourself. What is that compared to? A suicidal thought. A suicidal thought is a different thing. They can be connected, but they're not always. And you'll hear evidence about how a lot more people have a suicidal thought than ever act upon that suicidal thought; and then, you know, some people act upon it, and it's people that act upon it that are -- are doing suicidal behavior. That's the most important thing.

So, 760 percent increased risk, meaning 7.6 times the chance or the likelihood of suicide studied in the clinical

trials, known not from day one of the clinical trials, but clearly known by the time the clinical trials were being organized for reporting.

So, we had another signal, which is the combined signal, I almost always refer to it. This is taking the 45 patients, and here, we have more data. So, you might wonder, well, how many got the Paxil and how many got the sugar pill after they reached the baseline and were randomized? How many? And the numbers are right there.

And you don't have to remember these numbers. You'll see them plenty of times during the trial. But in these clinical trials, and this is around the time that they're going to apply for approval to sell this drug, around this time, it's 2,963 patients in the Paxil group and 554 patients in the placebo group.

So, here, you can see that 45, or 1-1/2 percent, of the people in the Paxil group either tried to kill themselves or actually did. Now, when you look at statistics -- and you'll hear evidence of various statistics in this case. One of them that you'll probably hear is what is the -- how common is suicide overall? And it's something like 8 out of every 100,000 people, which is way smaller than 1-1/2 percent.

And some of you are better with math than others, but the bottom line here is that the signal is calculated easily. Why do we say it's an 850 percent increased risk? And it's

not us saying this. There are scientists who will testify about this. And everything I'm talking to you about today is going to be from witnesses. I'll tell you about some of them in more detail, about their qualifications and who they are.

But bottom line is when you combine the information about the suicides and the attempts and then you look at how many happened on placebo and you calculate the difference, it's 8-1/2 times more likely, or 850 percent, increased risk on Paxil.

Now, there is -- there are standards in this industry. It's a regulated industry. The Food and Drug Administration does the regulating; but, of course, the evidence is going to show, the Food and Drug Administration is not a pharmaceutical company. It's not the one that has the obligation to do the clinical trials, to honestly report the clinical trials, or to write the warnings. They are kind of an oversight group.

So, the regulations governing that talk about: What is -- what's a pharmaceutical company supposed to do? And the law requires, as I put before you, and the evidence will show, because his Honor is the person who will give you all of the law, but the experts in this case will be testifying about the do's and don'ts of being a pharmaceutical company, so it's important even in the evidence to know something about the regulations.

So, what's required here is the labeling has to include -- it says, "Shall describe serious adverse reactions." Every witness in this case will agree that suicide is a serious adverse reaction. That you have to report not only known safety hazards, but also potential safety hazards; that the labeling has to be revised as soon as a warning that there is reasonable evidence of an association is known, and you don't have to wait until causation is proved.

So, you'll hear testimony in this case from regulatory experts that will explain to you that if there's a doubling of risk, that is not only an association, but it's causation. So, the kinds of risks that we're talking about right from the start were multiples of what required a warning under the law.

Here is another kind of board that takes the same data we talked about and adds on the layer that I just discussed. So, I think you already get the idea about 45-to-1, so it's really this other side here that I'm calling attention to now, which is: Was there a reasonable association with suicidal behavior and Paxil from the start? The overwhelming testimony in this case, if not all of it, will be yes, there was.

Was GSK obligated to warn right from the start that Paxil in clinical trials had these results? Yes, they were.

Those warnings were required. And you will hear the testimony of regulatory and other experts who know a great deal more than I do about this topic from that witness stand about this idea.

Who are some of these people? Well, this is what some of them look like, and here's a little bit more detail about the who's who and what's what of people you'll be hearing from.

This guy here who I'm showing you is David Healy, a world-leading expert on the SSRI class of antidepressants. So, let's pause there again, and we're going to talk plain English in this case. We're going to try hard not to play alphabet soup and not to be confusing.

So, what's an SSRI? It's this class of drugs. Paxil is one of the SSRI drugs. There was no such thing as an SSRI drug before the late 1980s. Then what happened was this form of antidepressant was invented and brought to market. There are several different antidepressants in this category. Some people may refer to it as antidepressants 2.0. It was more advanced technology. So, it came on to stream call it 1990 for round numbers, and you'll have a general understanding of it.

So, Dr. Healy is a medical doctor and a psychiatrist. He is a professor of psychiatry from Wales. He is a past secretary of the British Association of Psychopharmacology,

because some psychiatrists in addition to practicing, or sometimes instead of, use their specialized knowledge on things like drugs.

Dr. Healy has written over 200 peer-reviewed articles and over 20 books, including the books I've listed on the board here; and I won't take up our time together reading all that because I know that you can read just as well as I can.

Dr. David Ross is a medical doctor with a Ph.D. and a Master's Degree who is a former Food and Drug Administration new drug evaluator with 10 years of experience who knows all about the do's and don'ts of how companies like this defendant should behave.

Dr. Roger Grimson is a Ph.D. mathematician biostatistician and epidemiologist who we hope will be able to testify in this case, but -- and who has provided a report that our other experts will certainly rely on; but unfortunately, Dr. Grimson had a stroke recently, and he does live out of town, so it is questionable whether we will see him. But you will certainly hear about him and hear about his work.

There's Dr. Joseph Glenmullen, who is a psychiatrist in practice -- educated and practice Harvard Medical School, Cambridge Hospital 30-plus years as a psychiatrist, authored numerous peer-reviewed articles.

These are examples of some of the people that you'll

be hearing from.

So, what else is there? Signals. When we talk about signals, they don't get much louder than 7 or 8 times greater risk from the very first clinical trials; and fundamentally, all we're talking about here is: Do the doctors have a right to know? This is not the kind of thing that we're talking about how they advertise these kind of drugs. This is the kind of thing we're talking about: Does the doctor have the right to know? So, how else -- what else do we know about statistics over the years? Because those clinical trials were a long time ago.

