

In re: Baycol Products) File No. MDL 1431
Litigation) (MJD/SRN)
)
) Minneapolis, Minnesota
) January 30, 2007
) 9:00 a.m.
)

(DAUBERT HEARING)

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RICHARD LOCKRIDGE, ESQ.
RANDY HOPPER, ESQ.
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BERT BLACK, ESQ.

For Defendant Bayer: PHILIP BECK, ESQ.
ADAM HOEFLICH, ESQ.
TAREK ISMAIL, ESQ.
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For Defendant
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1 P R O C E E D I N G S

2 IN OPEN COURT

3 THE COURT: Let's call this matter.

4 THE CLERK: This matter is In re: Baycol,
5 Multidistrict Case No. 01-1431. Counsel, could you please
6 state your appearances for the record.

7 MR. ZIMMERMAN: Good morning, Your Honor. Charles
8 Zimmerman for the Plaintiffs' Steering Committee.

9 THE COURT: Good morning.

10 MR. LOCKRIDGE: Good morning, Your Honor. Richard
11 Lockridge for the Plaintiffs' Steering Committee.

12 THE COURT: Good morning.

13 MR. HOPPER: Good morning, Your Honor. Randy
14 Hopper for the Plaintiffs' Steering Committee.

15 THE COURT: Good morning.

16 MR. BLACK: Good morning, Your Honor. Bert Black
17 for the Plaintiffs' Steering Committee.

18 THE COURT: Welcome.

19 MR. ARBITBLIT: Good morning, Your Honor. Donald
20 Arbitblit of Lieff, Cabraser, Heimann & Bernstein for the
21 Plaintiffs' Steering Committee.

22 THE COURT: Welcome.

23 MR. BECK: Good morning, Your Honor. Phil Beck
24 for Bayer.

25 THE COURT: Good morning, Mr. -- I like the beard.

1 MR. BECK: Thank you.

2 MR. HOPPER: I am having an influence on him, Your
3 Honor.

4 MR. HOEFLICH: Good morning, Your Honor. Adam
5 Hoeflich for Bayer.

6 THE COURT: Good morning, Adam.

7 MR. ISMAIL: Good morning, Your Honor. Tarek
8 Ismail on behalf of Bayer.

9 THE COURT: Welcome.

10 MR. BAUM: Good morning, Your Honor. Ken Baum on
11 behalf of Bayer.

12 THE COURT: Welcome.

13 MR. MIZGALA: Good morning, Your Honor. James
14 Mizgala on behalf of Bayer.

15 THE COURT: Good morning, Jim.

16 MR. MAGAZINER: Good morning, Your Honor. Fred
17 Magaziner on behalf of GSK.

18 Your Honor, with Your Honor's permission, I am
19 going to leave sometime after the status conference and
20 Mr. Smith is going to stay for the Daubert hearing.

21 THE COURT: All right.

22 MR. SMITH: Good morning, Your Honor. Scott Smith
23 for GSK.

24 THE COURT: Good morning.

25 Anyone else want to be introduced?

1 MR. HOEFLICH: No, Your Honor, but before we
2 begin, Ms. Weber is not here today because of health issues.
3 She, of course, would want to be here if she could.

4 THE COURT: Keep me informed --

5 MR. HOEFLICH: We will.

6 THE COURT: -- on her condition.

7 Mr. Zimmerman.

8 MR. ZIMMERMAN: Thank you, Your Honor.

9 THE COURT: Someone's BlackBerry --

10 MR. BECK: We turned ours off.

11 MR. ZIMMERMAN: I'll check mine when I go back. I
12 thought I turned it off, Your Honor.

13 Good morning, Your Honor. We are here for a
14 two-part hearing. I think we're having a joint status -- or
15 the status conference first and then we'll move into the
16 Daubert hearings. I'm Charles Zimmerman on behalf of the
17 Plaintiffs.

18 Yesterday I think the Court issued Pretrial Order
19 156, which answers some of the questions contained in the
20 report about a deadline. I don't know if you want us to go
21 over those when we get into the body of the status
22 conference.

23 But the first item of business on the report is
24 the status of cases and the first thing I think it's
25 important to report is that there are approximately 1,116

1 active plaintiffs in the proceedings who have -- I'm sorry.

2 There are approximately 1,700 Baycol cases that
3 remain active, down from 14,800 filed in the litigation.
4 The active cases include approximately 1,200 cases filed in
5 or removed to federal court, down substantially from 9,100.

6 Obviously those statistics tell us a lot about the
7 last year that we've been working with the discovery,
8 case-specific discovery, and that the number of cases that
9 remain active are down dramatically.

10 I expect when we summarize Phase III and IV, where
11 we are, we will see that those numbers will shrink
12 dramatically, probably in the same proportion, if not
13 greater.

14 The report of Phase I and Phase II is contained at
15 paragraph B, which indicates that in Phase I we are down to
16 39 plaintiffs, down from 60 as of November 7, 2006.

17 What that means is with the completion of that
18 discovery in Phase I, there remain 39 cases for which I do
19 not -- I believe no further activity with regard to
20 case-specific discovery will now be taking place and they
21 would remain for whatever resolution through remand and
22 trial would exist in the transferor court should this Court
23 at the appropriate time remand those cases.

24 In Phase II we have 99 cases, down from 150. I
25 don't know if it's as of that same date, but it's down to 99

1 cases.

2 In effect what we have here, Your Honor, is about
3 138 cases from Phase I and Phase II that remain after the
4 case-specific discovery is almost completed in II, I
5 believe.

6 Is it totally completed or is there actually
7 expert reports -- I mean, there's expert discovery, I think,
8 in II left --

9 MR. HOEFLICH: Yes.

10 MR. ZIMMERMAN: -- to complete. So there may be
11 some more whittling down of those 138 cases.

12 In Phases III and IV, Your Honor, we just got the
13 schedule. We have 373 cases in Phase III and 546 cases
14 where discovery and case-specific work has to be done in
15 Phase IV.

16 It is more likely than not, in fact, it's highly
17 probable, that these numbers will be whittled down into the
18 same sorts of percentages we've seen out of Phase I and
19 Phase II.

20 What I would report to Your Honor is this, and
21 this is something that's --

22 THE COURT: Would everyone turn off their
23 BlackBerrys and their cell phones.

24 MR. ZIMMERMAN: Let me make sure mine is off, Your
25 Honor. It should be off, but we'll make sure.

1 THE COURT: Thank you.

2 MR. ZIMMERMAN: What I've asked my staff to do is
3 sort of look at what's out there if we were kind of to
4 project going forward and although the -- I don't want to
5 put these on the record at the present time, Your Honor,
6 although I would be happy to talk about them informally,
7 because I don't want anybody to think that we can make total
8 judgments about someone else's case.

9 We see that the number -- that there will be some
10 additional rhabdo cases coming out of Phase III and IV at
11 least in terms of the records that have been produced, the
12 medical records or the reports that have been produced.
13 It's our view there will be somewhere in the nature of 20 to
14 25 rhabdo cases coming out of Phase III and IV.

15 Defendants may object to that characterization of
16 those being rhabdo or not and that will go through the
17 mediation process or the process that at least would apply
18 to a rhabdo case, but that's sort of what we're looking at
19 coming out of Phases III and IV, approximately a total
20 between 20 and 25 rhabdo cases.

21 And we see about 200 cases generally where there
22 are some kind of elevated labs, elevated CK levels,
23 elevation beyond the upper limits of normal where we at
24 least have objective sorts of evidence that there could be
25 some seriousness associated with the alleged injury.

1 I just throw that out there, Your Honor, so we
2 understand what the order of magnitude is and the idea that
3 we're trying to look at the cases going forward before all
4 the case-specific discovery plays out to see what we're sort
5 of looking at. And that seems to be what we're looking at,
6 so the Court has some idea of the order of magnitude.

7 MR. HOEFLICH: Your Honor, the only point I would
8 add is that if Mr. Zimmerman has rhabdomyolysis cases he
9 would like us to look at, please feel free to provide them
10 to us.

11 In Phases I and II we're aware of one rhabdo case
12 and we are progressing well in settlement discussions.
13 That's a case that was not filed in the District of
14 Minnesota. It was filed in a transferor court. We hope we
15 will be able to resolve it soon.

16 MR. ZIMMERMAN: And we support that, Your Honor.
17 We agree there is one coming out of Phase I and II, and we
18 understand that's close to resolution or at least it's in a
19 program to be resolved.

20 MR. HOEFLICH: Yes.

21 MR. ZIMMERMAN: And we are looking at
22 approximately 20 to 25 coming out of III and IV, allegedly,
23 and we will get those people into -- we will get you the
24 names at least so you have them and we can begin that
25 process sooner rather than later.

1 MR. HOEFLICH: In addition, as we have committed
2 to the Court and as I committed to the Court at the November
3 status conference, we continue to look at rhabdo cases that
4 we're aware of.

5 At the November status conference I believe we had
6 settled at that point 3,052 cases for roughly \$1.154
7 billion. As of today's status conference we have now
8 settled 3,067 cases. So we are making progress.

9 If Mr. Zimmerman has more cases, we'll be happy to
10 look at them and we will do our -- we will endeavor our very
11 best to resolve those cases, Judge.

12 THE COURT: All right.

13 MR. ZIMMERMAN: Of course that's the next item and
14 I think it's appropriate to move to that, Your Honor,
15 because now we have, under C, Pretrial Order 156 which sets
16 a scheduling order for Phases II and III and a procedure for
17 remand that is contained within the order.

18 And also at the bottom of that order there is
19 this -- also this paragraph that addresses mediation saying
20 that the orders with regard to mediation protocol for the
21 rhabdo cases set forth in prior pretrial orders remains in
22 full force and effect, with the idea that if we have alleged
23 rhabdos in the Plaintiffs' group of cases, we want to get
24 them into the program as quickly as possible and resolve
25 those cases, which brings us back, then, now to number II,

1 which is the results of the settlement.

2 The only thing I wanted to add to that, Your
3 Honor, is really a congratulations to everybody. Settling
4 3,067 cases and 941 cases in this MDL is no small task and
5 it took a lot of work and it took a lot of focus and it took
6 Bayer stepping up and initiating the program and the
7 Plaintiffs participating in it over a period of significant
8 amount of time. It's a great success.

9 It sometimes gets lost in all of the other things
10 we're dealing with, but I just congratulate Bayer and I
11 congratulate the Plaintiffs and I congratulate everyone
12 involved with the process, including this Court, for getting
13 3,067 cases settled and 941 cases in the MDL settled for a
14 substantial consideration. It's a marvelous accomplishment
15 and it shouldn't ever be lost sight of as we continue in the
16 adversary proceedings with regard to the nonrhabet cases.

17 MR. HOEFLICH: Judge, for the record and because
18 we know the Court has taken the step of putting the
19 transcripts online for people to see, let me just let people
20 know what we've done in terms of settlement and what the
21 amounts are at this point.

22 To date Bayer has settled 3,067 cases with a total
23 value of \$1,154,343,835. Of this total, 941 cases have been
24 determined to be subject to the MDL assessment with a total
25 value of \$350,409,334.38.

1 As of the last status conference in November,
2 Defendants had settled 3,052 cases with a total value of
3 \$1,151,613,835. Of that total, 937 cases had been
4 determined to be subject to the MDL assessment with a total
5 value of \$350,121,334.38.

6 In addition, 141 cases have been submitted to the
7 MDL mediation process and we thank the Court for its
8 assistance with that.

9 THE COURT: All right.

10 MR. ZIMMERMAN: I like to roll those numbers off,
11 but I guess I was happy that you could do it.

12 I don't know about the 141 that have been
13 submitted to the MDL process. That doesn't mean they're
14 still in the process, that just means they were resolved
15 within that process?

16 MR. HOEFLICH: Correct. I believe that's a
17 cumulative number of what's been submitted.

18 MR. ZIMMERMAN: Okay. Thank you. Again, a hearty
19 congratulations to everybody involved. It's a remarkable
20 result.

21 THE COURT: Well, Mr. Zimmerman, if I can
22 interrupt for a second. I would like to again congratulate
23 both the Plaintiffs and the PSC and the Defendants on
24 resolving as many cases that they have. I think I've been a
25 cheerleader for you for three years telling you that this is

1 a process that is different than any other MDL that's come
2 down the pike.

3 It's a new paradigm that Bayer brought to the
4 table and I think Plaintiffs should look at it that they
5 have resolved a number of cases without having to go through
6 litigation, expensive litigation, in this matter and the
7 plaintiffs have been paid fair settlements.

8 When you have that many plaintiffs' attorneys
9 being involved in a settlement process, you know that Bayer
10 has so many people coming at them for different figures and
11 that the appropriate figures for the appropriate injuries
12 have been paid out; and I've said that from the beginning
13 when I saw the process started.

14 And it's important that you've come to realize, as
15 the PSC, that a tremendous amount of money has been paid out
16 in this litigation. It's been quietly paid out, no big
17 headlines. But it's not necessary for people to be
18 compensated and have a headline follow that.

19 And so I compliment your leadership for the PSC.
20 You've done a tremendous job. I've said that from the
21 beginning. And your stewardship of this MDL in a new
22 paradigm has been quite remarkable.

23 And certainly Bayer has come to the table with a
24 new philosophy of -- if the people that are on the phone
25 would put their phones on mute so we don't have to listen to

1 them rattle their papers and cough, that would be
2 appropriate.

3 Mr. Beck and his team has done a tremendous job
4 for the Defendants and it's just been a marvelous experience
5 for me and I hope we can wind this down by January of 2008
6 and go our merry way.

7 Mr. Beck.

8 MR. BECK: Your Honor, if I may. I would also
9 join Mr. Zimmerman in thanking the Court for your guidance.
10 When you said you were a cheerleader, I had a mental image
11 more of kind of a drill sergeant. I think there was some
12 more than gentle prodding that went into the process.

13 But on behalf of Bayer, I must say that we're
14 delighted with how it worked out. Obviously my client ended
15 up paying a great deal of money, but it was money to people
16 who had demonstrated side effects that could be associated
17 with the use of our medicine.

18 We were able -- with every single person who came
19 to us wanting to discuss settlement, we were able to resolve
20 the cases so far without having to go through a trial and
21 contest liability with one exception early on.

22 It's been an unusual couple of years for me where
23 I have had one MDL where I had one trial and 3,067
24 settlements and then I've recently been involved in another
25 MDL where I have had six trials and no settlements.

1 So it is a different paradigm, partly because of
2 the nature of the side effect that's at issue and a lot of
3 things went into that, but not least of which was the
4 Court's guidance as well as the cooperation and leadership
5 shown by the PSC in getting what I think we all think are
6 fair settlements through the process rather than getting
7 them all gummed up and opting instead for contested
8 litigation on every case.

9 So we appreciate the work done by the PSC and
10 their leadership and we thank you for that.

11 MR. ZIMMERMAN: And if I just might make one more
12 comment, Your Honor. I was in New York at a seminar in
13 December and I actually had the opportunity to congratulate
14 Bayer directly through their general counsel. Is it George
15 Lykos? And I stood up in public in a large group of people
16 and congratulated Bayer for doing the right thing and
17 stepping up, because that was his topic, about doing the
18 right thing.

19 And it's been through a lot of reflection because
20 obviously we battled over the nonrhabdo cases in this court
21 for some time, but it was a very enlightening moment, I
22 think, for both George and I to see us as adversaries stand
23 up and congratulate one another for doing the right thing
24 even though at times our reasonable minds differed on how
25 other parts of the litigation should follow.

1 But for the main we all did a good job and it's
2 through the Court's stewardship for sure and through the
3 great advocacy on both sides, but we did the right thing for
4 the people and we're very proud of that as we stand here
5 today.

6 We've got some issues left. We'll get them done
7 this year, I'm confident we will, and the chips will fall
8 where they may, but this was an outstanding MDL and I'm
9 proud to be a part of it.

10 The next and last topic is trial settings. There
11 are no trial settings for cases in the MDL. That's pretty
12 obvious.

13 A trial in the Lollar case has been set for
14 October 15, 2007 in Monroe County, Mississippi. Good luck
15 down there to everybody. I don't know too much about that
16 case. I don't even know where Monroe County, Mississippi,
17 is, but I guess we'll find out.

18 Then there's the class action in Oklahoma that is
19 scheduled for trial in June of 2007. The PSC is working
20 with class counsel down there and I don't know if there's
21 anything really to report on it other than it's proceeding.

22 No Baycol cases have been --

23 THE COURT: Is that really going to trial?

24 MR. ZIMMERMAN: It is scheduled to go to trial,
25 Your Honor. My guess --

1 THE COURT: Or is it going to be continued again?

2 MR. BECK: Right now it's scheduled to go to trial
3 and we're proceeding on the assumption that it will, but it
4 has been continued several times and that could happen
5 again.

6 THE COURT: What about the Lollar case, any
7 knowledge of that case? Is that in a lower court?

8 MR. HOEFLICH: It's scheduled now, Judge. I don't
9 know all that much about it or whether the trial date will
10 stick, but we will keep the Court informed.

11 MR. ZIMMERMAN: I don't know if counsel can
12 enlighten us, but I did read just yesterday of a settlement
13 in a case involving the attorneys general that I did not
14 have on my radar screen. I knew there were claims out there
15 and there was a class -- was it a class? -- or an attorney
16 general settlement that I read about the other day and I
17 don't know what the status of that is.

18 MR. HOEFLICH: Your Honor, we were not -- Mr. Beck
19 and I were not involved in that either, but if Mr. Zimmerman
20 has questions about it, he can communicate with me and I'll
21 get him what information is publicly available.

22 MR. ZIMMERMAN: All I know is there was some
23 settlement involving a group of attorneys general and that's
24 all I know. It just came over my Internet site.