This drug did go into the marketplace, and there's data not only from those clinical trials but from other ongoing clinical trials; and there's other information in published medical literature because there are -- you know, let's just say there are reasons why there's published medical literature about suicides from this drug and others in its class.

So, what do I have on here? I have images of some of the exhibits in the case that are too small to read because this is not the time to pull out medical journal articles and read them in detail. But I have in red what comes out from these particular sources of corroborating data that are from 2006 and I think are probably the most recent data.

So, the most important one of all is GSK's study.

So, GSK did a study that they concluded in 2006, and they concluded that there was a 6.7 times increased risk from Paxil even though they knew at the time that Paxil did not say on it, "Hey, by the way, there's an increased risk of suicide." Their statistic was for people who had Major Depression Disorder, which they sometimes call MDD, and you may hear that a little bit.

The federal government commissioned its own study down here, this 2.76 number that I'm showing you; and that one took some of the same data, but they looked at what they call all indications. So, the question could come up, "Well, what if somebody only had anxiety, that is, they didn't have depression? How does the risk look for them?" So, taking all comers, the federal government came up with an analysis, and this is on suicidal behavior that we're talking about, 2.76 more likely from Paxil, among the worst performances, if not the worst performance, in the entire class of drugs that we're looking at.

So -- and then this other one is an article that was published from an interesting study that you will hear testified about that happened up in Ontario in the 2000s, where a 5 times increased risk was found, but I'm not going to dig into further detail about that study or any of the rest of this work.

So, what should have happened in this case is

straightforward and is right here. What should have happened is -- let's just get it nice and big so it can be read. What should have happened is the suicide risks that were discovered in the clinical trials should have been revealed to the federal government and the doctors.

And if that had happened, then what would have occurred is Paxil -- a Paxil-induced suicide risk would have been revealed to the FDA and the doctors; and the result of that would be that Mr. Dolin would never have been given any Paxil, and he never would have died, which will be another topic that I will talk about in some detail here.

But first, we need to look at a comparison between what should have happened and what actually did. So, we have, I think, an understanding -- we have an understanding of what should have happened. Now let's see what did in fairly simple terms.

Suicide risks that were discovered in the clinical trials were not revealed to the FDA or the doctors. The data was misrepresented instead. Those are big words, and those are strong words, so I hope it won't surprise you to know that I'm going to show you what backs that up next.

What happened? Paxil-induced suicide risk was not revealed to doctors and has not been revealed to doctors fully to this day. Now, there is a 44-page exhibit that somebody's going to hold up in a minute that we call Joint Exhibit No. 1,

which is the 2010 version of the label. And if they don't have it, they don't have to, because it's going to look something like about the size of a pad of paper. Here we go.

So, this is a long, you know, detailed thing. And it's not meant to be on the bottle. This one's dated June of 2010 from GSK. And it's not meant to be in the bottle, but this is the information to the doctor. It comes out periodically. For many, many years, these were published in a book called the *Physicians Desk Reference*. Now that we're in the electronic age, we see it more in electronic format.

But this is the warning label. And what does this warning label, in all of its 44 pages, say about the risk of Paxil-induced suicide for people who are 57 years old or for people of any age above 24? It says nothing about that, zero. Okay?

Now, for many years, if we look at my timeline, from 1991, when these misrepresentations were made about suicide, until the mid 2000s, there wasn't a warning about the risk to adults 24 and under or children. They didn't have that, either. Okay?

In the 2000s, there was a big stink about that, and there is now suicide risk warning for up to 24. But these people have known that that risk has been there for people of all ages, and it has not been put in the label.

So -- oops. Let us progress.

In 1989, as I mentioned earlier, that's when GSK filed -- let me take a moment and define all of these names going on. So, there were some mergers involved, and I think everybody in the case is going to call the company GSK. SmithKline Beecham is part of it. They are the people who did this in '89 and who did everything we're talking about. So, they're GSK, but you'll sometimes see in letters and other things, SmithKline Beecham. You'll know that it's all the same because those are mergers.

So, this is a moment in time, and it's when GSK has applied to get Paxil approved for marketing as a prescription drug in the United States. The ruling about whether to let it happen or not had not occurred at this point, but something fairly dramatic did, which was Dr. Teischer, and Dr. Cole, and their co-author as well, Dr. Glod, were noticing with regard to another drug, the first SSRI, Prozak, they were noticing that it seemed like people were showing up in the medical offices shortly after they start this drug with violent -- talking about doing violent death to themselves. And this was alarming.

And these were very high-profile, very well-respected doctors who raised the question that the drug may be causing this and what's going on. I don't think that they were involved in clinical trials of Paxil, but the environment while the new drug application was pending was one of, "Hey,

wait a second. Are these drugs causing suicide? Is that what is happening here?"

And the article didn't really answer the question. It reported that this was being seen in medical offices and that it should be dug into in greater detail.

So, that little bit of background is very important to what happens next. So -- and this is one of the more -- well, I don't want to characterize it.

What happens? The FDA says, "You people, we want to hear from you about this issue. We want to hear more about your clinical trials. We want to hear more detail. We want you to take a really good look at what's what."

And that effort concluded in late April of 1991, and what I have here -- and I'm going to blow it up without all the red arrows. What you have here is a letter dated May 10th -- here you can see the May 10th right over here -- a letter dated May 10th, 1991, and it is addressed to the director of these kind of drugs over at the Food and Drug Administration. And it is by the director of regulatory affairs, Thomas Donnelly, Jr., Ph.D., from our defendant.

And what does this say, the part that I'm calling out here? Let me really call it out. Quote, for our record, this is GSK saying to the federal government in May of '91, quote, "To summarize in brief, this analysis of data from prospective clinical trials in depressed patients clearly demonstrates

that patients randomized to paroxetine therapy were at no greater risk for suicidal ideation or behavior than patients who were randomized to placebo or other active medication."

That is what this defendant told the federal government; and that, ladies and gentlemen, I'm sorry for my strong language, is a bald-faced lie.

MR. BAYMAN: Your Honor, there's no claim of fraud in this case. This is really getting argumentative now.

THE COURT: Proceed.

MR. RAPOPORT: All right. Now let's go further.

The director's letter attached two little charts to it that claimed that there were two placebo suicides and that there were six placebo attempts in the clinical trial, even though the evidence is going to show clearly in this case that there were no placebo suicides after randomization and that there was only one placebo attempt after randomization. And I do not think that you will hear a single witness called by the defendant to deny that fact. Okay?

But what do these charts show? They show that there were more placebo suicides than there were, because two is bigger than zero. And they show that there -- let me show you where that is. Here's where they say placebo. They say there were 554 people in the placebo group after randomization, and two of them committed suicide. Except you know what? They didn't.

And then we have this other piece for attempted suicides, that's what the next part is. The top one was actual suicides. And here you have their statement that on the placebo, consisting of 504 people after the baseline, after the randomization, six of them attempted to commit suicide; but the truth is it was only one.

So, what's going on here? Well, the impact of this change was -- there's a mouthful said here on this board, but I'm going to go through this slowly. The impact of the change was to lower the suicide attempt risk signal from 760 percent more likely suicide on Paxil than placebo, to, hey, you know what, placebo, you're more likely to have suicide on placebo than Paxil.

And you might wonder, but it's five versus two and how did you get that math? And the answer is because you had around 3,000 people who took the Paxil, and you have around 550 people, whatever the exact number there is, 554 that took the placebo. So, actually, two is a bigger number, if you can follow that math.

And it doesn't even matter if you do follow the math. The point is they flipped this. It's like a flip-flop. Okay? They've got screaming signals of danger that the drug causes suicide, and they flip it over to say, no, the sugar pill causes more suicide. Come on. That's what they did.

And they did the same thing. This is the

significance. They flip-flopped this the same way with the attempts, and the numbers are a little bit different. Let me find it. Oh, no, it's the combined. I've got to get this straight. The idea is the same. They flipped it upside-down so the combined suicides and attempts were an 850 percent signal that they flipped the other way and said, no, actually two-and-a-half times more people die on the sugar pill. It is false. It is false.

All right. So, let's go on. In the same letter, which is an exhibit in evidence in this case, I believe, or will be, on May 10th of '91, GSK's director of regulatory affairs offered this explanation for the two claimed suicides, for -- actual suicides. And they offered no explanation at all for the six claimed placebos. But here's what they said.

And at first reading, this is really complicated language, so we're going to have to break down some terms, which I'm going to do immediately after we read this once. I'm going to break down some terms, and then we're going to come back and read it again.

So, what they say -- what GSK says to the government, "Of the two suicides committed by patients randomized" -- and you'll note that they put quotes on randomized -- "to placebo, the method by which they took their lives was unknown." And let's pause there for a minute. You've got people who killed themselves, and unknown? But they say this. We've got two

dead people, and they were randomized to placebo. That's the statement.

Then it goes on to say, "Although these patients were actually participating in an active control study, the acts of suicide were committed during participation in the placebo run-in phase, and the specific points in time at which these individuals took their lives were two days," with a negative two in parentheses, "and 7 days," with a negative 7 in parentheses, "prior to the baseline evaluation."

Now, the -- keep that in mind for a second while we go and pick up some definitions and things so that we can better understand what is being said there, and then we're going to come back and take a closer look to how this adds up to what happened in this case.

So, what is randomization? We talked about that a little bit before and what is a run-in. So, the first thing I want to do is discuss this visual aid that I'm putting up to help with this a little bit.

So, we design a clinical trial. Those who run these and will testify in this case, you design it. You pick who you want to study. You recruit doctors to help you, and you try to recruit patients to study. And then your goal is to get to the point of randomization. You can see it here, because in randomization, that's when you can actually begin the comparison.

Up until then, you have this phase called run-in, and the run-in is all about making sure that nobody reaches randomization that doesn't belong there so it doesn't screw up the apples-to-apples comparison. So, in getting this, this piece of evidence explains run-in periods. And let me see if I can get that so it's readable.

There we go. So, here it's explaining to us that before patients enter a clinical trial, there's a run-in or lead-in period of placebo. And I should add that you may sometimes hear it referred to as a wash-out, although that's not as precise because washing out other drugs is only one of the things that happens in a run-in.

But in any event, there's no active treatment. There is some dietary control. There's no active maintenance therapy. You can kind of see that they're removing a lot of things. And I'm not going to read all of that, but I want to get to this list where it kind of lays out here some of the things.

It acts as a wash-out period to remove effects of previous therapy, meaning drugs.

No. 2, it can be used to obtain baseline data and to evaluate if the patient fulfills study entry criteria.

Case in point, this study is meant to exclude people that are really close to suicide because that would mess up the whole study. So, one of the central purposes of the

run-in period is to make sure that nobody gets past the randomization goal line that's real close to suicide.

Then you have it can be used as a training period for patients and investigators and their staff if the clinical trial is just getting going.

It helps identify placebo responders. What's a placebo responder? So, some people, you may give them a sugar pill, and they may tell you, "Man, I feel a lot better. Everything is good now." And you want those people out of the study because you want people to have enough anxiety or enough depression that, you know, it's not so likely that just telling them they're taking a pill, even though there's nothing in it, is going to make them all better. That's what a placebo responder is. You want to get rid of them, too.

And useful information about patient compliance, so, I mean, the point is during the run-in, people are excluded; and when we get to randomization, that's when the study starts. So, that's what is randomization. That's what is a run-in.

And what is baseline, it's really closely tied to the randomization idea; and as you can see here, we need to get to baseline for these various reasons and the reasons that were on the other presentation, too.

So, now, let's look at this again and get down to what did the top guy dealing with regulators at the

defendant's company say here in this? Did he reveal this? Didn't he reveal it? And after this, we'll see to what extent there's evidence that the FDA heard it if they didn't uncode this.