25 THE COURT: Regarding Baycol?

1 MR. ZIMMERMAN: Baycol having to do with --
2 something having to do with the economic cost or something
3 of the drug, but again, I'm not familiar with it and I have
4 to do more research on it.

5 MR. BECK: Your Honor, I know probably what
6 Mr. Zimmerman knows as it came over my screen as well. All
7 I know is that there was some sort of claims and that 22
8 different state attorney generals settled with Bayer for a
9 total of \$8 million. So whatever the claims were, they
10 went -- 22 state claims went away for a grand total of
11 \$8 million. That's all I know.

12 THE COURT: All right. If you get any more
13 information on that, why don't you pass it my way.

14 MR. ZIMMERMAN: I will be happy to do that and we
15 will certainly do that, Your Honor.

16 That is the -- concludes the status conference
17 with the exception of the Daubert motions, which are going
18 to be heard by the Court. Unless the Court has any further
19 questions, we could probably move right into that.

20 I want to make one other statement, however, and
21 that is that we will -- the PSC is committed, now that we
22 see so much of the landscape with regard to the nonrhabdo
23 cases, to encourage people to go through the discovery or
24 make their decisions early if they're not going to go
25 through the discovery so we can get to the nub of the matter

1 and perhaps even ramp up the schedule that is in Pretrial
2 156 to make this happen even faster.

3 That's our commitment to the Court and to counsel,
4 to try to on a voluntary basis do something to make sure
5 that people get -- are aware of the realities that are out
6 there and what is going on, what has happened in Phase I and
7 Phase II, and to get the cases separated from those that are
8 really going to be remanded at the end of the day or be
9 prepared for remand and they are really going to stand
10 behind for case-specific discovery and those that are not.

11 We just want to save wear and tear on everybody,
12 if possible, and we stand committed to do that through this
13 Phase III and IV.

14 THE COURT: I appreciate that.

15 Anything else from the Defense?

16 MR. HOEFLICH: No, Your Honor. Thank you.
17 Thanks, Bucky.

18 THE COURT: Fred, anything for GSK?

19 MR. MAGAZINER: No, Your Honor.

20 THE COURT: All right. We'll get situated for the
21 Daubert arguments. Mr. Beck, I think you're going to go
22 first; is that correct?

23 MR. BECK: Your Honor, yes, although I believe
24 that the Plaintiffs had requested that they be given 20
25 minutes or so to make some general remarks about Daubert

1 motions. We have no objection if they want to do that.
2 Whatever -- we'll weave ours into the specific motions.

3 THE COURT: Good morning, Mr. Lockridge.

4 MR. LOCKRIDGE: Is that all right, Your Honor, if
5 we do that?

6 THE COURT: That's fine with me. And I apologize
7 for not including you in my compliments for the PSC because
8 you are co-lead counsel and everything that I said about
9 Mr. Zimmerman applies to you. Your leadership and
10 stewardship in this matter has been invaluable for the
11 Court.

12 MR. LOCKRIDGE: Well, thank you, Your Honor. I
13 appreciate that, of course.

14 I would like to make some very preliminary
15 comments and then I would like Don Arbitblit from the Lief
16 Cabraser firm also to make a few minutes of some preliminary
17 comments because these are comments which really go to all
18 of the motions, and I think it will only take a few minutes.

19 At the outset, of course, we feel that we have
20 probably the finest set of experts that have ever been put
21 together in any case and we are exceptionally proud of them.

22 And I wanted to briefly address the overall
23 Daubert issue simply to emphasize a few things because
24 Daubert is so typically used by the defendants as an attempt
25 to prevent experts from testifying, but the reality is that

1 the actual Daubert case is very interesting.

2 When one goes back and reads it, the Supreme Court
3 said Rule 702 must be read in the context of a liberal
4 thrust of the Federal Rules of Evidence and must be
5 interpreted consistently with the general approach of
6 relaxing the traditional barriers to opinion testimony.

7 So I think it's clear that barring testimony,
8 expert testimony, is the exception rather than the rule
9 and obviously we hope the Court will keep that in mind. The
10 real threshold for admissibility is not how persuasive the
11 evidence might be, but rather the reliability of the
12 evidence.

13 And also as discussed in Daubert and subsequently,
14 I might note, of course, in Kumho Tire and others, the
15 courts, including the Supreme Court, really seem to be
16 saying that Daubert and the so-called gatekeeping rule is
17 not a substitute for defendants vigorously cross-examining
18 the experts at trial and, if they want, presenting contrary
19 instructions or having the court give carefully crafted
20 instructions to the jury.

21 Of course, Daubert specifies two requirements,
22 admissibility -- for admissibility, reliability and
23 relevance. Obviously relevance is not an issue here. And
24 for reliability, as the Court knows, it's to look at such
25 factors as scientific methodology; that is, as the Eighth

1 Circuit actually said in the Turner vs. Iowa Fire Equipment
2 case, the evidence must be grounded in the methods and
3 procedures of science. And that's what we have here.

4 Now, obviously I'm aware of the progeny of Daubert
5 and Kumho Tire where courts do, in fact, look at the
6 conclusions of various experts, but I want to emphasize that
7 of course we welcome the Court to look at the substance and
8 the conclusions of our experts.

9 Now, there will not be forward-looking clinical
10 studies here because they're not available because obviously
11 Baycol was pulled from the market. So what we have
12 primarily is extremely qualified experts examining and
13 looking at studies, sometimes Bayer's studies, looking at
14 the literature, sometimes relying on other experts and
15 sometimes relying on AERs, as we're going to get to, and
16 relying on other things.

17 And that is really the test here. I would submit
18 that the real test is that simply we have to prove, we have
19 to establish that the evidence is reliable and that we used
20 scientifically valid methodologies.

21 And I think it's clear that in every single case
22 our world-renowned experts have done that, Your Honor. I
23 would ask you to always keep that in mind as you are
24 listening to Mr. Beck's extensive arguments here this
25 morning.

1 If I could, Your Honor, I would like to have Don
2 Arbitblit from the Lief Cabraser firm now say a few words
3 also.

4 THE COURT: You may. Good morning.

5 MR. ARBITBLIT: Good morning, Your Honor. Thank
6 you for the opportunity to address the issues on this
7 hearing.

8 I've been -- just for a brief background, I've
9 been involved in the Baycol litigation since its inception,
10 although I have not appeared before Your Honor before. I
11 have worked extensively on my firm's individual cases and,
12 as others have, I have managed to resolve the rhabdomyolysis
13 cases with defense counsel. Again, I too appreciate the
14 spirit with which defense counsel came to those negotiations
15 and we worked very well together.

16 I expect that during the course of today we will
17 see that there are some disagreements, but I also think that
18 there are some agreements that will be presented today. And
19 I thought as part of the road map for where we are going I
20 would explain what I see, working with our experts and
21 counsel, as the principal issues and what is and is not in
22 dispute.

23 As I see it, there are a number of key issues, a
24 small number of key issues. One is whether Baycol is more
25 toxic to muscles than other statins and a second one is with

1 respect to statin myopathy, which is conceded to be a real
2 phenomenon and is not in dispute, how is it diagnosed and
3 how long does it last.

4 And as to each of those substantive questions that
5 are always going to come up in the procedural mechanism of a
6 Daubert hearing, we will present the evidence as to those,
7 but briefly what we would expect the evidence to show is
8 that there is a consensus that Baycol is more toxic than
9 other statins.

10 It started in August 2001 with the withdrawal of
11 the drug and the scientific community has spoken with one
12 voice since that time. We have and will present and have
13 submitted to the Court recent literature that validates and
14 confirms the existence of that consensus time after time
15 after time. Without exception Baycol is called the most
16 toxic statin, the statin that causes the most muscle injury.

17 And so it's important in the sense that clearly
18 we've come three years since these reports were served and
19 there's an issue that the Court undoubtedly has to face as
20 to what is the impact of subsequent research.

21 Our view of it is that our experts were on the
22 right track with what they had at the time. They came to
23 the right decisions based on reliable methodology and the
24 available evidence and that time has only confirmed and
25 validated what they said then.

1 There's a consensus that Baycol is the most toxic
2 statin and we'll be presenting the evidence in peer-reviewed
3 studies on that subject and that will include published
4 epidemiology studies finding Baycol with a 6- to 10-fold
5 increased risk of hospitalized rhabdomyolysis, as well as
6 evidence about Bayer's own clinical trials.

7 In terms of reliability, the clinical trial
8 evidence has not been the focus of the pleadings on the
9 defense side. They've tended to focus on the relative
10 reporting ratio study with the goal of undermining it by
11 saying it's all about adverse event reports and therefore
12 somehow unreliable.

13 Well, it's important that those are just one piece
14 of the puzzle. They're not the whole puzzle. They are a
15 piece of it. The clinical trial evidence that's cited in
16 Dr. Farquhar's report that shows an 8-fold increase in
17 rhabdomyolysis on published clinical trials is in his
18 report, but it's not the focus of what Bayer is attacking.

19 I think it's important to understand, in my
20 reading of the case law and the Reference Manual on
21 Scientific Evidence, that even isolated case reports may be
22 permissibly considered by an expert in the context of other
23 evidence.

24 This is not a case where the adverse event reports
25 are the sole or even main evidence. They do take up a lot

1 of space and time because there's a lot of data, but
2 clinical trial evidence is in the record, not only
3 Dr. Farquhar's analysis, but the analysis of defense
4 consultant Dr. Strom's assistant, Mr. Loutanbach, who
5 performed a very similar calculation to Dr. Farquhar on the
6 published clinical trials and came up with a very similar
7 result, showing a high rate of confirmed rhabdomyolysis for
8 Baycol in published studies, as well as a piece of data that
9 I found surprising when I saw it and that has not been
10 published, which is a comparison of 19 pooled clinical
11 trials that are called short-term studies in which the
12 relative risk for myalgia was 1.76 statistically significant
13 for Baycol versus placebo.

14 That has never been published. Instead what is in
15 the literature is 2.5 versus 2.3, essentially no difference,
16 and that's been cited time after time because it's in the
17 PDR, the label and the Physicians' Desk Reference, based on
18 a subset of clinical trials, only U.S. studies, only 3,000
19 people; whereas, the 19 studies that Bayer submitted in 2001
20 to European regulators consisted of almost 9,000 people and
21 larger samples are considered more stable and reliable. So
22 that's clinical trial evidence. That analysis was done by
23 Dr. Strom's assistant. He's a defense witness.

24 And it's important that as part of the evidence
25 that we don't focus just on the relative reporting rate

1 study. Now, with respect to that study, it's also important
2 that --

3 MR. BECK: Your Honor, I don't want to be
4 impolite, but I was told that they wanted a few minutes to
5 talk about Daubert standards and now we're --

6 THE COURT: We are going into argument already.
7 You will have certainly enough time to --

8 MR. ARBITBLIT: Thank you, Your Honor. I will
9 move on to one last point where I think we will have some
10 agreement because having taken the deposition of the defense
11 expert on the subject of duration of injury and how it's
12 diagnosed, the Plaintiffs' experts and the defense experts
13 agree on a number of points, Your Honor, but most
14 importantly, as Your Honor has held, differential diagnosis
15 is the way to determine causation in a toxic exposure case
16 such as this.

17 As far as how it's diagnosed, the criteria used by
18 the various experts are quite similar and compatible. The
19 issue of duration has advanced in the literature and, as
20 conceded by the defense expert at his deposition, that
21 there's a range of time that CK is a marker. It's not the
22 injury itself. When CK normalizes, that doesn't necessarily
23 mean the injury is over and that the range of injury is
24 subject to individual variation.

25 THE COURT: All right. Thank you.

1 MR. ARBITBLIT: Thank you, Your Honor.

2 THE COURT: Mr. Beck.

3 MR. BECK: Your Honor, I need just a moment or two
4 to arrange the technology here.

5 (Pause.)

6 MR. BECK: I think we're all set now if you're
7 ready for me, Judge.

8 THE COURT: Mr. Beck, you asked for an hour and a
9 half; is that correct?

10 MR. BECK: Yes, Your Honor.

11 THE COURT: I put that on the timer and the yellow
12 light will come on with 30 minutes to go so you will know
13 that you have 30 minutes.

14 MR. BECK: Where is this yellow light, Your Honor?
15 Oh, here it is. I see. Thank you.

16 Your Honor, I'm going to discuss several motions
17 together and then Mr. Ismail will do that with some other
18 motions this afternoon. For the ones that I'm going to be
19 discussing, I'm going to be focusing very much on questions
20 of methodology.

21 We are not here to argue about the academic
22 credentials of any of the experts and we're also not here
23 simply to dispute the conclusions that the experts have
24 come to.

25 Rather, the motions that I'm going to be

1 discussing focus on whether the experts in this particular
2 case in the opinions they've rendered in this case have
3 followed scientific methodology such that their conclusions
4 have sufficient reliability to be put before a jury under
5 Daubert.

6 The motions that I'm going to be discussing are
7 the adverse event report motion and there the question is --
8 a couple of important questions. One is whether adverse
9 event report data can be used to show comparative drug
10 safety, so the safety of one statin versus another. And we
11 believe that it cannot.

12 And that is particularly so given point number
13 two, which is that the adverse event report data that they
14 rely on relates mainly to one condition, which is rhabdo,
15 and then they rely on it to draw drug safety comparisons
16 concerning a different condition, which is myalgia or aches
17 and pains.

18 As Your Honor has heard this morning during the
19 status conference, we've done a pretty good job, all of us
20 involved, in cleaning out the rhabdo cases and we're left
21 with the nonrhabdo cases.

22 So they are using here in the adverse event
23 reports information concerning rhabdo and then drawing
24 conclusions of comparative drug safety concerning different
25 conditions that are not rhabdo. So that's one of the

1 motions.

2 A couple of the other motions that I'll be
3 addressing concern Drs. Farquhar and Austin and both of
4 them -- there is substantial overlap there, Your Honor. We
5 believe that they have misused the adverse event report
6 data, so there will be overlap with that motion.

7 And also we believe that they have improperly
8 manipulated the epidemiological study that actually was done
9 by PacifiCare that showed that when Baycol was used at
10 4 milligrams, the normal dose and was not used along with
11 gemfibrozil that, number one, there was no increase in the
12 incidence of rhabdo, but also, number two, no increase in or
13 difference in the incidence of myopathy.

14 And they have taken criticisms of that study,
15 which they're certainly entitled to advance, but then
16 purported to basically redo the analysis in an unscientific
17 way in reaching the opposite conclusion. So we'll be
18 focusing on their methodology there.

19 And then, Your Honor, what I'm actually going to
20 talk about first is the problem that we have with several of
21 their other witnesses where they have not relied on other
22 experts, as I think it was Mr. Lockridge said, but instead
23 they have parroted or adopted wholesale the conclusions of
24 other experts, chiefly Dr. Farquhar.

25 And all of these are related and that's why I

1 would like to discuss them as a group. And I will actually
2 start with the last one I mentioned, what we think of as the
3 parroting motion.

4 As I said, this is not a case where there are
5 several steps in an analytical chain and an expert says I am
6 assuming that proposition B is true -- in my A, B, C, D
7 chain of reasoning I'm assuming that proposition B is true
8 and the basis for my assumption that it's true is
9 Dr. Hoeflich's report and it rises or falls with
10 Dr. Hoeflich's report, but I'm assuming it's true for my
11 purposes.

12 That, I think, is appropriate for an expert to do.
13 As the Plaintiffs say, not every expert can be -- can have
14 expertise in every possible field. But they're not doing
15 that here.

16 And if they do something like that, when you've
17 got that kind of a situation, then if Dr. Hoeflich doesn't
18 show up, their analysis gets thrown out the window. It
19 either gets stricken or they're not allowed to put it in,
20 depending on the sequence of how the testimony comes in.

21 Or if Dr. Hoeflich does show up to establish
22 proposition B, I get a chance to cross-examine Dr. Hoeflich
23 and show that he's the charlatan that he is and that his
24 analysis is deeply flawed and that he's got biases and that
25 sort of thing. And so the jury gets to hear Dr. Hoeflich

1 and the basis for that part B, that assumption that the
2 other expert is entertaining.

3 But here what we've got are a whole series of
4 experts who are adopting as their own conclusions that were
5 reached, as I said, principally by Dr. Farquhar concerning
6 relative risk of different statins based mainly on the
7 adverse event reports.

8 And then these experts are purporting to take
9 these conclusions and say that they are their conclusions
10 without having done the analysis and without any basis other
11 than Dr. Farquhar's opinion. We gave examples in our brief.
12 I'll just highlight a couple of those for you.

13 I'm going to show first some testimony from
14 Dr. Smith. He's a toxicologist and he wrote an opinion that
15 says that Baycol when administered along with another drug
16 called -- well, it's Plavix, but it's got a hard to
17 pronounce generic name. He says that Baycol along with
18 Plavix has an interaction and increases risk. And so
19 here's -- that's his opinion, he claims, and here's what he
20 says as to the basis of that:

21 "Paragraph 32, The most serious interactions between
22 Baycol and other drugs appear to be with gemfibrozil and
23 clopidogrel. What's clopidogrel?

24 "Well, I forget as I sit here today. It's also a
25 commonly prescribed drug, but I forget for what condition.

1 "What's your basis for this statement?

2 "That that -- the report by Dr. Farquhar.

3 "Okay. Did you do a literature search or did you find
4 any other support for that statement other than
5 Dr. Farquhar's report?

6 "There are many reports, of course, with gemfibrozil.

7 "Right.

8 "The clopidogrel is from Dr. Farquhar's report."

9 MR. BECK: So here we have a toxicologist who is
10 proposing to render an expert opinion that Baycol and
11 clopidogrel are particularly toxic when taken together. He
12 doesn't even know what the drug is and his only basis is
13 that Dr. Farquhar says so.