So, first of all, you have this business of the two suicides committed by patients randomized to placebo. So, that part of the statement is incorrect because there were no patients that committed suicide that were randomized to placebo. And the author of that letter to the FDA had to know it.

Then it said, "We don't know the method that they killed themselves." That raises a question fundamentally about whether there even were two people that killed themselves on placebo. But we have no evidence -- we can't prove that they didn't have two people that killed themselves on placebo. We've just seen precious few details about it, and a pretty big motive, the evidence will show, for perhaps making it up altogether; but we're not making that accusation.

MR. BAYMAN: Objection.

MR. RAPOPORT: I'm not making that accusation.

MR. BAYMAN: That's argumentative. He just said motive, and then he said he had no evidence.

THE COURT: Stick to the evidence.

MR. RAPOPORT: So, the evidence is in front of us here, and what else did this top person at GSK in the

regulation field tell the government?

He said, "Although these patients were actually participating in an active control, the acts of suicide were committed during the placebo run-in." And then he says, "It happened so much before we reached baseline." So, what we should do is credit the last part of this for revealing a fact that the federal government certainly -- that it was their duty to reveal if they were going to play around with data like this.

So, now let's go further. The -- I wanted to add, they had more data by '91, or at least they analyzed the data; and what you see on this board are charts, and you'll hear, I think, Dr. Glenmullen testify about this. This is a way of unraveling the statistics. We kind of talked about this already. This is showing the difference between including and not including the run-ins that they were claiming. So, that's just showing -- both of these boards are showing the math for a point that we really already covered.

But here is the thing. The FDA approved Paxil for marketing in the United States on January 1st of 1992. There is no evidence that GSK submitted a warning telling people what had been learned in the clinical trials about suicide behavior risk, and here's what the FDA final report said.

They wrote down here, "Two patients randomized to placebo committed suicide," which is an incorrect statement.

They do not in that particular report say anything about these being in the run-ins. And the tables -- we'll see this momentarily, but the tables that were presented and I showed you briefly before showed that these were after randomization. Okay? And the FDA clearly thought that these suicides were after randomization because they said it in their report. They got it from GSK.

Next it says -- the FDA put -- and this is all from Plaintiff's Exhibit 28 in evidence as pages 29 and 31. "Six placebo-treated patients attempted suicide," which is, as I say, a misleading statement, because the fact is that the six patients referred to did those attempts during a run-in phase, so they were never in the post-randomization clinical trial. The FDA does not comment about that, and nothing in GSK's submission even told the FDA about that.

The number -- and that's very significant, by the way, because even without the two suicides that were slid in there, the attempts alone give a huge signal. So, they have run-in attempts and didn't reveal that to the FDA at all. They had two suicides, where in some fine print, they referenced that these were in run-in; but in other places they're saying -- in the same place, they're saying it's post randomization.

The number and incidence of the rates of suicidal acts and attempts are summarized in Table 55. This is what

the FDA says, and these tables do not mention a single thing about the run-ins that completely alter the data because the evidence will show that the FDA didn't know about it.

Then it says here, this last bullet point, "These analyses show that patients randomized to paroxetine were at no greater risk for suicidal ideation or behavior than patients randomized to placebo or other active-control therapies," when it should have said that there was this seven- to eightfold increased risk discovered in the clinical trials.

That is a verbatim adoption of the statement by GSK's top regulatory guy to the FDA in 1991 as if that were real instead of a fiction.

All right. So, here is the table just discussed, Table 55. Look at this table, and you'll see this again during the trial. The table lays out the two run-ins, but does not reveal that they're run-in suicides. And the table lays out the attempts, but does not reveal that those were attempts.

And the bottom line on this table is there is a remarkable piece of evidence that you'll see, because if you'll remember, all of this we're talking about in '91, in '89 was when they made the new drug application. And at the start with the new drug application, they have the same table, but a little bit different. There, it has asterisks on it

that say, "Two of these suicides and six of these attempts happened during the run-in phase."

So, in the years between '89 and '91, that disappeared. While under scrutiny from the Teischer article about suicide, all of a sudden, GSK is presenting a table that completely miscategorized two people who probably killed themselves in the run-in phase, and all of those people who did attempts that were in the run-in phase.

So, it's a funny thing. You know? We wouldn't normally make a big thing out of an asterisk, but I will tell you that during the course of our days together, you'll hear about an asterisk and understand that it's not merely an asterisk that we're talking about. We're talking about completely flipping the results from an increased risk of suicide to, "No, it's not."

All right. I'm not sure if you will hear any witnesses in this trial tell you that it's okay to include run-in attempts or run-in suicides in an analysis like this; but you're going to hear from a lot of people, if not everybody that's knowledgeable -- and here's the list of people. The one next to GSK, Dr. J. P. Garnier, CEO at the time he testified, of GSK, will admit that. So will Christine Blumhardt, who was the person who was the leader in 1989 when the new drug application was done.

You will hear that. You will even hear that from a

doctor whose name is Dunbar who will call himself the chief -- he doesn't say cheerleader, but he's the person from GSK who's promoting Paxil to the world. And he puts out articles after articles about how there's no suicide risks, it's even good for suicide, and says nothing about the known increased risk, and instead complete -- keeps repeating these same tables that have false data in them.

And when questioned about this years later, you will hear the -- I believe you will hear the remarkable testimony from him that says, "I didn't know. No one told me. I didn't know."

All right. So, we're back to we have these signals. They needed to be reported to doctors because doctors can't do their job. They weren't reported to doctors. That, we have reasonably well covered already.

So, what does GSK have to say about all of this? You'll see -- you'll hear evidence of a few different things from them and from us. And we believe that we will show the various points that are listed here. There's only seven. I actually think by the time it's over, we're going to prove 13 different ways that they -- sometimes in what looks like a sloppy manner and sometimes in a very devious manner, how this signal has been covered up and not given to doctors for all of these years.