14 Now, Dr. Farquhar may or may not pass Daubert
15 muster on that and Dr. Farquhar, if he does pass Daubert
16 muster, may or may not stand up to cross examination on
17 that, but Dr. Smith shouldn't be allowed to just adopt as
18 his own a conclusion that is based 100 percent on
19 Dr. Farquhar and that he doesn't even understand.

20 We've got a similar situation with Dr. Raskin.
21 He's a cardiologist and he offers opinions on comparative
22 drug risks based on the adverse event reports, and here's
23 what he says:

24 "Have you ever published an article, Dr. Raskin, in
25 which you make comparative statements between two drugs

1 using spontaneous adverse event data?

2 "No, sir.

3 "Have you done any research in which you make
4 comparative statements between two drugs using spontaneous
5 adverse event data?

6 "No, I haven't.

7 "Has anyone ever asked you to undertake an investigation
8 into the comparative safety of two drugs using spontaneous
9 adverse event data?

10 "Only for the purposes here to review this data. No, I
11 haven't done a study."

12 MR. BECK: And then he goes on.

13 "So the only investigation you made into how potential
14 biases affect the reporting rate of adverse events for
15 statins is to review the reports of Dr. Farquhar and
16 Dr. Strom, correct?

17 "That is correct."

18 MR. BECK: As I said, we have other examples in
19 the brief, but I think that those two are illustrative.

20 And the concern that we have, Your Honor, is that
21 by having these other experts claim Dr. Farquhar's opinion
22 as their own, the Plaintiffs' lawyers are trying to
23 accomplish two things. One is -- and this surprised me when
24 I reviewed the papers -- that they're actually trying to
25 shield Dr. Farquhar's opinions from Daubert review.

1 To be sure they're going to stand up and say that
2 Dr. Farquhar is the most qualified person in the world and
3 he passes Daubert muster. But they also say in their brief
4 that even if he doesn't, even if this Court finds that
5 Dr. Farquhar's methodology is so flawed that he should not
6 be allowed to present his analysis to the jury, they say,
7 well, that's okay because the other experts are entitled to
8 adopt his conclusions as their own because experts can rely
9 on inadmissible evidence.

10 And they cite no support for the proposition that
11 if a court excludes as unreliable one expert's conclusion
12 that another expert can come along and rely on that. And I
13 can't believe that ploy is going to work.

14 What they also hope to do -- would you like to say
15 something?

16 MR. ARBITBLIT: Mr. Beck, I would like to waive
17 that argument if it were made in the papers. Your Honor, I
18 would not --

19 MR. BECK: Then we don't need to take any more of
20 my time. If that argument was made, which it was, they've
21 now waived it.

22 MR. ARBITBLIT: I would not have made that
23 argument. And having worked with Dr. Farquhar, I'm prepared
24 to stand on the merits of his opinion. And if it's not
25 admitted by the Court, then I would not expect any other

1 expert in this litigation to rely on it.

2 MR. BECK: Good. So that's done.

3 What they're also doing through this mechanism of
4 having other experts adopt Dr. Farquhar's conclusions is
5 they shield Dr. Farquhar from cross examination.

6 When defending Dr. Farquhar's analysis in their
7 briefs, they say that the criticisms that we make go to the
8 credibility of the analysis rather than its admissibility
9 and that that's an issue for searching cross examination. I
10 think that some of the remarks that Mr. Lockridge made this
11 morning were along the same lines.

12 But if other experts can simply adopt
13 Dr. Farquhar's conclusions without having done the analysis
14 or, in the case of the toxicologist, without even knowing
15 what drug he is talking about, then the conclusions come in
16 without any cross examination of the methodology or the bias
17 of the person who came up with the conclusions.

18 And, Your Honor, that -- this is not just some
19 hypothetical concern. Many of us at both of the tables have
20 been involved in the Vioxx litigation over the last year.
21 And I don't want to suggest that what happens in Vioxx
22 should drive what happens in this proceeding, but they make
23 a point in their papers of saying Dr. Farquhar was found
24 qualified to testify by Judge Fallon in the Vioxx cases and
25 then they quote at length Dr. -- Judge Fallon's opinions

1 saying that Dr. Farquhar could testify there.

2 It is interesting. Judge Fallon found that
3 Dr. Farquhar was qualified to testify. He had a much
4 different analysis than he has here. They list him in every
5 case as one of their experts and they never call him.

6 And instead -- I keep getting ready to
7 cross-examine Dr. Farquhar and I never get to and instead
8 what happens is other experts come in and they purport to
9 rely on Dr. Farquhar even though Dr. Farquhar doesn't
10 present himself for cross examination.

11 And we think that in this case that it's very
12 important that the Plaintiffs not be able to backdoor
13 Dr. Farquhar's conclusions in through other experts, that
14 they put him up -- if he passes Daubert, which we don't
15 think he does, that they put him up to testify as to his own
16 conclusions rather than having somebody else act as his
17 mouthpiece.

18 We have serious questions for Dr. Farquhar,
19 including who really wrote his report, you know, what
20 involvement the lawyers had. You're going to hear from
21 Mr. Arbitblit. What involvement he had with the report, how
22 many drug cases Dr. Farquhar has testified in where
23 Dr. Arbitblit -- or Mr. Arbitblit has been the principal
24 lawyer who handles him. Documents refer to Mr. Arbitblit as
25 his handler.

1 There are questions as to who came up with the
2 specific calculations and analyses, the ideas for those,
3 that are contained in Dr. Farquhar's report. And you'll see
4 later that on a key one it wasn't Dr. Farquhar. It was the
5 lawyers who told him what to do and how to do it.

6 So we would like very much, if Dr. Farquhar is
7 going to pass Daubert muster, that he be required to present
8 his own opinions and that they not be allowed to take
9 Dr. Farquhar, have him pass Daubert, and then have a bunch
10 of other experts say, well, Dr. Farquhar's report says this
11 and I rely on Dr. Farquhar because he's world renowned and
12 we never get to cross-examine the supposed author of these
13 opinions.

14 And I should say in this regard, Your Honor, just
15 on a practical note, that in November in the Vioxx
16 litigation they said that, well, Dr. Farquhar recently
17 became sick and he couldn't travel to other trials that were
18 scheduled and so they said they needed an immediate trial
19 preservation deposition and they wanted to take it in the
20 one week I had between two different Vioxx trials. Judge
21 Fallon said okay. We said we'd send one of my partners to
22 do the deposition. Then it was canceled and to my knowledge
23 there's been no effort made to preserve his Vioxx testimony
24 since then.

25 And, Your Honor, I say that only because if, in

1 fact, the Court holds that Dr. Farquhar passes Daubert
2 muster, we do not want to be in a position down the road
3 where they say, well, gee whiz, he's too sick to travel to
4 Minnesota, just like he was too sick to travel to New
5 Orleans, and therefore he's not going to be here to defend
6 his own opinions, but luckily for us we've got other experts
7 who will adopt his opinions as their own.

8 So I don't know what the solution for that problem
9 is, but I wanted it on record that they've announced in
10 another MDL that he is too sick to travel and testify and if
11 he passes muster and if that is still the case, then we
12 don't want to forfeit our right to cross-examine him on
13 these opinions just because other experts have been adopting
14 them.

15 Let me now turn -- so that's the parroting issue
16 and that's why we feel so strongly about these other experts
17 adopting Dr. Farquhar's analysis as their own without doing
18 the analysis.

19 I mentioned the adverse event reports. I think
20 Your Honor is pretty familiar with this general subject, so
21 I'm not going to spend a huge amount of time on it, but it
22 is very important.

23 Here what we have is the plaintiff experts seek to
24 rely on comparative rhabdo adverse event report reporting
25 rates for the opinion that Baycol was more toxic to muscles

1 than other statins and you heard Mr. Arbitblit say that,
2 well, there's a consensus, he claims, that Baycol is the
3 most toxic of the various statins.

4 And their reasoning for this, their expert's
5 reasoning, is that because Baycol had a higher rhabdo
6 adverse event report reporting rate that it somehow must
7 also cause more nonrhabdo injuries than other statins. And
8 that runs throughout the reports of Dr. Farquhar.
9 Dr. Austin does the same thing. And then that's parroted by
10 the experts who adopt Dr. Farquhar's analysis.

11 And we believe this proposed testimony of theirs
12 that's based on adverse event reports is inadmissible as a
13 methodological matter for two reasons:

14 First, the adverse event reports themselves are
15 inherently unreliable and the FDA itself, which administers
16 the Adverse Event Report System, has said that they cannot
17 be used for the purpose that the Plaintiffs' lawyers and
18 their experts try to use them here and that is to, number
19 one, establish causation and, number two, establish
20 differential safety between different statins with different
21 reporting rates. So the FDA says that that's a misuse of
22 the Adverse Event Report System.

23 And then secondly, and I hope this doesn't get
24 lost here, and that is, as I mentioned before, these are by
25 and large rhabdo adverse event reports and not myalgia

1 adverse event reports and therefore it's an extrapolation
2 from data that is itself unreliable without any basis for
3 doing so.

4 So let me give you some background on the Adverse
5 Event Report System. These adverse event reports are what
6 are called anecdotal reports. When somebody -- it can be a
7 nurse. It can be a doctor. It can be a patient. It can be
8 a plaintiff's lawyer.

9 When somebody says, gee whiz, here's a person who
10 experienced this event contemporaneously with taking this
11 medicine, they can send that in either directly to the FDA
12 or to the pharmaceutical company, which then passes it onto
13 the FDA, and that's an adverse event report.

14 So if you're taking Baycol and sprain your ankle,
15 you can get an adverse event report saying that there was an
16 ankle sprain while on Baycol. People are encouraged to
17 gather all this information without making judgments about
18 whether there was causation or not.

19 And they also report this without regard to
20 whether other medication, for example, is being taken or
21 whether there were other causes that could account for this.
22 Somebody who is taking Lipitor who experiences muscle aches,
23 they may have been taking Lipitor for two years. They
24 experience muscle aches one day and somebody sends in an
25 adverse event report, and on that same day they happen to

1 for the first time in five years go to the gym and work out
2 and lift weights for a long time, but the adverse event
3 report goes in anyway and that's how the system is devised.

4 Then the FDA collects this as part of their
5 postmarketing surveillance and what they do, the FDA as well
6 as the pharmaceutical companies, is they use this data to
7 generate signals to say, well, there's a bunch of adverse
8 event reports of this condition along with the drug.
9 There's all sorts of issues about the reliability of it, but
10 there's enough of these that it's a signal that we ought to
11 go out and do a scientific study and then you go out and do,
12 for example, an epidemiological study.

13 Mr. Lockridge said there aren't going to be
14 massive placebo controlled clinical trials. There actually
15 were some that we're going to report on. But there was an
16 epidemiological study that was done called PacifiCare at our
17 behest based on the signal that was raised by the adverse
18 event reports of rhabdomyolysis along with the use of
19 Baycol.

20 As I said, the adverse event reports themselves
21 are not verified. They're not even verified to see whether
22 someone is taking the medicine or not, let alone whether
23 there are -- there's no verification whether the adverse
24 event was real or not real. As I said, there's no causation
25 requirement at all.

1 This is what the FDA says on the absence of
2 causation requirement and the adverse event reports. This
3 is from the CFR. They have a disclaimer at the end where
4 they go on to say, A report or information submitted does
5 not necessarily reflect a conclusion by the applicant or the
6 FDA that the report or information constitutes an admission
7 that the drug caused or contributed to an adverse effect,
8 and then they go on and elaborate on that.

9 As I mentioned, the FDA has said itself that there
10 are limitations on how these things can be used and I want
11 to put up an important document on that issue, Your Honor.

12 What happens with adverse event reports is
13 somebody who wants to see all the adverse event reports from
14 Baycol or Lipitor or Zocor can file a Freedom of Information
15 Act request and then they get this information from the FDA
16 and the FDA sends out a cover memo. You are looking right
17 now at page 1 of the cover memo describing the information
18 that's being turned over.

19 And then page 2, this is caveats that the FDA
20 itself sends out when they release this information to
21 people who want it. And there they say, number 1, it's only
22 those reactions that have been voluntarily submitted or
23 reported; number 2, the information contained in the reports
24 has not been scientifically or otherwise verified.

25 And that's very important, Your Honor, because the

1 information is subjected to lots of different types of bias.
2 One form of that is how recently a drug came on the market.
3 And here's one of their experts, Dr. Austin, acknowledging
4 that.

5 "The newer the drug, the more likely it is that a
6 healthcare provider will make a voluntary report, correct?

7 "I believe that is correct.

8 "Two drugs could have the exact same safety profile, but
9 if one was introduced ten years ago and one was introduced
10 five years ago, you may observe a difference in the rate of
11 voluntary reports, correct?

12 "You may, and for a number of reasons."

13 MR. BECK: So how recently a drug came on the
14 market affects how often adverse event reports are sent in.
15 And Baycol was the youngest of all of the statins. That was
16 Dr. Austin acknowledging that.

17 There's also something called publicity bias,
18 which he also was asked about.

19 "Have you ever heard of the term 'publicity bias'
20 before?

21 "Yes.

22 "What is that, sir?

23 "My understanding of the term is that more spontaneous
24 reports would occur if, in fact, there was publicity
25 pertaining to that drug and its adverse events and adverse

1 events thought to be associated with it."

2 MR. BECK: So that's another reason that the FDA
3 and others recognize the limitation of these adverse event
4 reports. So they haven't been scientifically verified, as
5 paragraph number 2 said.

6 And paragraph number 3 specifically says, again,
7 that there's no causation requirement. It says, For any
8 given report, there is no certainty that the suspected drug
9 caused the reaction. This is because physicians are
10 encouraged to report suspected reactions. The event may
11 have been related to the underlying disease for which the
12 drug was given, to concurrent drugs being taken, or may have
13 occurred by chance at the same time the suspected drug was
14 taken.

15 And here we're talking -- ultimately the cases we
16 have left are myalgia cases. These are aches and pains by
17 old folks, so there's a million different reasons that that
18 can take place. Even by not so old folks we occasionally
19 have our aches and pains.

20 And they go on to say -- because of these
21 limitations, paragraph 4, the FDA says, Accumulated case
22 reports cannot be used to calculate incidence or estimates
23 of drug risk. And that's for a particular drug. They
24 cannot be used for that. And that is exactly what
25 Dr. Farquhar uses them for and exactly what Dr. Austin uses

1 them for.

2 And then they go on to say, Numbers of these data
3 must be carefully interpreted as reporting rates and not
4 occurrence rates. True incidence rates cannot be determined
5 from this database. But that's what their experts do.

6 And then the last paragraph -- or last sentence
7 here is extremely important, Your Honor. They say,
8 Comparison of drugs cannot be made from these data.

9 So they say, first of all, you can't draw safety
10 conclusions, causation; and secondly, you certainly can't
11 compare one drug to another based on these AERs. But that
12 is precisely what Dr. Farquhar has done, precisely what
13 Dr. Austin has done, and then precisely what all the
14 hangers-on do when they adopt Dr. Farquhar's analysis.

15 Now, courts -- and the parties have put the cases
16 in front of Your Honor. Courts have routinely excluded
17 expert testimony based on adverse event report data and this
18 is often true when the only question is whether -- is
19 general causation, i.e., is it possible for Baycol, for
20 example, to cause rhabdomyolysis, and courts have excluded
21 adverse event report data or opinions based on it because of
22 the limitation.

23 But there are courts that have allowed it in for
24 general causation, they say on that issue we'll allow it in,
25 but the courts have consistently excluded it where people

1 have tried to do what the Plaintiffs' experts have done
2 here, which is to say not only can I draw a causation
3 conclusion, but then I'm going to compare the adverse event
4 report rates for Baycol with the adverse event report rates
5 for different drugs and I'm going to make a judgment as to
6 which one is more likely to cause this, which one has a
7 greater risk. And that kind of attempted testimony has been
8 consistently excluded.

9 But here what they've done is they've gone a step
10 further and they say, okay, we're going to use adverse event
11 report data to establish causation, even though the FDA says
12 we should not, and we're going to use comparative adverse
13 event report data to say that Baycol is more likely to cause
14 rhabdo than other statins, even though the FDA says we
15 cannot.

16 And then we're going to do a third thing. We're
17 going to stop talking about rhabdo, as Mr. Arbitblit did,
18 and start talking about toxicity and we're going to take the
19 rhabdo adverse event reports and then we're going to change
20 the language that we use and we're going to talk about
21 muscle toxicity. And then once we've generalized it to
22 muscle toxicity, we'll pretend that it applies to aches and
23 pains and myalgia.

24 So we think that that is way over the top,
25 beyond any legitimate use of adverse event report data on

1 rhabdo, to then make a drug comparison on a different
2 condition.

3 And that's very important here, Your Honor,
4 because, as Mr. Ismail is going to get into in more detail
5 when his green light is on this afternoon, they really have
6 a theory here, their doctors do, that there's a different
7 mechanism at work with rhabdo and myalgia or these other
8 aches and pains.

9 But rhabdo involves, as Your Honor has heard so
10 many times, the destruction of muscle cells. And when
11 muscle cells are destroyed, a couple of things happen. One
12 is the cells destroy and these CK enzymes leak out into the
13 system and so you can measure and get these highly elevated
14 CK levels. And another thing that happens is myoglobin ends
15 up in the urine. And so we have destruction of muscle cells
16 as evidenced by these two things. Meanwhile -- and so we've
17 been settling all those cases.

18 And then there are a bunch of people who say that
19 their arm hurts, but that's not the same -- assuming that a
20 statin can cause that, it's not the same mechanism because
21 by definition they don't have the highly elevated CK levels
22 that come with destruction of muscle and they don't have the
23 myoglobin in the urine. If they did, we would have settled
24 their case because they would have had a different injury.
25 Instead we have a different condition which presumably,

1 according to their experts, results from a different
2 mechanism.