So, one of the ways I talked about at great length

already about including run-ins. One of the ways is an emotional ability label. So, instead of labeling suicide attempts as suicide attempts, many of them were put into coding in these clinical trials under a vague term that, you know, makes you wonder. And it was only after there was major scrutiny on some of the suicide risks that some of these suicides we now know about came to light.

I want to say a word or two about this third thing, including studies 057 and 106. So, when they came under pressure under the juvenile thing in the 2000s and were sort of fighting the fight to not have a warning for --

MR. BAYMAN: Objection, your Honor. Again, this is argumentative. "Fighting the fight to not have a warning"?

THE COURT: Yes. Just tell the jury what you think the evidence will show.

MR. RAPOPORT: So, here's what I'm getting at with studies 057 and 106. These -- what are they? There were two studies where the selection criteria went for depressed people that were at real high risk of suicide. In other words, most of the studies were set up to not go for those people, but then they did some studies to study that cohort, if you will.

And as you might expect, there was more suicide in those two cohorts. So, at some point, GSK moved down the path of trying to include those because the people getting the drug were very carefully monitored; but people were at a very high

risk, and so there were more suicides, apparently.

You'll hear about that issue. That issue was not in play until the 2000s, and our center of focus really is in the 1998, '99 area. But you'll hear about it, so I wanted to comment about it here. And you'll hear about these other techniques as well.

But I think so that we don't get too deep into the forest and we stay at the -- too deep into the trees and we stay at the forest level, I'm going to move forward a little bit here and keep this moving.

So, this chart is an interesting sort of chart. It shows, both with suicides and attempts, the cluster of these in the early form of treatment -- in the early times of treatment. So, there's a certain pattern that you can see for the attempts, and to some extent, for the suicides, where they tend to come on very quickly with the therapy.

And you'll hear the Juurlink study in Ontario, which had a million patient years under it and is probably the richest study that you'll hear about it in the case. You'll hear that it found that the greatest risk was in the first 30 days of the treatment and that the hallmark characteristic of the suicide was extreme violence, though not in every case, but those are kind of a hallmark pattern.

Here is an example -- I mentioned Dr. Dunbar before, so here's an excerpt from Plaintiff's Exhibit 34, which

highlights a published statement in December of '91 that says, "Suicides and suicide attempts occurred less frequently with paroxetine than either placebo or active control." That was not a correct statement.

Same thing in '92, this one by Christine Blumhardt, "There's no evidence that this increases suicidal ideation."

Over time, there was more data. As you can see here, the numbers went up to 4,126 people, so the analysis goes on, but it's still a 750 percent risk in '94 for -- and the combined risk 840 percent, the first one being attempts and the second one being combined attempts and completed. In 2002, there was even more data, and this is the lowest that their signal ever got, which is 2.38.

And these numbers, you know, different studies, different numbers of people get different amounts of risk. So, what the evidence will show that we're watching for is risk at 2 or so or above. They were consistently there on suicide and suicide attempts signal, suicide behavior throughout the combined signal in 2002. The best it ever got was 361 percent.

Here you can see for yourself, this is the 6.7, they call it an odds ratio, and what this is telling us is that results in 2006 by GSK for suicide attempts in adults with depression, MDD-type depression, treated with paroxetine compared to placebo, that the risk is 6.7. So, an odds ratio

is another way of showing the percentages I've been showing. 6.7 is the same as 670 percent risk or 6.7 times more likely.

So, this just goes back to '89, because there's a peculiarity, and I did want to touch upon this before moving further forward, which is in '89, strangely enough, when they first submitted data, they actually had 42 people on attempted suicides instead of 40. We never have found out, and maybe we'll find out during the trial, what happened to those other two. We're not saying that's the center of everything. It's not, but we're just pointing it out.

So, you will hear evidence from a very well-qualified psychiatrist in Dr. Glenmullen, that -- proof -- about proof that Paxil causes suicidal behavior, and it gets down to these three categories.

Since 1989, the Paxil clinical trial data has signaled a statistically significant and substantial increased risk of suicidal behavior in patients of all ages taking Paxil compared to placebo.

Second, that GSK researcher causality assessments have concluded Paxil has caused suicidal behavior on many occasions.

And third, published medical literature establishes a statistically significant and substantially increased risk of suicidal behavior in patients of all ages taking Paxil compared to placebo and other antidepressant medications.

So now, this is what I call my transition board, and gives Matt Sims a signal, because for the next part of my presentation, I'm going to use a slightly different manner of communicating visually.

But what we have here, I think you'll recognize, is the board that -- okay. Well, we switched. We just had the board that I showed at the outset showing the five suicides in the clinical trial and how they happened, the different ages of people, how they were hangings and drownings, except for one overdose. And then sadly, I added a picture of Stewart Dolin and wrote, "57-year-old man on Paxil for six days, violent suicide by subway train."

Now, that tells you one of the stories that this case involves, the story of what GSK did. A second story that will be involved here is a little bit about what has happened in the medical profession, especially with general practitioners, as it relates to antidepressants in the last 25 years.

So, you will hear testimony in this case from Dr. Sachman, who is a family practice doctor based in the northern suburbs, who has lived in this community for the better part of his life and has been practicing family practice medicine for many, many years. You will hear from him about his education and how he was educated as a doctor in the late '70s, and he practiced starting in the late '70s and through the '80s, '90s, thousands, '10s, and -- I guess we're

in the '10s, so practiced all that time.

And you'll hear about the change that has occurred, because GSK and other companies that manufacture the SSRIs have really taken these things and marketed them to general practice doctors because in the early years of Dr. Sachman's practice, when he had somebody that was -- had some anxiety, they weren't treating that with medications. If somebody was bad enough, there would be a referral into mental health professionals. And for the most part, antidepressant medications were not being handed out by family practice doctors the way that they are today.

That has something to do with this lawsuit, and you will hear evidence about the obligation of a pharmaceutical company to tell the general practice doctors that they're pitching this stuff to about the dangers and not to hide those dangers. That is not a controversial idea in this case. So, that's a second story.

Now, I'm going to bring to you the third story here, and I'm pretty sure that you know what that story is going to be. So, the timeline of Stewart Dolin's life is not easy to share. I guess we'll just -- the timeline of his life is not easy to share on a simple timeline. As the trial goes along, we will help you.

We, you know, heard loud and clear about how you don't have notes, and this case is -- it's well to digest the

way the Court has suggested; but we will help by not only making sure that people speak plain English, but by bringing you charts and other things so that you can follow these dates and times.

And if I was to do a proper job -- you'll pardon me -- if I was to do a proper job of timelining what I'm about to, I would need a timeline that would be bigger than this courtroom. So, today's technology, though, gives us the ability -- I think we've all walked in to museums that have that kind of giant timeline, and you can look at one thing at a time and then step back and see the timeline, and that's what we're going to do.

So, Stu Dolin was born in 1952 in Chicago. He went to Senn High School. He was a football player there. While on vacation, he met a cheerleader from Sullivan that he didn't know. And for those of you that know the Chicago area, you may know these schools. Otherwise, these are two high schools on the North Side of Chicago, not that far away from each other. Sorry.

So, anyway, Mr. Dolin graduated in 1970. He followed Wendy -- they were dating by then -- down to the University of Illinois. She was a year older. And so, they were married in '74. Stewart went to law school. Wendy graduated the University of Illinois, and a year later Stewart graduated the University of Illinois.

Stewart went to law school at Loyola. He got a summer associate job at a nice law school in Chicago, which is a good thing. It indicates that he did very well at Loyola, because those jobs are sort of precursors. Unlike a law clerk, someone who has a summer associate job is being told, you know, "If everything works out, we're going to hire you when you get out of law school," and that's what they did.

So, he graduated in 1977. He passed the bar exam on his first attempt and began practicing law in 1977 at that firm that he had clerked, stayed there for several years. During this time frame, his son -- their son Zachary was born. You'll meet Zack.

He was continuously employed as an attorney, and a productive one, from the day that he got his law license. Actually, before he got his law license, he was employed. He just couldn't be a lawyer until he got his ticket. But he practiced law full-time from that day forward until the day that he died. And there is no evidence in this case that he ever lost a single day from work for anything having to do with mental health.

So, this -- Bari, so they have two kids, Zack and Bari, there you see Bari born in 1983. And here you see that after several firms, including starting his own -- so the way this worked at the start is the first firm hired him. Then he was recruited out of there by Fox & Grove, which is a fancy --

well, I shouldn't say fancy, but it's a fancy firm in Chicago. Then he and three or four other people started their own firm for a period. That accounts for the first 12 years of his practice.

And in 1989, he began his career that he really had for the rest of his life at the fine law firm of Sachnoff & Weaver, a firm of substantial size here in Chicago. He worked at that firm continuously, and it merged into another law firm called Reed Smith, a worldwide major law firm. When it merged in, he merged in with it; and at the time of the merger, I believe that he was chair of the business department of the Sachnoff Weaver firm.

By all measures, you will hear evidence that this guy was a nice guy, smart, a great personality, a good lawyer, very well-liked by his clients and others that he came to deal with, in addition to being an outstanding father and husband and friend.

Now, you're going to meet this gentleman who I spoke about a little bit earlier, so let me tell you a little bit more. I already told you about Dr. Sachman's qualifications, but I didn't tell you about Dr. Sachman's personal relationship with the Dolins.

So, Dr. Sachman, a well-established family practice physician by 2004 of many years of experience, was also friends with the Dolins. And Mr. Dolin came under

Dr. Sachman's care as a family practice physician in 2004 and remained under his care from that point forward until the time of his death.

The evidence will show that many times, family practice physicians, in fact, treat family members and friends. The evidence will show that there is no ethical prohibition of that, and that's what occurred in this case.

So, we have now -- I'm going to focus in more on Mr. Dolin's health situation and mental health situation, so the evidence that I'm about to show and through the remainder of this session is mostly a distillation of the medical records that are in evidence and the pharmacy records that are in evidence because I want you to see all of the facts. And I'm doing my best within a reasonable amount of time to give you all of the facts that will be proved in this case.

So, the visit in '04 was just a well visit. Annual physicals are in here, and Mr. Dolin was feeling fine. Mr. Dolin had no significant known health problems.

So, in '05, though, Dr. Sachman prescribed Paxil for the first time, and he did this and Mr. Dolin was on it for about a year there of 10-milligram Paxil, and you'll hear Dr. Sachman's testimony about how Mr. Dolin --

MR. BAYMAN: Your Honor, excuse me. He was on 10 milligrams paroxetine, not on Paxil.

THE COURT: All right.

MR. RAPOPORT: He's on 10 milligrams of paroxetine, which is another name for Paxil. Sometimes it's the generic form; sometimes it's not. But as his Honor told you already, that has nothing to do with the issues that are involved in this case.

So -- and the reason for that is you will hear evidence and understand that it was GSK, this defendant, that developed this drug, that sets the warnings for this drug, and that writes the label for this drug that is used by everyone else. You will hear evidence that it is foreseeable to GSK that people who get Paxil might get Paxil or might get a generic, and whether it's a generic or not has nothing to do with this.

So, in any event, what I was trying to talk about was Dr. Sachman put Mr. Dolin on paroxetine and had him on it, in retrospect, for a year at that point in time. You will hear the testimony from Dr. Sachman about why he did that, which had to do with some anxiety that Mr. Dolin was experiencing.

Now, to understand this clearly, at this point in his life, Mr. Dolin had not had any mental health treatment that we know of. He had not had a mental health diagnosis. He was not diagnosed at that point with depression. He was -- he had not missed any time from work. He had not had any suicidal thoughts. He had not had any suicidal actions.

He was, you'll hear evidence, experiencing some

anxiety, and you'll hear all about that. But this is really the start of the story of antidepressants in this case.