3 And so to say that we're going to stretch and
4 stretch and stretch and use adverse event reports in a way
5 that the FDA says we should not as to rhabdo and then from
6 that we're going to extrapolate to a different condition
7 that has a different mechanism we think is a completely
8 inappropriate methodology and doesn't pass the Daubert
9 standards.

10 So let me now turn more specifically to
11 Dr. Farquhar, and there's really two issues that we have
12 with Dr. Farquhar.

13 One is what he calls a meta-analysis of the
14 adverse event report data. Meta-analysis in this context,
15 Your Honor, means that he's taken not just the FDA database,
16 but a couple of -- you know, a worldwide database, an
17 Australian database, put them all together, and had somebody
18 else analyze it is what he did. So that's point number one.

19 And then point number two is what he's done with
20 the PacifiCare results where instead of just criticizing and
21 taking issue with the conclusions, he's manipulated the data
22 in a methodologically nonsensical way to try to come up with
23 a result-driven conclusion that fits the Plaintiffs' lawyers
24 theories.

25 First on his AER meta-analysis, as I said, he

1 combined data from several different databases. They all
2 have the same limitations that we have up on the screen and
3 very importantly, Your Honor, in none of these was the
4 principal focus myalgia or aches and pains. He's looking at
5 rhabdo information.

6 Now, maybe, in fairness, it was back when he
7 thought there were going to be or the Plaintiffs' lawyers
8 thought there were going to be a lot of rhabdo cases, but
9 there aren't anymore.

10 And so he's looking at adverse event reports from
11 different databases concerning rhabdo and then extrapolating
12 backwards somehow to myalgia and we have that same issue
13 that I just talked about, how that's inappropriate, and I am
14 not going to go through that again.

15 But in addition to that flaw, to the basic flaw of
16 using adverse event reports to compare medicines even if you
17 had the right injury, he's got other methodological flaws
18 that I want to talk about.

19 The biggest one is that whatever his credentials
20 are, in this case what he did was the antithesis of science.
21 In this case what he did was he concluded and accepted the
22 conclusion that Baycol is more toxic to the muscles than
23 other statins based on what other people had said and then
24 he turned around and analyzed the AER data as well as the
25 PacifiCare data in order -- in an effort to support that

1 conclusion. And the Eighth Circuit has said in the Sorensen
2 case that when you do that, which is clearly what he did
3 here, you stood science on its head.

4 Instead of testing a hypothesis and trying to
5 prove that the hypothesis is false, which is the scientific
6 method, instead what he did is he said here's the conclusion
7 that I'm supposed to reach and let me see if I can
8 manipulate the data in a way that supports the conclusion
9 that I'm supposed to reach; and that is the antithesis of
10 the scientific method.

11 Here's one place in his report, paragraph 43,
12 where he says basically what Mr. Arbitblit was arguing and
13 that is he claims the scientific community has reached a
14 consensus that Baycol is substantially more toxic than other
15 drugs in the same class.

16 And then -- and so then what he does, having
17 started with what he claims is this consensus, is he then
18 sets about in an effort to prove that that's true by
19 manipulating the data from the adverse event report
20 databases.

21 And so he uses the adverse event reports in a way
22 that the FDA says you cannot do, compare one drug to
23 another. Even as to rhabdo they say you can't do it, but
24 that's exactly what he does.

25 And he admits, meanwhile, that he doesn't have any

1 real experience with adverse event reports and how to
2 analyze them and what their limitations are prior to his
3 being hired to give testimony in this litigation.

4 I'm going to go through some of what he says about
5 his prior lack of experience with anything having to do with
6 adverse event reports.

7 "You've never had responsibility for collecting
8 spontaneous postmarketing adverse event reports on behalf of
9 any regulatory agency or any pharmaceutical manufacturer?

10 "No, I have not.

11 "You have not had any responsibility in any professional
12 capacity for coding spontaneous postmarketing adverse event
13 reports either for a pharmaceutical company or a regulatory
14 agency; is that correct?

15 "That is correct.

16 "You've not had responsibility in any professional
17 capacity for analyzing spontaneous postmarketing adverse
18 event reports on behalf of any regulatory agency or any
19 pharmaceutical company; is that right?

20 "That's correct, until being involved in this case where
21 the analysis of the AERS data and others was --

22 "Right.

23 " -- under my supervision.

24 "Right, I understand -- that's what I'm -- and let's
25 make sure we're clear. I'm talking about -- I'm not

1 including this case as answering that question. I'm talking
2 about prior to your involvement in this case you've not had
3 any responsibility in a professional capacity for analyzing
4 spontaneous postmarketing adverse event reports; is that
5 right?

6 "Correct.

7 "Have you ever conducted any study of two or more drugs
8 in the same class based on spontaneous postmarketing adverse
9 event reports prior to your involvement in this case,
10 whether the results were published or not?

11 "No.

12 "Had you ever before your involvement in this litigation
13 used the FDA's Adverse Event Reporting System database to
14 obtain numbers of adverse events for different drugs?

15 "No, I have not prior to this done research on drug
16 toxicity and comparisons among drugs using the Adverse Event
17 Reporting System.

18 "Do you know -- do you understand the way data are coded
19 in the FDA's adverse event database?

20 "Well, I really don't. You know, this was under
21 Dr. Ahn's -- he was directed to do the search.

22 "Okay.

23 "And I didn't look to see what the ingredients were
24 within the database in the sense that you're asking.

25 "Outside of the context of litigation, have you ever

1 done a meta-analysis of this type?

2 "On drugs?

3 "Yes.

4 "No."

5 MR. BECK: Then the last clip in this sequence I'm
6 going to show, Your Honor, has to do with his proportional
7 reporting rate analysis. This is one of the calculations
8 that he does and that he claims to rely on. And here's
9 where he's asked whose idea was this.

10 "Did Mr. Arbitblit suggest to you to do a proportional
11 reporting rate analysis?

12 "The idea of proportional reporting rates was given to
13 me in a telephone call by Mr. Black, and I don't remember
14 when.

15 "Okay. Had you ever personally done a proportional
16 reporting rate analysis prior to this date?

17 "I don't know that I had done it at this date, but --
18 no, I certainly have not.

19 "Is the first -- is it fair to say that the first time
20 you learned about proportional reporting rates was in
21 connection with your services as an expert in this case?

22 "That is correct."

23 MR. BECK: So, Your Honor, we have this threshold
24 question about whether it's appropriate to use adverse event
25 reports as they've been used here. We think it's not. But

1 if it could be used, if they could be used that way,
2 Dr. Farquhar is not the man to do it.

3 He has no acquaintance with the Adverse Event
4 Report System whatsoever. He didn't do the work himself.
5 There's some other person he said, Dr. Ahn I think his name
6 was, his assistant, he just turned the job over to him. He
7 doesn't know how the data is coded. He doesn't know how the
8 data was analyzed. He's never done the kind of calculation
9 that the lawyers told him to do and put in his report in
10 this case.

11 And so he's not the man who ought to be
12 manipulating the adverse event report data this way, if
13 anybody in the world could be allowed to do it.

14 One of the big problems with his manipulation of
15 the data is that, again, coming back to the scientific
16 method, the scientific method involves establishing a
17 protocol in advance for how data is going to be collected
18 and analyzed.

19 And it's very important to follow that. Otherwise
20 you can make it up as you go along in order to jigger the
21 results to come out the way that the people who hired you
22 would like them to come out.

23 And so it's important to have a written protocol
24 in science that lays out the steps in advance that are going
25 to be followed. It, number one, minimizes the chance that

1 you're going to manipulate the data as you go and, number
2 two, a written protocol allows other scientists to test your
3 thesis.

4 And that repeatability is also, of course, a
5 hallmark of the scientific method, where people should be
6 able to go to the same data and use your methods which
7 you've laid out and replicate the analysis and see whether
8 you are right or wrong.

9 And that can be a very important issue in
10 admissibility under Daubert and, in fact, that was one of
11 the factors that was emphasized by the Supreme Court in
12 Daubert.

13 Here's what Dr. Farquhar had to say on this key
14 question of whether there was a written protocol that he
15 used when he compared the adverse event report rates from
16 one drug to another.

17 "Well, the studies, right, the studies that you did that
18 are -- the results that are set forth in 8a and 8b, did you
19 have a written protocol for conducting that study?

20 "No, I didn't have a written protocol. I had a mental
21 protocol. I knew what search terms I was going to ask be
22 used.

23 "Okay. Well, that's my next question. What were -- so
24 there is no written protocol anywhere, just so I'm clear on
25 that?

1 "No, no written protocol. Dr. Ahn and the data and then
2 there's also a data tape. Okay?"

3 MR. BECK: So there's no way for us to tell
4 whether and how he changed the analysis along the way
5 because he never set forth his protocol. He just claimed to
6 have it in his head. But meanwhile he's not even the one
7 who did the searches, it was somebody else who did that.
8 And so we can't test his analysis, which you're supposed to
9 be able to do under the scientific method.

10 There's other problems with his analysis. For
11 example, because he uses these different databases, there's
12 overlapping data and there's double counting and he made no
13 effort to try to correct for that.

14 "Now, did you -- one of the databases on which you did a
15 meta-analysis was the FDA's U.S. adverse event reporting
16 database, right?

17 "Right.

18 "Another of the databases on which you did the analysis
19 was the FDA's worldwide reporting analysis?

20 "Right.

21 "Did you determine that there was -- did you attempt to
22 learn whether there was any overlap of cases between those
23 databases?

24 "There is overlap."

25 MR. BECK: So he knows there's overlap.

1 "Did you take steps to avoid duplication of individual
2 cases in your meta-analysis?

3 "There was -- no, I did not. There was no way to do
4 that with the information that we had available. We were
5 taking the data as given to us. Of course, when we went to
6 the -- what we have in Table 8, that was something where we
7 did the entire extracting of the cases and relating it to
8 the denominators, as we have discussed earlier."

9 MR. BECK: Your Honor, one of the problems with
10 the Adverse Event Report System, one of the reasons why you
11 cannot compare one drug to another is that different
12 pharmaceutical companies may take different approaches in
13 terms of how they report information.

14 A lot of these adverse event reports come from
15 doctors or nurses. They're sent to Bayer or Pfizer and then
16 Bayer or Pfizer makes a judgment on is this -- does this
17 fall, go in the rhabdo bucket, does it go in the myalgia
18 bucket, does it go in the myopathy bucket.

19 And there are no consistent standards used from
20 one pharmaceutical company to another. So you could have
21 exactly the same -- you could have 50 situations that are
22 exactly the same, all reported as rhabdo by one company and
23 reported as something else by another company.

24 So that's a known limitation of the system and,
25 again, Dr. Farquhar knew that that was a limitation, but

1 made no effort to account for it.

2 "Well, what I would like to say at this point is that
3 when I have used rhabdomyolysis or myopathy or myositis or
4 toxic myopathy or myalgia from the AERS data, I have to take
5 those terms at face value as they were used."

6 MR. BECK: And, Your Honor, it may be that there
7 is nothing that he could do to account for that, but that's
8 precisely one of the reasons why you can't use adverse event
9 report information to make comparative safety conclusions,
10 because there is no way to correct for that.

11 And the FDA recognizes that and uses the word
12 "cannot," that the information cannot be used for this
13 purpose, partly for that reason. And then he says, well,
14 there's no way that I can correct for it, so I used it
15 anyway for exactly the purpose the FDA says that I cannot.

16 I think I have already touched on the new drug
17 phenomenon. When a drug comes onto the market and it's the
18 new boy in the neighborhood, people are paying more
19 attention and more likely to report adverse events than they
20 are with drugs that they've been -- that have been on the
21 market for a long time. That, again, is an inherent
22 limitation and he did not properly take account of that
23 either.

24 As I said before, Baycol was the youngest of the
25 statins, so that effect was going to be felt most strongly

1 by Baycol. And what he did was he said, well, I looked at
2 it with Lipitor, which was around the same age, just a
3 little bit older than Baycol, and there was a difference
4 between Baycol and Lipitor, so I don't see that the new drug
5 phenomenon was much of a big deal.

6 And in doing that, that again is a flawed
7 methodology because you can't just compare it to one drug,
8 especially if you're going to say it is the most toxic of
9 all of the statins.

10 If you're looking to see whether there's -- you
11 know, the reporting rates in the first couple of years, you
12 have to look at all of the drugs, which is what the FDA did
13 and which he ignores.

14 This is an FDA table and if you can see up here on
15 the highlighted part, it's talking about cases of rhabdo in
16 the first two years of marketing and then it lists for
17 statin or fibrate as used as monotherapy. So they're trying
18 to take out gemfibrozil.

19 And then they have where my arrow is crude
20 reporting rate, which is basically the ratios that he relies
21 on. Cerivastatin, that's Baycol. There you have, you know,
22 5.96 and it's higher than the next two, but it's lower than
23 simvastatin. It's lower also than lovastatin. So it
24 basically ends up right in the mid range in terms of the
25 reporting rates for the first two years that it's on the

1 marketplace.

2 And yet Dr. Farquhar when dismissing the
3 phenomenon of the new drug effect chooses to just look at
4 one of the other drugs, of course one of the drugs that had
5 a lower rate, and he says when I look at that there's a big
6 difference and so these higher rates can't be due to a new
7 drug effect and he ignores all the other statins during
8 their first two years on the market. Again, it's a
9 methodological flaw that goes to admissibility rather than
10 to quibble with his conclusions.

11 Another --

12 THE COURT: Before you move on, you said something
13 earlier that caught my attention dealing with the adverse
14 event reports. You said that the reports came -- are
15 different depending on how the -- can't be compared between
16 drug companies because they report them differently and put
17 them in different categories.

18 Now, you made a big deal about adverse reports
19 coming into the FDA if someone took Baycol or took aspirin
20 and sprained their ankle, that an adverse report would
21 come in.

22 But does -- is there a screening process that we
23 have here that would take that kind of case out of the realm
24 of possibility because Bayer would get the category and get
25 the report and take a look at it and say, well, it doesn't

1 fit rhabdo --

2 MR. BECK: No, Your Honor, there's --

3 THE COURT: -- it doesn't fit --

4 MR. BECK: No. It would go in under sprained
5 ankle. So every adverse event report -- there are some, and
6 my understanding is it's a pretty small minority, that get
7 sent straight in to the FDA by people. The vast majority
8 get sent by doctors, healthcare workers.

9 THE COURT: So there is a screening process that
10 Bayer went through by taking a look at --

11 MR. BECK: There's a categorization process, but
12 there's not a process where Bayer says we got this adverse
13 event report, but we don't think it makes any sense because
14 it's a sprained ankle, so we're not going to send that on to
15 the FDA. That would be against the law. All the adverse
16 event reports that come in get sent to the FDA. What Bayer
17 would do is Bayer has, you know, established --

18 THE COURT: They would put them in categories.

19 MR. BECK: Would put them in categories, right,
20 and Bayer -- and there are no criteria imposed from on high
21 by the FDA to say, for example, here is the definition we
22 want you to use for rhabdo and if it meets these criteria
23 put it in the rhabdo pile. And so -- and what has happened
24 over time is definitions of "rhabdo" have changed and
25 evolved and different companies have used different

1 definitions.

2 And rhabdo is just one adverse event report out of
3 a large universe of possible adverse events and many others
4 have the same problem that rhabdo does, and that is there is
5 no precise, generally accepted definition that all
6 pharmaceutical companies adhere to and therefore there
7 are -- and it's not that anybody is doing anything wrong or
8 fudging.

9 THE COURT: I understand that.

10 MR. BECK: They just have different criteria. And
11 so because they have different criteria -- and yet they're
12 all doing their best to apply those criteria consistently.

13 So therefore you can get cases that are on the
14 margin of whether they would qualify as rhabdo or not and
15 depending on the approach to the criteria that a company
16 takes, they might all get swept into rhabdo, they might all
17 get excluded from rhabdo. And everybody is acting
18 aboveboard and being honest and doing their best. They may
19 not even know what one another's criteria are.

20 But that reality in life is one of the reasons
21 that the FDA says you cannot use these to compare drug
22 safety between one drug and another. So it's not -- no one
23 is doing anything wrong. It's just the realities of the
24 system mean that you can't -- it's point number 5, the last
25 sentence of the caveats, that it cannot be used for this

1 purpose. And yet, as I said, that's precisely the purpose
2 that they try to use it for here.

3 Another flaw in the methodology, Your Honor, is
4 the denominator. We've been talking about the numerator,
5 which is the number on top of the fraction $1/3$, and then
6 there's the denominator, the number on the bottom, the 3.

7 And so you're looking at how many cases of rhabdo,
8 however the particular company defines that, are being
9 reported and that is as a function of some other number, you
10 know, how many people are taking the medicine, and then you
11 come up with a reporting rate of whatever it is. So you
12 have to have a good idea of how many people are taking the
13 medicine in order to come up with that percentage or that
14 fraction.

15 The problem here, Your Honor, is that this -- this
16 is another reason why you can't compare one to another,
17 particularly with Baycol because it was the newest of the
18 statins and was trying to get a foothold in the marketplace,
19 lots and lots of samples were given out. And, in fact, when
20 they sued us in the rhabdo cases, they complained that we
21 overpromoted and gave so many samples away.

22 But the problem is that the reporting rates that
23 they use don't take account of the samples. It's based on
24 prescriptions that are filled by pharmacies rather than
25 samples that are given out by reps to the doctors and then

1 by the doctors to the patients.

2 And this is no small matter. I'm putting up here
3 Dr. Farquhar's report, paragraph 118. He says here
4 apparently Bayer's marketing of Baycol included distribution
5 of a very large absolute number and a percentage of free
6 samples in comparison to prescription purchases.

7 So the denominator is all fouled up because what
8 happens is if you have, you know, 5 cases of rhabdo and 100
9 prescriptions, then the way that Dr. Farquhar has done the
10 analysis, the rate is 5 percent.

11 But if you had 5 cases of rhabdo and 100
12 prescriptions and you also had 50 samples, those samples are
13 not included in his analysis. He's made no effort to
14 include those in the denominator.