You'll also hear evidence that at the time that this prescription was made, that Dr. Sachman had no idea that there was increased risk of suicide for some patients that take Paxil. You'll hear his testimony that if he knew that, he would never have prescribed any paroxetine or Paxil.

You'll also hear evidence by the way that in Dr. Sachman's records, he frequently refers to the drug as Paxil. So, speaking the word "Paxil" is totally consistent with the evidence in this case.

So, anyway, we go on from here. He was on. Dr. Sachman saw him and noted that he was feeling fine. Here are some pictures showing -- and you will see, because his Honor has allowed into evidence an 11-or-so-minute video montage that really kind of shows Mr. Dolin's life from childhood through late in his life. I'm not going to show that today. That will be shown during the evidentiary phase. But what we have here are some clips taken out of that just to give you a flavor of what we're talking about.

So, here, you can see him in his warmth, and that's his daughter, wife, and son in approximately 2006.

He stopped taking the paroxetine. Dr. Sachman felt he was generally fine. And our timetable here is the death occurs July 15th of '10. So, we are a few years before that.

Now, this was around -- 2007 was around the time of the merger between the substantial Chicago firm and the substantial international firm. Oh, I skipped a part which was important there, which was he was at times a chair and at times a co-chair of the U.S. Corporate and Securities Group, which is a group of lawyers at that law firm.

So, meanwhile, around this time, Mr. Dolan comes under the care of Sidney Reed, a social worker. He comes under her care in February of '07, and he sees her periodically, including the night before July 15th of 2010.

So, Ms. Reed is an experienced social worker. She is based in Evanston; but we have had a misfortune, so -- she has had a misfortune associated with her health. But she has -- it's going to prevent her from being at the trial; but she has given a video -- a videotaped deposition of her testimony, so you will hear from her. But because of her health problem, she can't be here. And that happens sometimes.

I should comment that some of the evidence you will hear, maybe a considerable amount, as it turns out, will be by videotape deposition because some people are beyond the subpoena reach of the Court, and some examples of that are some of the GSK employees that are former employees. So, you'll hear testimony, and his Honor will explain to you that testimony is testimony, whether it's in person or whether it was given out of court and played to you in video form.

So, in any event, you'll hear from Sidney Reed. So, this is a summary of care, so he came in there anxious about the merger and with fears of being able to do the job without some strong mentors; that in this time frame, you can kind of see the dates and sort of see, I won't read every one of these, but in February of '07, she's seeing him with some frequency, and he is expressing fears and concerns that I've put on the board here about feeling that his life is totally different in the new firm and some fears that this may have him stop functioning. This is all chronological. We're just moving forward in time. Sidney Reed was encouraging him to exercise and do deep breathing.

At no point throughout her care did she ever feel it necessary to make a referral to a psychiatrist. She was working with him, and you'll see that he has ups and downs with what he's struggling with.

Here, they were talking about his fears and traced the development of his stress and origin of his fears, and the evidence in this case will show that he had no -- you know, some of us have horrible, horrible things that occur to us in our childhoods. We may have some of this ourselves. We may have this with somebody we know. That's not Stewart Dolin. There's no evidence that he was ever abused as a child. There is no evidence that he had any illegal drug problem or use. There is no evidence of alcoholism. There is no evidence of

lack of performance in the workplace in a meaningful way. There is no hospitalizations for psych issues or anything like that.

So, these origins are all in Sidney Reed's testimony, and you'll hear about it; that he's had insecurities; that he's cut off from his brother, and you'll hear more about that; that he wants or needs to contain his anxieties.

And during this time frame, Dr. Sachman put him on Zoloft, and you can see that he put him on 50 milligrams. And milligrams are going to matter here in a minute, and I'll show you why.

So, meanwhile, Sidney Reed is reporting that his wife has always been a cheerleader, that he got good feedback from his boss. She's helping him try to keep things in perspective. That's what's going on here in the summer of '07. We're roughly about three years away from what happened. That he had feelings at times of not being a winning person on the team.

And there's much more in these records, but these are highlights that are an attempt to show what were the problems at different points in time.

He was caught up in a triangle with his wife's sister, but brightening up a little bit and seeing some new opportunities to bring in business in late July of '07.

Here is a reference to his mother passing away in

'06, to the fact that there was this merger, to the fact that he had an assignment in Pittsburgh that he felt shy and inexperienced about, but it seems to be going well.

You'll hear evidence that he was a very sophisticated lawyer, but he hadn't practiced international law before; and his firm had just merged into an international firm, and he had a big job, and he had concern. He had concerns about that, in spite of the fact that his performance was generally very good, if not excellent.

He had concerns about no longer being his own boss because a bigger company had come in. He was feeling better in later summer of '07, feeling much better by the fall of '07.

But at around this time, there was a doubling of the dosage of the Zoloft, for reasons that Dr. Sachman will explain. And it's not 100 percent clear. The doubling prescription was written in October of '07, but there was probably a phase-in period, so he probably didn't start taking the Zoloft then until a month or so -- the increased dose until a month or so later.

But in any event, he's doing better by late October of '07, as you can see. He's really starting to almost get over this bout and feeling really good in late November -- early November of '07.

And then here we have an entry that I'm sure you'll

hear discussed at length during the trial. It says here that he's feeling very depressed and down. It says, "suicidal thoughts." Now, this is the first time that there is any reference to any suicidal thoughts in any of Mr. Dolin's records. Ms. Reed will tell you about it. She testifies about it.

She examined these thoughts carefully. They appear to be relating to wanting to escape pressure at work. He had no plans of suicide and calmed down after talking about the situation and how he could handle it. And he was looking forward to seeing his kids for the holiday.

So, Sidney Reed will explain that she was keeping a close eye on that, but was not concerned because she felt these were passive thoughts and because of what happens next.

So, he's seen by Dr. Sachman and fine shortly after -- again, I'm sorry, this is just kind of what he's looking like in that time frame. And he's feeling very good. By the time she sees him next, he's explaining he's doing very well at work. He's laughing. He laughed when he was reminded that he once expressed a fear of becoming a bag lady.

At some point, he had a fear like that, and Sidney Reed, you'll hear her testimony, is going, "Wait a minute. You're an elite partner in a major law firm. You've missed no time from work. You're doing just fine. What do you mean bag lady?" But he was worried that that was something that he

really at least talked about once, but in January of '08, he's looking back and laughing at that, back to his old self and fine.

And you will hear testimony about the increased dosage of Zoloft and the connection between that one-time mentioned suicidal thought with no plan. You'll hear an opinion by a psychiatrist that that's the most likely cause of that.

MR. BAYMAN: Objection, your Honor. This is the subject of a motion *in limine* with respect to Zoloft and a ruling by the Court.

THE COURT: Well, you can state what you think the evidence will be.

MR. RAPOPORT: Okay.

So, the -- here, you have this reference in February of '09, back to himself. March of '08, things going well. March of '08 in the doctor's office for a cough and otherwise seeming fine.

And throughout this, the social relationship between the Dolins and the Sachmans, they are friends as couples, and so a month wouldn't go by when they weren't together socially as well. So, Dr. Sachman knows Stewart -- knew Stewart, and knows Wendy Dolin very, very well.

And so we keep going here. Sidney Reed, we're now spring of '08, and there's some talk about the sister, and

you'll hear that whole story.

Here, Mr. Dolin comes off of the Zoloft. That's June of '08, about two years before the events that bring us here.

Here in June of '08, he's ready to stop sessions, got through the hopelessness, survived, more careful, more sensitive to other people, promises to call if she's needed.

And then we go forward now. There's just the evidence of Zoloft again. Dr. Sachman will explain all of that. Here he's doing very well in December of '08. Here, he's decreasing weight, which is a good thing. That was part of the medical recommendations and doing well.

Here's one of my favorite images. I never had a chance to know Mr. Dolin, but here, you can see the face of depression. So, there -- and you will see -- you will hear evidence in this case when we get to it that for the most part, people interacting with Mr. Dolin had no idea that he was having these anxieties. I'm not talking about what his wife knew. We'll get to that. But to the outer appearances, he really seemed just fine.

So, hernia problem. It's just there for completeness. Here, he's off of the Zoloft in May of '09. Here, he sees his doctor for an annual physical in December of '09. Now we're getting closer in time to what brings us here, feeling just fine.

Here, he saw Sidney Reed. He hadn't been seeing her

much, but he sees her for one visit, and it's the only one that's going to happen even for five months after this; but he had some concerns actually about an overdue debt from a friend, and not sure how to work with that. But that's what that visit was about.

He had a vaccination. And he's back to see Sidney Reed in May of 2010 and talking a little bit now again about work stresses. He's not sure that he wants to continue as head of the leadership group.

Now, you'll hear evidence in the case that explains that in law firms, they're measuring time worked, and sometimes what you do to manage is not necessarily valued in the same way. It can get complicated. And he's -- there's -- the evidence is that he's considering to what extent he wants to continue being in a managerial role versus doing more legal service, you know, delivering the service to people.

So, anyway, his father-in-law is declining. It's May of 2010. He was highly anxious. He had a visit in June of 2010, but this was a highly stressful time in the family due to the impending death of Mr. Dolin's father-in-law, to whom he was very close.

Around this time, Dr. Sachman writes a prescription for Zoloft, but will testify that Mr. Dolin didn't feel well from this. So, on June the 27th -- and let me not get ahead of myself. First June the 26th. So, on June 22nd of '10,

there's a Sidney Reed visit where Mr. Dolin again expressed the fear of failure, pointed out that the last year had been his best financially, yet he was feeling depressed. Said he was getting medication from his doctor because that had helped the last time. So, that's the situation as of June 22nd.

Now, on June 27th, Mr. Dolin stopped taking the Zoloft, and it was at this time that Dr. Sachman prescribed the 10 milligrams of paroxetine that Mr. Dolin began taking, although he was instructed to wait until the Zoloft was out of his system. And by virtue of a medical record I'll go over shortly, we know exactly when it was that -- we know exactly when it was that Mr. Dolin started taking the paroxetine, which was July the 10th. And I'll show you momentarily why we know this.

But here's a new player. So, June 29th, Mr. Dolin started seeing a Ph.D. psychologist who did behavioral therapy. That's who Dr. Sahlstrom is. Dr. Sahlstrom has moved to another part of the country, so her testimony will be by video deposition as well, but she sees him for the very first time and writes a couple of things down.

She did a clinical interview. He had long-standing feelings of some work insecurity. He had no history of depression or suicidal ideation or attempts. Prognosis is good. She assessed the trauma history, the leisure time, friends and family history, and wanted to see him again in a

week.

So, at that visit, this is documentation and Dr. Sahlstrom's testimony that Mr. Dolin probably had no memory of any brief moment of a suicidal thought. The other possibility is he chose not to tell her, but --

MR. BAYMAN: Your Honor, this is speculation now.

THE COURT: Sustained. Just tell the jury what you think the evidence will show.

MR. BAYMAN: I'd ask the jury to disregard that.

THE COURT: That may go out, right. The jury will disregard it.

MR. RAPOPORT: So, anyway, the fact is that on June 29th of 2010, Stewart Dolin told Dr. Sachman that he had never had suicidal thoughts and that he was not feeling depressed.

And the fact is that he didn't have an official depression diagnosis, though clearly, he was feeling anxiety and some bad -- feeling in a bad way enough to see Sidney Reed for all of these times that we've looked at.

So, this is what happened. She recorded and will testify that his prognosis was good. She assessed his trauma history and didn't find any big, you know, horrible trauma like sometimes people have. That she's -- you know, understands that his leisure, friends, and family are all good.

So, she --

THE COURT: All right. Mr. Rapoport, we're going to take a recess now. And, ladies and gentlemen, we'll take a 10- to 15-minute recess. You may step into the jury room.

(Jury exits courtroom.)

(Recess had.)