15 And so the rate would go from 5 percent to
16 something less than 5 percent, which I can't figure out, but
17 it would get cut down because there's a larger universe that
18 it's being compared against. And he had to acknowledge that
19 that would affect the validity of his analysis.

20 "If there were a lot of people who should have been in
21 the denominator for analysis purposes who weren't in the
22 denominator because they received samples rather than
23 prescriptions, that would cause the reporting -- the adverse
24 event reporting rate for rhabdo for Baycol users overall to
25 be artificially higher; is that correct?

1 "It would be higher assuming that the reporting rate is
2 unaffected by samples versus prescriptions."

3 MR. BECK: So he acknowledges that it's going to
4 affect the reporting rate if, in fact, there are lots of
5 samples. And in his report he says that there's a large
6 number of samples both in absolute terms and as a
7 percentage. So that's still another methodological flaw in
8 his use of the adverse event reports.

9 And as I said, Your Honor, then once he does all
10 of that, he gets reporting rates basically for rhabdo, he
11 improperly compares reporting rates that are driven by
12 rhabdo for different medicines and then he says those must
13 apply to a different condition that has a different physical
14 mechanism from rhabdo.

15 So all of those are hopelessly flawed
16 methodological problems.

17 In terms of his PacifiCare approach, the
18 background here is that we're getting these adverse event
19 reports, "we" being Bayer, and Bayer sees that there is this
20 large number of adverse event reports and we use them the
21 way the FDA says you're supposed to use them and that is we
22 commission an HMO, you know, who has a big database showing
23 people who use different statins over time and what problems
24 they encountered, we commission them, PacifiCare, to do an
25 epidemiological study, a controlled scientific study. And

1 PacifiCare compared the rates of myopathy across statin
2 users in this large HMO. This is the basic finding of
3 importance from the PacifiCare study.

4 And, Your Honor, I don't know -- I think you'll
5 probably remember that we had big issues in the rhabdo world
6 where people were taking our medicine along with gemfibrozil
7 when we told them not to and we couldn't get them to stop.
8 And also people were starting on .8 when we told them not to
9 start on .8 and we couldn't get them to stop that either.

10 And so one thing we were interested in is what if
11 there is monotherapy, no gemfibrozil, at .4, which is
12 supposed to be the starting dose, what do the data show
13 there?

14 And this is what PacifiCare concluded doing an
15 epidemiological study, that there was no increase in the
16 risk of myopathy for Baycol monotherapy compared with other
17 monotherapy statins and hospitalization rates for myopathy
18 was not elevated for Baycol compared with other statins
19 except when gemfibrozil was used concomitantly.

20 So those are the key conclusions that came out of
21 a real-life epidemiological study that was done looking at
22 the health records of thousands and thousands of people.
23 Dr. Farquhar agrees that that's the conclusions that the
24 authors reached, but he says that there were flaws in the
25 PacifiCare study.

1 And, Your Honor, I want to say that we have no
2 quarrel with him criticizing the PacifiCare study if that's
3 what he is called to do, but what he has done is not simply
4 criticized the PacifiCare study and say here are some
5 important limitations and its conclusions cannot be taken at
6 face value. He's changed the results of the PacifiCare
7 result study and he has done so through arbitrary means that
8 are not -- again, don't follow scientifically proper
9 methodology.

10 Again, he worked backwards from his conclusion.
11 His conclusion, which he set forth, is that Baycol is more
12 toxic to the muscles than others and therefore let me see
13 how I can massage the PacifiCare data to come up with that
14 result.

15 And so he points out supposed flaws in the
16 PacifiCare data. One of them he says is, well, there's a
17 healthy person effect and he says that Baycol numbers may
18 not show the true extent of rhabdo because people who took
19 Baycol by and large were being switched from other statins
20 and therefore they must have been tolerant of statins
21 already. So we have statin tolerant people who are taking
22 Baycol.

23 That's an interesting hypothesis, but he didn't
24 test it in a scientific way and he just -- what he did is he
25 said there's a possibility for why it is that Baycol doesn't

1 look worse and because that's a theoretical possibility I'm
2 going to assign a number, 30 percent, and make an adjustment
3 with no basis at all for the number that he used to make the
4 adjustment.

5 And meanwhile the people who actually did the
6 PacifiCare study looked to see whether there was a healthy
7 person effect. And this is from the PacifiCare study.
8 Excuse me. I'm on the wrong page. There we go.

9 So he's saying, well, those who were on Baycol,
10 they switched, more of them switched to Baycol than switched
11 to other statins and switchers are going to be healthier
12 than nonswitchers, so Baycol got the benefit of that.

13 Well, the folks who did the PacifiCare study
14 looked at switchers regardless of which statin they were
15 started on and switched to and what they found, you'll see
16 over here, is ever switching HMG, being a statin. No and
17 the rate was .385. Yes and the rate was .359.

18 So they were basically indistinguishable in real
19 life and yet he assigns arbitrarily, with no scientific
20 basis, his own plug number to make an adjustment to make the
21 numbers come out his way. Again, that's a methodology
22 issue, not just disagreeing with his conclusion.

23 Similarly, he says, well, there may have been
24 misclassification of cases where people, you know --
25 PacifiCare, they probably made some mistakes in putting them

1 in the rhabdo category or the myopathy category or the
2 myalgia category.

3 So he says they probably made some mistakes and if
4 I assume that 10 percent was their error rate and they all
5 went in favor of Baycol, then the numbers come out against
6 Baycol.

7 So he says they probably made some classification
8 mistakes and without any effort to see whether those somehow
9 benefitted Baycol versus other statins, he just assigns a
10 plug number that drives the PacifiCare numbers in his
11 direction.

12 So what we've got -- and here's how he does this,
13 Judge. I'm scared because my yellow light is on and it
14 takes a few minutes to explain it.

15 THE COURT: You've got 19 minutes.

16 MR. BECK: Oh, okay. Well, then I'm starting to
17 get relaxed. I think I can do it in 19 minutes.

18 What he does is this is hopelessly circular and
19 bootstrapping. He says, well, Baycol is coming out just
20 like the other statins in the real-life epidemiological
21 study and I've already concluded that Baycol is worse, so my
22 theory is that there's a misclassification of results.

23 So how do I decide on what percentage correction
24 I'm going to make? Well, I'll go back to the adverse event
25 reports and I'll see that there's a difference in the

1 adverse event reports of a certain magnitude, so I will take
2 that differential and apply it as a correction to the actual
3 epidemiological study.

4 So he's taking these pieces of data and these
5 analyses and he is completing standing them on their head.
6 The function of the adverse event reports is to raise a
7 signal to do an epidemiological study to find out what the
8 real story is and the function of the adverse event reports
9 is not to make drug safety comparisons between two
10 medicines.

11 And so Bayer sees the adverse event reports,
12 doesn't know what it's from, is it from monotherapy, is it
13 from gemfibrozil, is it from .8, is it from some
14 combination. Let's do an epidemiological study and see. So
15 someone does an epidemiological study.

16 Dr. Farquhar is being paid by lawyers who don't
17 like the way it comes out, so he goes back to the AER in
18 order to come up with an adjustment to the epidemiological
19 study. And it's just not good science. There's no way that
20 that is proper scientific methodology.

21 The proper use of the adverse event reports is to
22 prompt somebody to do an epidemiological study. It is not
23 to change the results of an epidemiological study so that it
24 comes out the way that the people who hired you wished that
25 it came out.

1 So much of what I said about Dr. Farquhar applies
2 also to Dr. Austin. He is another epidemiologist and
3 biostatistician. He's got the same issues with misuse of
4 adverse event reports and making comparative drug safety
5 conclusions when the FDA says you cannot do that because of
6 the inherent limitations in the data.

7 He also goes into PacifiCare and instead of simply
8 criticizing it and saying you can't take it at face value,
9 he tries to change the results through a series of flawed
10 computations as well.

11 He did a couple of calculations. In fact, we saw
12 one of them already, the proportional reporting ratio. I
13 mean, here we have an epidemiologist who is coming in and
14 doing a proportional reporting ratio. This is when he's
15 using the adverse event report data and he's never heard of
16 this before.

17 Mr. Black, one of the lawyers for the Plaintiffs,
18 told him to do it. It wasn't -- he didn't sit down and say
19 what's the proper way to analyze the data. Mr. Black called
20 him up and said, I want you to analyze the data this way.

21 He had never done that in his life, he had never
22 analyzed data like that in his life, and he did it because
23 the lawyers told him to because the lawyers knew that if you
24 do that particular computation, it comes out their way.

25 So he's never done this computation in his life

1 and he does it only because a lawyer tells him to do it and
2 then he puts it in his report and that's the basis for his
3 conclusion that the adverse event reports can be used to
4 show difference in drug safety.

5 And on that one, Your Honor, there's a real irony
6 here that I want to touch on, if I don't get to cover the
7 other matters with him, on this witness. If you look
8 closely at this proportional reporting ratio, it's this
9 formula (indicating) and he has it in his report. But
10 here's the funny thing is it's rhabdo over all other adverse
11 events and then you compare that for Baycol on the top of
12 the formula, for one of the other statins on the bottom of
13 the formula. So rhabdo as a function of all other adverse
14 events.

15 And the core assumption in the formula that
16 Mr. Black came up with is that all other adverse events are
17 going to be the same for Baycol as well as for Lipitor. And
18 so that is a core assumption, which he admits is a core
19 assumption, in this formula of Mr. Black's.

20 Well, the problem is, of course, that then what
21 they do is they say in applying Mr. Black's formula, rhabdo
22 is more common with Baycol than it is with other statins.
23 Okay. If they had a rhabdo case, but they don't. They've
24 got a myalgia case.

25 And so then they extrapolate from that and they

1 say we can tell from this formula that because it's more --
2 it causes more rhabdo, it also must cause more myalgia and
3 more myopathy. But in the formula itself, the assumption is
4 that there is no difference because that's the denominator
5 under each thing.

6 So it's a crazy formula and, you know, that
7 happens when lawyers come up with the formulas instead of
8 epidemiologists. You come up with a formula that gives you
9 the answer that you want, but it doesn't make any sense
10 scientifically. And so that's a deep flaw in the
11 methodology.

12 Dr. Austin has got the same problems that
13 Dr. Farquhar does in terms of the new drug effect. He
14 recognizes that it exists, but he hasn't accounted for it.
15 Publicity bias, he recognizes it exists. He didn't account
16 for it. He didn't make any effort to account for any of the
17 biases that can creep in.

18 And, again, that's inherent limitations in the
19 data. That's why the FDA says don't use it this way. And
20 he uses it that way anyway without any effort to correct for
21 those things.

22 I went through the weird deal with his formula.
23 Once you get the lawyers writing the formulas you're going
24 to get the results you want, but they don't make any
25 scientific sense. So it's not a surprise that he never used

1 this formula in real life for any purpose other than writing
2 the report that Mr. Arbitblit and Mr. Black asked him to
3 write.

4 In terms of the PacifiCare data, while he does
5 slightly different types of computations, it's the same
6 basic methodological problem where he starts with the
7 proposition that Baycol is worse than other statins.

8 And then instead of simply criticizing PacifiCare,
9 he tries to manipulate PacifiCare data in order to support
10 that conclusion in ways that don't make any sense as a
11 matter of science or epidemiology.

12 For example, he says that, well, perhaps there are
13 false positives that account for the fact that Baycol .4
14 monotherapy, there's no difference there in myopathy between
15 Baycol and the other statins. So he assumes that there may
16 be false positives, but without any evidentiary basis for
17 that and without any methodology to establish what they
18 would be.

19 And similarly he says, well, maybe the reason they
20 come out the same is because of differences in exposure, how
21 long people were exposed. But, again, he doesn't have any
22 scientifically based methodology to make his corrections.
23 They're just plug numbers that he uses in order to change
24 the results.

25 For example, on the false positives, without any

1 basis at all he says, I just think I'll assign a 30 percent
2 number. And if I say that there's 30 percent false
3 positives, that changes the results more in line with the
4 way I think the conclusion should be. But there's no basis
5 for the 30 percent.

6 And then he assumes a correction of two to four
7 times once he does this with false positives. Again,
8 there's no basis for the false positive rates that he's
9 assuming.

10 Same thing is true for what he calls the
11 misclassification of exposure. He just inflates the Baycol
12 rate by 10 percent and he says I think there may have been
13 misclassification; and if so and if it's 10 percent and if I
14 combine that with my false positive 30 percent, why, voilà,
15 the results come out different and Baycol is worse.

16 So, Your Honor, for both of those gentlemen, they
17 may be highly credentialed, but that's not the end of the
18 inquiry. The Court, you know, tedious although it may be,
19 is really required to take a close look at the methodology
20 that they followed here.

21 They start with a fundamentally flawed methodology
22 of using adverse event reports in a way the FDA say they
23 should not be used and they use it not only to show
24 causation, but then to compare Baycol to other statins,
25 which the FDA says you should not do.

1 And all of that is for rhabdo and then they change
2 the term and call it a muscle toxicity. And by changing the
3 terminology they pretend that myopathy and myalgia must
4 follow the same course even though they're fundamentally
5 different mechanisms, if they result from statins at all.

6 And then the same kind of result-driven
7 methodology leads them to manipulate the PacifiCare data,
8 not just criticize the study, but to manipulate the data in
9 ways that are methodologically unsupported in an effort to
10 support their own conclusions.

11 Thank you, Your Honor, for your patience.

12 THE COURT: Thank you. We'll take a 15-minute
13 break, 15 minutes.

14 (Recess taken at 11:15 a.m.)

15 * * * * *

16 (11:30 a.m.)

17 **IN OPEN COURT**

18 THE COURT: Let's continue.

19 MR. BLACK: Good morning, Your Honor.

20 THE COURT: Good morning.

21 MR. BLACK: My name is Bert Black. I don't
22 believe I have appeared before Your Honor before, but I have
23 been involved in the case from the very beginning and I have
24 at least attended a couple of the earlier hearings.

25 I've prepared a PowerPoint on the adverse event

1 reporting issue and I certainly don't intend to go through
2 it slide by slide, but I think there are some slides that
3 will be helpful to the Court in understanding what's really
4 at issue here.

5 And in order to facilitate Your Honor's following,
6 if I might approach, we have a paper copy of it that we can
7 leave with the Court.

8 THE COURT: You may.

9 I'm going to give you the same amount of time I
10 gave Mr. Beck.

11 MR. BLACK: Which would be an hour and a half,
12 Your Honor?

13 THE COURT: Yes.

14 MR. BLACK: I will not be taking up that whole
15 time because Mr. Arbitblit will follow me on Dr. Farquhar
16 and then I will get up again and talk about Dr. Austin and
17 finally Mr. Lockridge will deal with the reliance issue.

18 THE COURT: We will -- what we'll do, we'll stop
19 at 12:30 for a luncheon break and start up again at 1:30.
20 So you will have an hour to -- I don't know how you want to
21 do that. How long is the PowerPoint going to be?

22 MR. BLACK: Might I suggest, Your Honor, just in
23 the interest of keeping things together, if we broke for
24 lunch at the end of my presentation on the adverse event
25 reporting, that would probably take us to about 12:00.

1 THE COURT: That's great.

2 MR. BLACK: And then Mr. Arbitblit could continue
3 in one piece.

4 THE COURT: We will break at 12:00 noon, then.
5 We'll break at 12:00 noon, I'm just telling my staff so I
6 can have my lunch available.

7 All right. Go ahead.

8 MR. BLACK: Thank you, Your Honor. I want to
9 really start off with trying to explain what the adverse
10 event reporting issue really is, and I'm going to go through
11 this rather quickly.

12 You have something called relative risk and then
13 we have relative reporting ratio or relative reporting rate;
14 it goes by different terms. But for relative risk you start
15 off with two populations that you're going to study,
16 population A, population B. You expose one to some
17 substance or give them a drug. The other one is unexposed.
18 And then you see what happens in terms of the development of
19 the disease. Here it's the dreaded yellow circle disease.

20 And if you count up the dots, there are 50 dots or
21 50 people in each population. In the people that were
22 exposed, there were 8 cases of yellow circle disease. In
23 the other population there were 2. So you get 8/50 divided
24 by 2/50 and you get a relative risk of 4. A relative risk
25 greater than 2 has been held by a number of courts to be

1 strong evidence of a causal relationship.

2 And I do want to add a note here that I was
3 dealing just with the number of people in each population.
4 Epidemiologists actually allow for the fact that some people
5 are exposed more than other people. If one person is
6 exposed for six months, that would be considered a half a
7 person-year. One person exposed for two years would be two
8 person-years.

9 And so they use this concept of person-years in
10 the denominator instead of just the number of people to
11 account for the fact that some people are exposed for
12 different amounts of time than others.

13 Now, the problem when you're dealing with adverse
14 event reports is, first of all, we don't have all the
15 reports -- excuse me -- all the cases come in. Estimates
16 are that something less than 10 percent of the adverse
17 events that actually occur in a population get reported as
18 adverse event reports.

19 Not only that, you don't have an idea of what your
20 denominator was either in terms of person-years or people.
21 But you can approximate the denominator by using
22 prescription data. It makes sense that the more people who
23 take a drug, the more prescriptions there are going to be.

24 I would like to address one of the points raised
25 by Mr. Beck in terms of sampling. That might have been an

1 issue earlier on with Baycol, but the differences that were
2 seen by the experts who went through the adverse event
3 reports persisted.

4 And so the sampling might have been there early on
5 when they were trying to develop market share, but the same
6 problem persisted throughout the time the drug was on the
7 market. So I don't think the sampling problem in terms of
8 using prescriptions as a denominator really applies here.

9 What you do, then, is you take the number of
10 adverse event reports for a given period and you divide by
11 the number of prescriptions for the same period, recognizing
12 that the prescriptions are a reasonable approximation of
13 person-years of use. And what you come up with is something
14 called the reporting rate ratio, the reporting rate for
15 Drug A over the reporting rate for Drug B.

16 And I've gone through an example here, a numerical
17 example. All the bases for the example are in the
18 PowerPoint, but you can have a reporting rate of 20 reports
19 per 100,000 prescriptions, recognizing that we probably have
20 something like 1/10th or less of all the cases that really
21 occurred. And then if you knew the actual incidence rate,
22 it might be something -- in my example here, 40 cases per
23 1,000 patient-years. Now, in the example I'm assuming that
24 we know both the reporting rate and that we have the actual
25 incidence rate.

1 And by the way, another point that Mr. Beck
2 raised, he said that we were using adverse event reports to
3 calculate incidence rates, which you can't do. And
4 obviously you can't because you're only getting 1/10th or
5 less of all the cases. So you're not going to get an
6 accurate incidence rate that way.

7 No expert for the Plaintiffs in any way ever tried
8 to approximate an incidence rate with adverse event reports.
9 What you can do is divide one reporting rate by another
10 because then the incidence problem goes away. That's what
11 we did.

12 In any event, that's Drug A. You can have similar
13 data for Drug B and then you can do a comparison of the two.
14 You do a relative risk, A versus B, of 1,000 cases over
15 25,000 patient-years versus 100 cases over 12,500
16 patient-years and you come up with a relative risk of 5.

17 Now, if you do it in terms of the adverse event
18 reports and do a reporting rate ratio, you have 100 adverse
19 events -- that's 1/10th of the 1,000 cases -- per 500,000
20 prescriptions and Your Honor can follow the math, it comes
21 out to 5 again, lo and behold.

22 Now, in order for that to happen -- that shows, by
23 the way, that you can use the relative reporting ratio or
24 the reporting rate ratio as an approximation of relative
25 risk. That's what our experts did.

1 What conditions have to apply for you to be able
2 to do that? Well --

3 THE COURT: Excuse me for a second. Lori, is this
4 too fast?

5 COURT REPORTER: No, it's okay.

6 MR. BLACK: Excuse me?

7 THE COURT: Just making sure that you weren't
8 talking too fast.

9 MR. BLACK: I'm sorry, Your Honor. I'm trying to
10 fit a lot into a limited amount of time. Please do slow me
11 down because I do talk fast.

12 THE COURT: She will.

13 MR. BLACK: Thank you, Your Honor.

14 What conditions have to apply? First of all, the
15 percentage of reporting, whatever it may be, 4 percent,
16 5 percent, 10 percent in my example, has to be roughly the
17 same for both drugs and the ratio of patient-years to
18 prescriptions has to be roughly the same for both drugs.

19 Important point. The bigger the reporting rate
20 ratio, the less exactly these conditions have to be met
21 for you to make some reasonable conclusions from your
22 analysis.

23 Just like big bold print is easier to read, if
24 you've got a real big signal coming through in your
25 reporting rate ratio, things don't have to be as precise as

1 they would be for a smaller signal.

2 Now, let me go on here. This is a document, it's
3 Exhibit 11 to the Arrowsmith-Lowe deposition, but it's a
4 report -- not a report. It was a study that was done by
5 Bayer. And the point is that they were doing reporting rate
6 ratio. That's what's shown here.

7 If Your Honor looks, there's a column that says
8 atorvastatin. Let's see if I can point here. I guess I
9 can't do -- yeah, here we go. There's a column that says
10 atorvastatin.

11 They used patient-years because they do a multiple
12 that -- but it's based on prescriptions. They approximated
13 patient-years with prescriptions and they wound up with .2
14 cases per 100,000 patient-years.

15 And for Baycol, cerivastatin, it was 2 cases per
16 100,000 patient-years. Well, 2 divided by .2 gives you 10.
17 That number right there, Your Honor, is a reporting rate
18 ratio. That's what Bayer did. So it's a method that Bayer
19 itself used to consider what the effects of Baycol might be
20 in terms of myopathies.

21 And this is just some quotes from the report.
22 I'll bypass that.

23 Here's Bayer's arguments on adverse event reports
24 and the reporting rate ratio. Especially with regard to
25 Dr. Kapit, they're arguing that adverse event reports aren't

1 good for anything, can't use them at all.

2 Dr. Kapit, as I'll explain later this afternoon,
3 was essentially just giving opinions about whether or not
4 there was a signal at certain points in time. He isn't
5 primarily an expert on causation.

6 So by criticizing his reliance on adverse event
7 reports, I assume that Bayer is saying you can't use them
8 for anything at all. I guess we are just wasting our
9 taxpayers' money collecting them.

10 Then they say -- and this is what Mr. Beck
11 addressed -- that you cannot use a reporting rate ratio to
12 determine if there's a difference between two drugs in terms
13 of the rate of occurrence of a disease.

14 And even if maybe you can do that for a disease
15 like rhabdomyolysis, you certainly can't do it for the
16 lesser myopathies.

17 I think those are the three steps to Bayer's
18 argument. I'm not going to go -- this is just an outline of
19 our response.

20 What I would like to start with is that numerous
21 courts have recognized the value of adverse event reports,
22 but no court has considered the reporting rate ratio.
23 There's no precedent on that at all. We are going to have
24 to go take a look at the scientific literature.

25 But to briefly go through some of the cases, a

1 number of courts have recognized that even considered
2 anecdotally, even just using a single adverse event report
3 or a small group of adverse event reports, not this kind of
4 statistical analysis that we did here, even that limited
5 number of adverse event reports can provide sufficient
6 evidence for an expert to give opinions.

7 The Neutraceutical Corporation case, it's an
8 administrative law case, but adverse event reports were a
9 big part of the evidence the FDA considered in banning
10 ephedra.

11 There's a number of other cases here. I won't go
12 through them in any detail. I will say that -- where is it?
13 Here they are -- a number of the cases that Bayer relies
14 upon happen to be cases that arose in the context of
15 litigation over a drug called Parlodel.

16 And some courts held that testimony based on
17 adverse event reports would be excluded. And this, again,
18 is the anecdotal use. This isn't the reporting rate ratio.
19 And some courts held that such testimony was, in fact,
20 admissible.

21 The Globetti case from the Northern District of
22 Alabama is one that held that this testimony was admissible
23 and the judge in Globetti cited the Kittleson case from the
24 District of Minnesota.

25 That's an unpublished decision, but it was another

1 case in which adverse event reporting data was considered to
2 be admissible as a basis for expert testimony. Again, a
3 limited number of reports. And then there's another case
4 that was also cited there.

5 The bottom line on adverse event reporting case
6 law, Your Honor, is that no court has yet considered the
7 reporting rate ratio.

8 And there's two cases that are cited by Bayer and
9 I do have to address them. The Doe case involved claims
10 about -- it's a drug that had a preservative in it called
11 thimerosal, I believe. In any event, the substance was
12 taken out of the drug and then the expert did a comparison
13 of adverse event reports for the drug with the substance in
14 it and without.

15 First of all, our comparisons of adverse event
16 reports were contemporaneous. This was subsequent. And
17 there's all sorts of methodological problems because of the
18 changes that took place there, some of which involve some of
19 the publicity that Mr. Beck talked about.

20 But in any event, we're not sure what methodology
21 the expert used in the Doe case. The court in excluding the
22 testimony noted that the Institute of Medicine had
23 criticized the lack of transparency in the statement of the
24 expert's methods. No evidence in that case that there was a
25 reporting rate ratio done.

1 And then the other case is the Meridia case. The
2 Meridia case didn't involve reporting rate ratio. It
3 involved this proportional reporting rate ratio that
4 Mr. Beck described to you and about which I will talk more
5 in a little bit, but it wasn't RRR.

6 So what we're left with is we have to consider
7 what the scientific literature says about reporting rate
8 ratio, what the logic of the method is. And I think I've
9 outlined the logic pretty clearly. I hope that I've
10 explained that adequately.

11 Let's take a look and see what the literature
12 says. There's an article by Pierfitte. The conclusion is
13 the ratio of reporting rates approximates the ratio of
14 actual risks. That's exactly the point we're making. That
15 validates the method.

16 And there are a number of other examples. There's
17 the letter that Staffa, et al., submitted to *The New England*
18 *Journal of Medicine* on Baycol, a peer-reviewed publication,
19 and they used the reporting rate ratio.

20 And from this they concluded that the increased
21 reporting associated with the use of Baycol appears to be
22 more than an artifact related to an increased awareness of
23 statin-associated rhabdomyolysis or to secular trends in
24 reporting.

25 So that's the method that the FDA used. That's

1 the method that served as the basis for withdrawing the drug
2 from the market.

3 Here's an article by Psaty, et al. This is the
4 point that I was trying to make earlier, Your Honor, when
5 you have a reporting rate ratio as high as we've seen here.
6 Given the highly elevated RRRs for Baycol, the usual
7 limitations of AER data were largely overcome.

8 This article by Pasternak, et al., that's several
9 very prestigious organizations, American College of
10 Cardiology, American Heart Association --

11 COURT REPORTER: Wait a minute.

12 MR. BLACK: Too fast?

13 COURT REPORTER: Too fast. Several very
14 prestigious organizations, start over after --

15 MR. BLACK: -- American College of Cardiology,
16 American Heart Association, National Heart, Lung, and Blood
17 Institute.

18 The point here is after Baycol goes off the market
19 there's concern about statins and so these three
20 institutions get together and they want to compare the
21 safety of the other statins.

22 And they say all the other statins are just about
23 as safe, one is about as safe as the other. What do they
24 base that on? Adverse event reports. So you can use
25 adverse event reports to compare the safety of drugs.

1 That's exactly what the National Heart, Lung, and Blood
2 Institute did.

3 There's an article by Bays which indicates that
4 adverse event reporting data is a highly reliable form of
5 data.

6 An article by Chang, again, from the FDA. This
7 one in -- this is Chang and staff and others in their
8 official capacity.

9 And Wiholm on spontaneous reporting systems
10 outside the United States, again, verifying the use of the
11 method.

12 Okay. Mr. Beck relies heavily, Bayer relies
13 heavily on the FDA caveats about adverse event reports.
14 Let's go through the caveats.

15 The medicine in the AER may have had nothing to do
16 with the reported event. That's true enough, but that's
17 going to be true -- if you are comparing two drugs, that's
18 going to be true for both drugs if you are comparing adverse
19 event reports.

20 And to the extent that that's a problem, it biases
21 the comparison towards unity in favor of Bayer in the
22 current situation and here's why that would be. If you
23 start out with cases related to the statin for two drugs,
24 you might have 5 with one and 30 for the other. And if you
25 take the unrelated cases, they're going to be about the same

1 for both. Let's say that there's 25 unrelated cases.

2 So here for purposes of this example I assumed
3 200,000 prescriptions for each drug. Then you get a
4 reporting rate ratio of 6 for the related cases and less
5 than 2 because it's biased downward because of the other
6 cases. The point here is, Your Honor, that if that's a
7 problem, it favors Bayer, it doesn't favor us.

8 Underreporting and biases, again, true enough, but
9 there's no reason to believe that there was any bias in
10 favor of reporting Baycol events; and the articles by Psaty,
11 et al., and Chang make that point.

12 Publicity bias. Again, the comparison with
13 Lipitor shows both in terms of temporal comparisons -- in
14 terms of publicity bias, you could compare Lipitor to Baycol
15 and show that that problem didn't exist.

16 Now, if you want to test the hypothesis that there
17 wasn't any problem because of reporting bias or lack of
18 being at the same time, Lipitor is the best comparison
19 because that's a contemporaneous period.

20 Going back and comparing the first year of the
21 drugs, the first year one may have occurred in 1997 and
22 another occurred in 2000 or whenever it was. That's got a
23 whole set of other problems attached to it.

24 So verifying the hypothesis about there being no
25 problem with those biases, the best comparison is with

1 Lipitor alone.

2 New drug bias. Again, comparing with Lipitor,
3 I've already explained that.

4 Variability in coding, the point about which Your
5 Honor asked a question, that doesn't make any difference
6 because -- let me try and explain how the system works and
7 the MedWatch form comes in.

8 And I think we have an example maybe we can put on
9 the screen. My monitor here isn't working. I don't know if
10 we can do that. It's not letting me switch back and forth,
11 so let me just --

12 THE COURT: You can.

13 MR. BLACK: Let me just --

14 THE COURT: You can switch back and forth.

15 MR. BLACK: The light isn't on to let me do that,
16 Your Honor.

17 THE COURT: There's another monitor down --

18 MR. BLACK: Okay. Well, let me just do it this
19 way in the interest of time. There's some MedWatch reports.
20 There's an example. This is the way the system works, Your
21 Honor.

22 Your Honor will notice that on the left-hand side
23 there's a block number 5, describe the event or problem. It
24 says please refer to the next page in this case. But in any
25 event, what goes there is the problem that comes into the

1 company. A doctor calls up. The description that the
2 doctor gives has to go virtually verbatim in that block.

3 Then if Your Honor will look over to the right,
4 there's a block number 4 that says diagnosis. Okay? And
5 then -- in any event, there's a block here and I'm not
6 finding it where -- the classification of the adverse event,
7 there's a block available to do that. The company doesn't
8 have to fill that in at all. That can be left blank.

9 And the reason is that when these reports go into
10 the FDA, the FDA looks at the coding and then recodes based
11 on the description, the raw data that came into the company.
12 It's got nothing to do with what the company did to the
13 data. It's the raw information that came into the company
14 the FDA recodes, if necessary. So there's uniformity.
15 Everything in the AER system was effectively coded by the
16 FDA.

17 And lest there be any doubt about that, that's
18 what Dr. Arrowsmith-Lowe says. Who puts the information
19 into the form? Well, the company. It can be modified by
20 the agency? Right, correct. That's what happens.

21 And, Your Honor, with regard to Baycol, you could
22 look at the Clintrace system, the internal collection of
23 adverse event reports, the way the company coded it, and you
24 can compare that with what's in AERS.

25 And I'm not sure of the exact number. I think

1 it's 10 or 12 examples that we found of where Bayer would
2 code something based on the description as muscle pain and
3 then the FDA would recode as rhabdomyolysis.

4 So in the Bayer system it would -- there's nothing
5 wrong with this, by the way. We're not accusing Bayer of
6 doing anything wrong. They sent the report in. They didn't
7 have to code it at all. But when the FDA saw it, they
8 called it rhabdomyolysis. They actually did some recoding.
9 So for all companies the coding is uniform and that problem
10 just simply does not exist.

11 Lack of scientific review or verification, to the
12 extent that there's that problem, it again is one of those
13 things that would bias towards unity.

14 Can't be used to calculate incidence rates, well,
15 we certainly agree on that. I think I covered that right up
16 front. You're only going to have an incidence rate that
17 would be about 10 percent or less of what it should be. But
18 you can when you compare and do the relative reporting rate
19 or reporting rate ratio. That washes out.

20 Can't be used for drug comparison, well, maybe as
21 a general rule, but certainly not when you're doing RRR.
22 And, in fact, the FDA itself recognizes that comparisons of
23 reporting rates can be valuable, particularly across similar
24 products -- that's what we have here, all statins -- or
25 across different product classes prescribed for the same

1 indication. That's certainly what we have here.

2 The leading treatise on pharmacoepidemiology
3 recognizes that with adverse event reports and prescription
4 data, comparisons can be made to approximate relative risk.
5 So this isn't something that we've cooked up. It's
6 something that the FDA recognizes, you can do the drug
7 comparisons.

8 The RRR is valid and reliable for determining
9 causation of both rhabdomyolysis and lesser myopathies.
10 I've got some slides on this.

11 Basically what happens is that you have a
12 continuum of injuries and everybody recognizes that these
13 are all essentially the same family of injuries. It's just
14 a question of degree of seriousness, with rhabdomyolysis at
15 the top and other muscle injuries at the bottom.

16 And rhabdomyolysis -- if you have people taking
17 statins who contract rhabdomyolysis, it almost certainly was
18 from the statin. So your comparison there is very precise.
19 It gets less and less precise because there are, as Mr. Beck
20 pointed out, other causes for some of these lesser muscle
21 injuries.

22 But what comes out here is that the signal is so
23 strong that despite the fact that you've got those other
24 sources which bias you towards unity, despite all that you
25 still see a signal coming through.

1 And I want to let -- Mr. Arbitblit is going to
2 address some of these issues, too, in connection with his
3 discussion of Dr. Farquhar. I will discuss the PRR a bit
4 more when I talk about -- the proportional reporting rate
5 ratio -- when I talk about Dr. Austin.

6 I want to make one thing clear, Your Honor. I
7 didn't cook that up. It comes straight out of
8 Dr. Farquhar's -- Dr. Strom's book. Their expert's book
9 discusses the proportional reporting rate ratio. And as a
10 matter of fact, it's one of the methods for analyzing
11 adverse event reporting data that's recommended by the FDA
12 in its guidance document on pharamcovigilance. And I will
13 talk about that a little bit more when I discuss Dr. Austin.
14 I may have suggested to experts that they look at these
15 sources to see if it might be a method that would be
16 applicable in this case. I sure as the devil didn't cook it
17 up.

18 And with that I will turn it over to
19 Mr. Arbitblit, who will talk about some of these same issues
20 and others in the context of Dr. Farquhar.

21 THE COURT: Should we stop here?

22 MR. BLACK: Yes, I guess at this point we should
23 stop, I having suggested that originally.

24 THE COURT: Let's stop here and we'll start up
25 again at 1:00.

1 (Lunch recess taken at 11:55 a.m.)

2 * * * * *

3 (1:00 p.m.)

4 **IN OPEN COURT**

5 THE COURT: All right.

6 MR. BECK: Your Honor, before Mr. Arbitblit assumes
7 the con, I am happy to report --

8 MR. ARBITBLIT: As in pro and con, you mean?

9 MR. BECK: That's right.

10 MR. ARBITBLIT: Thank you.

11 MR. BECK: I am happy to report that the one case
12 that was mentioned this morning that was a rhabdo case in
13 Phase I and Phase II that was close to being settled has
14 been settled. So that case is now off of the docket.

15 And also, Your Honor, violating the BlackBerry
16 rule, but I can read, if you would like, a two paragraph
17 explanation about the settlement with the states.

18 THE COURT: Please.

19 MR. BECK: This, I understand, comes from -- was
20 adapted from a standby press release. I have to get it at
21 exactly the right distance so that I can read the small
22 type.

23 Bayer Corporation entered an agreement with
24 attorneys general of 30 United States states and/or
25 commonwealths to resolve concerns regarding the company's

1 promotional and marketing practices for Baycol. Under the
2 terms of the agreement, Bayer will pay \$8 million to be
3 shared among the signatory states and/or commonwealths.
4 Bayer has also agreed to register all nonexploratory Phase 2
5 and all Phase 3 and 4 Bayer sponsored clinical studies on
6 ClinicalTrials.gov when those studies are initiated and post
7 summaries of clinical study reports from all Phase 2
8 exploratory and nonexploratory, Phase 3 and Phase 4 trials
9 on ClinicalStudyResults.org for all Bayer products that are
10 approved for marketing in the United States. Bayer will
11 post links to these websites prominently on the Bayer home
12 page. States entering this agreement will terminate their
13 respective investigations regarding these matters.

14 THE COURT: So that's just not specifically
15 pertaining to Baycol, it's --

16 MR. BECK: It was -- the investigations pertained
17 to Baycol and as part of the agreement Bayer agreed to do I
18 think what it was already in the process of doing, which is
19 to post all the clinical trials on these government websites
20 so that people can look at the data; and that would be
21 obviously for products other than Baycol.

22 THE COURT: All right.

23 MR. ARBITBLIT: May I begin, Your Honor?

24 THE COURT: You may.

25 MR. ARBITBLIT: May it please the Court, I also

1 have a PowerPoint that's quite lengthy and I will try to go
2 through it as quickly as you would like and I will hand one
3 to Mr. Beck.

4 Your Honor, I will not spend much time on
5 credentials since Mr. Beck essentially said they were
6 qualified, but I do want to point out just a couple of
7 things about Dr. Farquhar since the Court has not had any
8 opportunity to meet with him. It will only take a minute of
9 the time.

10 Dr. Farquhar is 80 years old. He's been a
11 physician since 1952. He is a distinguished scholar. He
12 has received a series of awards for pioneering achievements
13 in health primarily relating to his work on preventive
14 cardiology, which is the study of how to keep people from
15 getting heart disease in the first place, including awards
16 from the National Cholesterol Education Program for lowering
17 cholesterol, a research achievement award from the American
18 Heart Association, and recently the Fries award for
19 promoting public health.

20 He has been a fellow of the AHA --

21 MR. BECK: It's not coming up on the screens.

22 MR. ARBITBLIT: I'm sorry. Thank you for the
23 courtesy, Phil.

24 MR. BECK: Sure.

25 MR. ARBITBLIT: I apologize, Your Honor. I've

1 been telling people all week that I'm a low tech person. I
2 will try to do better. Is this going to eventually come on
3 or do --

4 MR. BECK: I've been telling everybody I'm a high
5 tech person. I think you need to do -- I'm a high enough
6 tech person to call up the guy who really knows what he is
7 doing.

8 MR. ISMAIL: It's the function key.

9 MR. ARBITBLIT: Thank you very much. I appreciate
10 it.

11 In any case, Dr. Farquhar has addressed Ninth
12 Circuit judges on issues of cardiovascular health; a member
13 of the World Health Organization continuously since 1984,
14 expert panel on cardiovascular diseases; over 200
15 publications.

16 One of his principal works has been the Stanford
17 Five City Project, which helped communities learn how to
18 protect themselves against heart disease by lowering risk
19 factors. And that program has been the model for the
20 Minnesota Heart Health Project, where he is a member of the
21 advisory board for 13 years. That's a sister project.

22 And as far as his previous testimony, in 50 years
23 he's served as an expert witness in only three cases, which
24 I don't think qualifies him as a hired gun, and in the two
25 prior cases where he's been challenged his opinions were

1 permitted.

2 I think that it's fair to say that this is not a
3 person whose character speaks of concocting things for
4 litigation, but instead is a person of distinguished
5 character who has devoted his life to serving the public.

6 And with that, I'll proceed to the substance of
7 this presentation.

8 Now, in summary, the methodology that was used was
9 reliable because Dr. Farquhar relied on multiple, consistent
10 sources, not only on the adverse event reports that were
11 discussed this morning.

12 And I did hear that we were going to get something
13 from Bayer about clinical trials. Maybe that's yet to come,
14 but I haven't heard anything about it yet. But we will
15 present what some of that data shows that's in the reports
16 and the documents.

17 The literature review showing unanimous conclusion
18 of the scientific community that Baycol is more toxic, we
19 will go through 18 separate sources on that.

20 Epidemiology studies that have been done since the
21 reports confirm the findings that were made and the
22 reporting ratio study that followed peer-reviewed methods,
23 the same methods applied by Dr. Staffa and her FDA
24 colleagues, who have subsequently published in their
25 official capacity a very similar analysis.

1 So we have clinical trials, the gold standard for
2 proof of causation. And Bayer's clinical trials showed, in
3 summary, that there was more rhabdomyolysis than other
4 statins, greater CK elevations than other statins, more
5 myalgia than placebo patients.

6 There were no direct comparisons to other statins,
7 but the import of that is that it's distinct from what
8 appears on the label and then gets into the literature, that
9 there's no difference between Baycol and placebo for
10 myalgia; and we will go through that data.

11 Dose-responses, one of the hallmarks of causation.
12 If you are exposed to a higher dose and you have more of the
13 disease, it's presumed by scientists that that shows
14 causation; and we will show the data on that.

15 And statistical significance indicates the
16 reliability of the data, that it was not due to chance.

17 So another -- some other things that were not
18 shown or discussed by defense counsel that were raised by
19 Dr. Farquhar as additional sources of his opinions:

20 An epidemiology study from the general practice
21 research database in Great Britain where the medical records
22 were reviewed showing Baycol was more toxic than other
23 statins despite lower doses.

24 PacifiCare, which has been challenged in terms of
25 what Dr. Farquhar's interpretation was. However, we will

1 show that his analysis followed exactly the recommendation
2 of Bayer's own head of regulatory affairs, Dr. Posner, and
3 that subsequent studies have used the same methodology in
4 terms of person-years rather than simple percentages in
5 published peer-reviewed articles, validating the methodology
6 that Dr. Farquhar used.

7 So the reporting rate study itself used the Staffa
8 method and this relative reporting ratio that Mr. Black
9 addressed. That was not litigation driven and her
10 conclusions have been accepted as estimated incidence rates,
11 for example, in the Thompson JAMA article of 2003. That's a
12 quote from what he described in that.

13 In other words, as Mr. Black was saying, under the
14 circumstances unique to this case, where you have such an
15 excessive risk compared to what you would expect with other
16 drugs or background, there are -- if you're arguing about
17 what's on the margins, you might not want to do what they
18 call a rigorous comparison. If you're talking about 1.5
19 versus 1 or 2.0 or 3, as the Psaty and Furberg article said,
20 those would be places you wouldn't go on a relative
21 reporting ratio.

22 But when you're talking about 16 to 80 times, the
23 peer-reviewed literature calls that clearly excessive and
24 accepts the Staffa findings as the equivalent of
25 epidemiology studies; and that's -- I'll show you where that

1 is in one of the 2006 publications.

2 So the idea that Dr. Farquhar started from a
3 conclusion is turning science on its head. Dr. Farquhar
4 read the literature, which established a consensus. And
5 that's a good place to start, Your Honor, because a
6 consensus shows that people have already looked at this and
7 come to some decisions. Dr. Farquhar didn't start that
8 process. He read the literature that showed it and what's
9 happened since is that it's been confirmed even further.

10 Now, Mr. Beck -- I don't want to talk a lot about
11 Vioxx, but I am involved in that litigation and I know
12 Mr. Beck from that litigation. I'll just briefly say that
13 in the Vioxx case there's been a document introduced after
14 Vioxx was off the market which the defense uses to try to
15 show that there's no difference between COX-2 inhibitors in
16 terms of cardiac arrest.

17 And we dispute what the import of that is, but the
18 point I'm making here is that's been introduced by them
19 because it helps their case, they think, to show that the
20 FDA is not sure which drug is worse out of the COX-2 class.

21 There's been nothing like that presented here,
22 Your Honor. There is nothing in the published literature
23 that says Baycol is on a par with the other statins. All of
24 the literature, as we'll show, says more toxic, more toxic,
25 more toxic.

1 Here are the peer-reviewed studies and I will show
2 you that this same analysis was done not just by
3 Dr. Farquhar, but by the defense consultant, Mr. Loutanbach,
4 whom I mentioned earlier, who is a consultant with their
5 testifying expert, Dr. Strom.

6 And of course they criticize Dr. Farquhar for
7 working with an assistant, but Dr. Strom did the same thing.
8 He didn't do all the work himself. And it is normal to have
9 assistance, just as lawyers and judges depend on clerks to
10 do some of their work. We can't do it all ourselves.

11 He is 80 years old and he has a history of working
12 with Dr. Ahn as a statistician who helps follow his
13 instructions. And we'll show that that was hands-on,
14 person-to-person, face-to-face, not just handing off the
15 ball through selective deposition cuts.

16 What we see here is all of the published clinical
17 trials gathered and presented by Bayer to the EMEA, the
18 European regulators. And what you see in this column, the
19 relative risk column, is it's 8.6 at the .4 dose, 8.8 at the
20 .8 dose.

21 And the P-values are highly significant, showing
22 that for confirmed rhabdomyolysis Baycol was much more toxic
23 and statistically significantly so in clinical trials, the
24 gold standard. And that's in Dr. Farquhar's report. It's
25 not mentioned today.

1 Now, in fairness, there are data on the same page
2 of some of the EMEA for unconfirmed rhabdomyolysis that are
3 not -- that do not match these, but the EMEA itself
4 concluded that the confirmed rhabdomyolysis cases were more
5 reliable because they had gone through a review process to
6 show that they were real rather than simply unconfirmed
7 reports.

8 Now, what about myalgia? Now, Mr. Beck is a fine
9 lawyer, excellent representative of his client, but he's not
10 speaking from the published literature when he says that
11 myalgia is a different disease from rhabdomyolysis.

12 They are on a continuum of mild to severe from the
13 same mechanism. And that's what the defense expert,
14 Dr. Dorfman, said. That's what Plaintiffs' expert,
15 Dr. Richman, said. And that's what the literature says.
16 It's a matter of degree, Your Honor.

17 Myalgia is muscle pain that corresponds to
18 increases in creatine kinase or CK, which comes from
19 the destruction of the muscle cells that cause the
20 pain.

21 So sure there are confounding factors, sure
22 people can get aches and pains, but that doesn't mean that
23 it's a different disease when you have a statin-induced
24 myalgia.

25 When you have a statin-induced myalgia, what you

1 have is a mild form of the same condition that could
2 progress in some people who can't handle that much of the
3 drug to a more severe condition, such as myopathy or in some
4 categories myositis or in the worst-case scenario
5 rhabdomyolysis. There's no evidence before the Court that
6 those are different diseases. There is simply lawyer talk.

7 Now, here's the data on myalgia versus -- for
8 Baycol versus placebo that was never published, and it's in
9 the defense exhibit. We didn't get it until after our
10 expert reports were in because it was in his file. He was
11 deposed in March 2004. Our expert reports were all in by
12 February.

13 So here's -- excuse me. Here's the data. On the
14 label it says 2.5 versus 2.3, pretty much of a wash, so you
15 would think. But what it also says -- and this is in the
16 exhibit that I'll show you in a moment -- is that that only
17 included about one-third of the patients, less than 3,000 of
18 them.

19 And what was submitted after the drug was off the
20 market to the EMEA was a larger data set with a relative
21 risk of 1.76 and a statistically significant P-value, which
22 is the hallmark of reliability in clinical trials.

23 A "P" less than .05 means that scientists will
24 presume that in the absence of some other really good
25 explanation, there's likely to be a cause and effect

1 relationship.

2 And that was on all the trials that they labeled
3 short-term trials, up to 24 weeks. Now, it may be
4 suggested, well, what about the long-term trials, did they
5 change that? But what you will see from the exhibit is that
6 there wasn't any data collected, that the comparison they
7 did in the long-term trials was against other statins rather
8 than placebo.

9 So for common doses you'll see it was even higher,
10 which corresponds to the dose relationship, dose-response
11 relationship; and Dr. Farquhar mentioned these tables in
12 response to deposition questions.

13 Now, the defense consultant analyzed, just as
14 Dr. Farquhar did, the published trials on rhabdomyolysis and
15 also came up with similar numbers. That tends to validate
16 that Dr. Farquhar was on the right track in the first place.

17 And in terms of the .8 milligram dose, we looked
18 earlier, in fact, I think it's -- here we see that at the
19 .8 milligram dose Dr. Farquhar's relative risk was 8.8.
20 Now, if we go on to Dr. Strom's consultant, what we have is
21 on slide 19 you'll see that for the .8 milligram dose the
22 analysis by the defense consultant was almost identical,
23 8.68. So, again, that speaks to a good methodology being
24 verified by the other side's expert but not talked about
25 this morning.

1 Now, on the .4 milligram dose Dr. Farquhar's
2 relative risk was higher, it was 8.6, but you'll see under
3 the column Pr, pravastatin, that there were 18,000 people
4 there with no cases. So that's going to raise the relative
5 risk because Baycol had cases and the other drug didn't.

6 And you'll see that in the analysis by the defense
7 consultant for whatever reasons that pravastatin was not
8 included at the .4 milligram dose and so the relative risk
9 came out here at 3.42, still elevated, but not to the same
10 degree because some of the data was not included.

11 So this is a graph made from the data in Bayer's
12 report, the CIOMS report, to the EMEA showing a
13 dose-response relationship between the Baycol dose and
14 confirmed rhabdomyolysis. Well, that's proof of a cause and
15 effect relationship.

16 And going on to the -- here's the data on myalgia,
17 Your Honor. This is from the Exhibit 11 that's been
18 submitted to the Court from the Strom deposition and
19 identified by Dr. Strom as having been prepared by his
20 assistant, Mr. Loutanbach.

21 And here's what he finds, that for the short-term
22 analysis the -- instead of 2.5 versus 2.3, it's actually 2.5
23 versus 1.4. And I would like to make sure that I find the
24 actual slide where that statistical significance finding
25 appears.

1 Here it is. This is the analysis by the same
2 gentleman, Mr. Loutanbach, where the myalgia is shown as
3 1.76 relative risk, the 95 percent confidence interval is
4 higher than 1, and the P-value is under .05. That means
5 it's statistically significant.

6 This was data that was never published, never
7 available to the public. The Defense has relied upon the
8 2.5 versus 2.3 in the Thompson article which says that it's
9 from the PDR, which is the equivalent of the label. The
10 Physicians' Desk Reference is the equivalent of what's on
11 the package insert. So this data was not out there.

12 Is there some other analysis? Is it fair to use
13 only the U.S. data? The label says that over 5,000 were
14 tested worldwide, but when they report the myalgia they're
15 only reporting U.S. trials and it's only 3,000 people
16 instead of close to 9,000.

17 So Dr. Farquhar didn't make this up. He didn't
18 concoct anything. The defense expert did these
19 calculations.

20 And what you'll also see in terms of the continuum
21 and the relationship between these conditions is that
22 myalgia is elevated, CPK is elevated for Baycol versus
23 placebo at a relative risk of 4.73, and you see that each
24 level of CPK is in a diminishing percentage of people, but
25 always higher for Baycol than placebo.

1 So what you're seeing is exactly the continuum of
2 injury that's talked about in the literature and that for
3 tactical reasons the Defense would like to say it's a
4 different disease. But it's not a different disease. It's
5 a different severity of the same disease.

6 And so we have the Thompson Table 1 that's
7 mentioned in the briefs of the Defense. It comes from
8 the PDR. It's incomplete data. Thompson couldn't have seen
9 it.

10 Now, these clinical trial results, it's important
11 to say that even though they are higher, they are not as
12 high as they would be in the real world. And the reason for
13 that is, as stated in Dr. Farquhar's report, clinical trials
14 involve typically younger people, average age in the 50s;
15 whereas, for example, in the HMO studies the average age of
16 Baycol users was 67.

17 They exclude people who are most susceptible, like
18 diabetics who don't have good renal clearance. And
19 18 percent in the PacifiCare, for example, were diabetics.
20 And they used lower doses in the mix. The .1 and .2
21 milligram doses are in the table that we just reviewed.

22 And so those are part of the data that's used to
23 calculate these rates while excluding some of the people
24 most at risk and also excluding the most dangerous use,
25 which is the combination with gemfibrozil, which is

1 described in the Insull study of Baycol as a protocol
2 violation.

3 So you would expect -- and Bayer's own scientists
4 say this when they're looking at the adverse event data,
5 well, why is it higher than we saw on clinical trials.
6 Because the clinical trial populations are healthier,
7 they're younger, it's a narrow population where you don't
8 get as much data.

9 So here's another dose-response relationship
10 between Baycol and an abnormal CK from Bayer's data, and
11 you see that with dose the abnormal CK goes up.

12 Same thing for the -- there's a missing blue line
13 to connect the two dots at the end, but the point is that
14 the incidence from the clinical trials is higher in Baycol,
15 especially at the higher doses. There is some variation at
16 the lower doses, but as you move up the chain of doses, you
17 see it's substantially higher for Baycol than placebo.

18 Similarly with the myalgia data, there's the
19 percentage going up with dose.

20 Now, moving on to the consensus. And I apologize
21 if I am going quickly, Your Honor. I am trying to cover a
22 lot of material. If I go too fast, please stop me.

23 So the consensus -- now, I want to talk just a
24 moment about McClain vs. Metabolife. The McClain case
25 distinguishes between cases where there's a consensus of

1 causation and cases where there is not and it says that the
2 court needn't concern itself extensively with the Daubert
3 analysis of general causation when there is a consensus and
4 the examples they give are tobacco and asbestos, tobacco and
5 cancer, asbestos and mesothelioma. And I am sure Your Honor
6 is familiar with the case.

7 Now, that case comes up again in Leathers vs.
8 Pfizer and it's distinguished in Leathers vs. Pfizer and I
9 think that the Defense has raised it, and I want to talk a
10 little bit about Leathers vs. Pfizer because it's not this
11 case for a lot of different reasons.

12 Number one, in Leathers vs. Pfizer the plaintiff
13 did not make the record with any of this data for the
14 particular drug that there was a cause and effect
15 relationship based on clinical trials.

16 As the court reviewed -- importantly, in Leathers
17 vs. Pfizer the plaintiff was trying to make a case that we
18 are not trying to make. That plaintiff was trying to show a
19 permanent myopathy with a CK that had never been elevated,
20 never. And there's no -- we are not making that claim, Your
21 Honor.

22 We do say, our experts have relied on articles
23 saying that if your CK is not elevated, you can have a mild
24 myopathy that stops when you stop the drug. That's a
25 reasonable position. It's supported by literature. Some

1 people might disagree with it, but it's got support in the
2 literature.

3 THE COURT: Do you have another set of this for my
4 law clerk?

5 MR. ZIMMERMAN: We can get you one.

6 MR. ARBITBLIT: Yes, I believe we do, Your Honor.

7 MR. HOPPER: We do, Your Honor.

8 MR. ARBITBLIT: The point of it is that the
9 difference is the principle in McClain vs. Metabolife is
10 viable here because there is proof of a consensus that
11 Baycol causes the injury and that it's more toxic.

12 In the Leathers case that involved Lipitor, there
13 is no such consensus that it's more toxic nor is there a
14 consensus that it causes permanent injury with no elevation
15 of CK.

16 And, in fact, some of the case reports that are
17 cited by the judge as proof against the plaintiff in
18 Leathers would be proof consistent with the position that
19 we've taken here, which is that there is a variability in
20 the mild to moderate range of from weeks to months to
21 possibly over a year in recovery time.

22 And some of the case reports cited in Leathers vs.
23 Pfizer include statements that the patient recovered in
24 three months or five months. That's similar to what our
25 experts are saying and that's what the literature says as

1 well.

2 So I just want to quickly go through some of these
3 statements on Baycol being more toxic, and these articles
4 have been submitted to the Court.

5 MR. HOPPER: May I approach?

6 THE COURT: (Nodding.)

7 MR. ARBITBLIT: In 2006 the Jacobson article
8 mentions not only the higher rate of rhabdomyolysis than was
9 observed with other statins, but also the incidence of
10 myopathy increases dramatically to 1.5 percent in the new
11 drug application and that's higher than for any marketed
12 statin, suggesting threshold dose, again speaking to the
13 dose-response.

14 This is authoritative in one of the leading
15 cardiology journals where doctors go to read about drug
16 safety and they want to know, they want to know are we going
17 to run into another Baycol if we use rosuvastatin or another
18 drug. So it's current events. Even though it is past
19 history as far as Baycol, it's very current for doctors to
20 be wondering are these drugs safe.

21 And so there are comparisons to rosuvastatin and
22 Baycol in the literature. And here's what you see, higher
23 than for any marketed statin. That's a recent statement.

24 And that's -- here's what Jacobson says about it.
25 The now obvious conclusion from the cerivastatin experience

1 is that as the statin dose or more likely serum
2 concentration increases, the risk of CK elevation increases
3 to the point where a threshold level is reached. Above this
4 level, myotoxicity begins to accelerate to levels beyond
5 acceptable risk/benefit ratios. From the NDA data and
6 additional postmarketing FDA data, the cerivastatin
7 threshold dose appears to be at the 0.4 milligram dose.

8 And you will see that they have incorporated both
9 the clinical trials and the postmarketing data in the same
10 analysis, same support for the concept that Baycol is more
11 toxic.

12 And for statins currently on the market, the
13 threshold concentrations appear to be above currently
14 approved doses except in certain populations that don't
15 metabolize it right or have drug-drug interactions.

16 But only Baycol, according to this article,
17 reached toxic concentrations in monotherapy at standard
18 doses. And that's the consensus position in 2006 and
19 2007.

20 Here are some of the articles that Dr. Farquhar
21 relied on that were saying the same thing four and five
22 years ago when he was first involved in looking at this
23 project:

24 The Staffa article, again, it's criticized by the
25 Defense. Initially they tried to claim it wasn't peer

1 reviewed. Well, they had to back off of that because *The*
2 *New England Journal* submitted an affidavit saying that it
3 was peer reviewed. Even though it's a letter to the editor,
4 it was a serious issue and they peer reviewed it externally.

5 And this is what it showed. It showed that there
6 was this relative reporting ratio that was 10 to 50 times
7 higher in monotherapy, 16 to 80 times higher in combination
8 therapy with gemfibrozil.

9 And the statement was made that a comparison to
10 Lipitor was more than an artifact. Well, what can that
11 mean? If it's more than an artifact, it's real. Those are
12 the two options. If it's an artifact, it's not real. If
13 it's more than an artifact, it's a real excess risk and
14 that's how it's been interpreted.

15 So then you see early articles like Farmer and
16 Hamilton-Craig that rely on Staffa and say we think this
17 shows it's higher, that cerivastatin is an exception to the
18 favorable risk/benefit ratio, that Baycol is at least 10
19 times the risk of other statins.

20 Thompson says that Baycol is the statin with
21 the greatest risk of muscle injury alone or with
22 gemfibrozil in *The Journal of the American Medical*
23 *Association*.

24 Thompson states, citing Staffa, that these are
25 considered estimated incidence rates showing Baycol the most

1 toxic. They're not -- Bayer would like to call them a
2 signal. Well, they are a signal, but they are more than
3 that. They are estimated incidence rates for the reasons
4 explained by Mr. Black during the AER analysis, which is
5 that where you have drugs that are marketed at the same time
6 for the same population and you don't have any -- a priori
7 reason to expect vast differences in the reporting rate,
8 these types of numbers are not otherwise explainable.

9 And here's the American College of Cardiology
10 consensus statement, again interpreting Staffa as an FDA
11 report that it's more frequent. They're not pulling any
12 punches. They're not saying careful, these are adverse
13 event data. They're saying this is how we interpret it.
14 And they are the leading cardiology groups, including
15 National Heart, Lung, and Blood Institute, which is part of
16 the United States government, so that's a very authoritative
17 interpretation.

18 Clinical trial data supports postmarketing data,
19 demonstrating higher incidence. Dr. Farquhar looked at
20 both, just as Evans did.

21 And here's a recent statement from the -- this is
22 not quite as recent, but it was when rosuvastatin or Crestor
23 was being marketed, coming to market, and here's what he
24 says in blunt terms. Because the FDA had been burned by the
25 particularly toxic effects of cerivastatin, which

1 subsequently was withdrawn from the marketplace,
2 rosuvastatin received a particularly careful scrutiny by the
3 FDA before giving its approval. So particularly toxic.

4 Arora, 2006, extremely rare for all statins save
5 cerivastatin. I'm sure that it could be stated that
6 Dr. Arora, the author, didn't know what was in Bayer's mind,
7 but nevertheless Dr. Arora said that Bayer concluded that
8 cerivastatin monotherapy did substantially increase the risk
9 compared with other statins and in August 2001 it was
10 withdrawn. Now, that's specific to rhabdomyolysis, but as
11 we've discussed, there was data showing higher rates of
12 myalgia as well.

13 These are two recent studies, the high quality
14 peer-reviewed *American Journal of Cardiology* and an expert
15 opinion on drug safety. Cziraky is the epidemiology study
16 that showed that there was a 6.7-fold increased risk of
17 hospitalization from muscle disorders with Baycol compared
18 to other statins. And the Davidson article says that it's
19 not a class effect, meaning that even though these are part
20 of the same class of statins, that doesn't mean they all act
21 alike, there are differences within the class that can make
22 one more dangerous; and that is what Davidson is saying.

23 Psaty -- as the Court is perhaps aware, Psaty and
24 Furberg were Plaintiffs' consultants in one of the Baycol
25 actions. Nevertheless, they disclosed that affiliation and

1 had their paper peer reviewed in a prestigious journal of
2 the American Medical Association.

3 And as Mr. Black addressed, and I won't go into
4 it, they found that there was no reason to think that there
5 was any explanation for 16 to 86 times higher besides an
6 inference of cause and effect.

7 Now, Chang, Staffa, these are the same authors
8 that wrote the 2002 article. And in 2004 they enlarged
9 their study. Instead of just fatal rhabdomyolysis, they
10 analyzed all rhabdomyolysis.

11 And this time they did it in their official
12 capacity and the paper says on the front of it that it's a
13 work of the United States Government and in the public
14 domain; whereas, the 2002 paper said that they were not
15 speaking in their official capacity.

16 And they do a similar analysis using the same
17 methodology and the same data sources as Dr. Farquhar and
18 they come up with very similar conclusions, that there's a
19 much higher rate of rhabdo with Baycol than any other
20 statins and the risk for reported rhabdomyolysis associated
21 with cerivastatin is evident.

22 Yes, the caveats are in that article too, Your
23 Honor, but there's no denying that they're saying the risk
24 is evident and compared to all other statins it had higher
25 reporting rates.

1 In 2006, relying on the Graham study, Neuvonen
2 finds that the study shows 10 to 100 times higher
3 rhabdomyolysis with cerivastatin.

4 And then this is the Graham study itself that
5 shows incidence of hospitalized rhabdomyolysis and the risk
6 is substantially greater, 10-fold in monotherapy and
7 1,400-fold with a fibrate such as gemfibrozil, which is
8 given often to people on statins because it lowers
9 triglycerides. So it's a concomitant medication to treat a
10 related problem.

11 And here we have the -- what I think is a
12 particularly important confirmation of the consensus because
13 it is so recent, 2006, and in an authoritative journal,
14 *American Journal of Cardiology*, and because of what it has
15 to say about the Staffa article that's now had a few years
16 to be considered by the scientific community. The situation
17 surrounding cerivastatin's withdrawal confirms that some
18 statins at marketed doses have shown a greater risk for
19 muscle adverse experiences when compared with other statins
20 at their marketed doses.

21 And that's very consistent with what was shown
22 in the first article I presented, which was the Jacobson
23 article, which is also in *The American Journal of*
24 *Cardiology*.

25 Now, what Bays goes on to do is provide what's

1 called an evidence grading system and he grades things as
2 Level A, Level B, all the way down through F, where things
3 are -- where there's evidence contrary to what's being
4 asserted by a particular statement.

5 "A" refers to clinical trials. That's always the
6 gold standard. But the next level down is epidemiology
7 studies, cohort, case control, claims database studies, and,
8 significantly, reports to regulatory agencies of hard safety
9 endpoints, i.e., death, that clearly exceed that of
10 population averages and/or comparator treatments.

11 Now, that Level B then goes on to a statement in
12 another table about various types of assertions about
13 statins and the assertion some statins are safer than others
14 with regard to potential adverse muscle experience is given
15 a Level B or the equivalent of all these epidemiology
16 studies and the hard endpoint adverse event reports.

17 And the references that are given for that include
18 the Staffa 2002 article and it's described as a high level
19 of evidence because there was such a clear excess of risk
20 that's not explainable by any of their means.

21 I'm not going to talk about it much at this point,
22 but there's a mechanism study also cited that was cited by
23 our toxicologist, Dr. Smith, who is subject to a Daubert
24 motion as well.

25 Very briefly, general practice research database,

1 it's in Dr. Farquhar's report, but it's not in Bayer's
2 papers. It shows that Baycol was more toxic even at lower
3 equivalent doses than other statins without any adjustment,
4 correction, only taking the data and comparing other statins
5 to Baycol at much lower doses on an equipotent basis than
6 the other statins because in Europe they were using lower
7 doses of Baycol primarily.

8 Now, the PacifiCare study was done for Bayer and
9 Dr. Posner, who is the head of regulatory affairs for Bayer,
10 recommended the analysis of the PacifiCare data that was
11 done by Dr. Farquhar, but not by the PacifiCare authors.

12 Specifically, the healthy patient effect is not
13 something that Dr. Farquhar dreamed up. There are multiple
14 sources for what's called the healthy worker or healthy
15 person effect where you have to consider whether a
16 particular population is more tolerant.

17 And the issue that's raised by that is whether
18 there's selection bias, meaning that the results of the
19 study can be altered if one population is somehow different
20 from the other population.

21 And people who have tolerated statins are
22 considered in Bayer's own documents to be statin tolerant,
23 not a so-called naive population; and people who have never
24 been on a statin are more of an open book, no one knows
25 what's going to happen.

1 So what happened here is that Dr. Posner
2 recommended that you do the never switched category. And,
3 in fact, Dr. Farquhar did not do any corrections,
4 adjustments, or fancy footwork. He just took the data in
5 PacifiCare itself, which I will show you in a moment
6 Dr. Strom's consultant, Mr. Loutanbach, also used, and
7 showed that Baycol had a higher relative reporting rate. He
8 just didn't do the overall relative risk, but he looked at
9 the same data and confirmed that this is the right way to do
10 it.

11 Now, the never switched category was recommended
12 for analysis also by Dr. Faich, Bayer's consultant, because
13 the switchers were more statin tolerant so you're not going
14 to get a fair picture.

15 So this is data that was in PacifiCare and when
16 you looked at it without any adjustment whatsoever, it
17 showed a statistically significant 1.54 increase risk for
18 Baycol and a highly significant P-value that shows it's not
19 likely due to chance, not likely.

20 And so here's the same data. Let's go to the
21 chart here, and I think it's probably easier for Your Honor
22 to see it with these little call-outs. What you're looking
23 at here is the relative risk and the top row where it says
24 ever switching HMG, that's a statin, and the answer is no.

25 So what you're looking at here in the top row is

1 Bayer's own consultant looking at the same data that
2 Dr. Farquhar looked at and showing that in each case, each
3 comparison to each statin you have a higher relative risk
4 for Baycol. The only thing that he didn't do was the last
5 step and that is put them all together and compare them.

6 And if you do, this is what you get. If you look
7 at the data on both sides, they both have the same
8 comparison and this is the calculation. And that's what
9 Dr. Farquhar did with raw data from PacificCare. No funny
10 business. Just took the data and did the analysis.

11 Now, as far as the adjustment for time, this is a
12 no-brainer, Your Honor. Every published study of Baycol in
13 a claims database -- and now there are two that are recent
14 and not just for Baycol, but let's talk about Vioxx.
15 Patient-years of treatment is the denominator in the Vioxx
16 studies and it's the denominator in the Baycol studies and
17 it's the denominator that should be used because relative
18 risk is an incidence rate in the exposed over an incidence
19 rate in the unexposed.

20 And an incidence rate, as stated in the Reference
21 Manual, involves the rate of disease and reflecting the
22 number of cases that develop during a specified period of
23 time.

24 So if you don't look at the amount of time, you
25 are biasing the results in favor of the group that has the

1 shorter duration because you're cutting out some of their
2 numerator, you're cutting out time when some of those events
3 would occur. And that's what happened with Baycol is
4 because they were switching Baycol into this HMO, they had a
5 shorter duration of use on average.

6 So this is just an example. This is not from the
7 PacifiCare, but just an example. If you've got 10 events in
8 100 people and you just -- versus 5 events in 100 people and
9 there's no time adjustment, that's an obvious relative risk
10 of 2.0 because you have twice as many with the same
11 denominator.

12 Let's assume that the patients in Group A average
13 two years of use while on Drug B they averaged four years of
14 use. Then if you calculate by patient-years, which is the
15 standard method, you see that there were five events in
16 .125 -- you see that the rate is .125 and the rate is .5, so
17 the relative risk is 4 instead of 2. So if you don't take
18 that into account, you wind up with distorted results.

19 And so Dr. Posner from Bayer's head of regulatory
20 affairs says, "Has there been any adjustment for time in
21 these data?" Well, yes, now that Dr. Farquhar has done it,
22 but not previously. "It would make a difference if patients
23 were on other statins longer than Baycol." Yes, it did. It
24 made a big difference.

25 So to say that Dr. Farquhar dreamed this up,

1 concocted it, or manipulated the data is false. It's
2 insulting. What he did was standard epidemiologic methods
3 that were not done by the health economists at PacifiCare
4 who did not have his credentials or his experience to know
5 what the right methodology was.

6 "Have we looked at the switch versus nonswitch
7 patients? Switch patients will have a lower incidence of
8 adverse events because they previously tolerated another
9 statin." This is exactly what Dr. Farquhar did for the best
10 analysis, which is nonswitch patients adjusted for time, and
11 that's what we have Dr. Farquhar doing.

12 So as Dr. Farquhar points out, Dr. Posner of Bayer
13 made the same criticisms that he stated and that he did
14 these corrections.

15 So the correction for time would not be so
16 important if all the events happened quickly. Now,
17 Dr. Strom thinks that they do happen quickly, so you
18 shouldn't adjust for time, but he is looking at the wrong
19 data. The reason he is looking at the wrong data is his
20 basis for that is the rhabdomyolysis events in the MedWatch
21 reports.

22 The reason that's not appropriate to compare to
23 PacifiCare for this purpose is that rhabdomyolysis in the
24 adverse event reports in MedWatch actually did happen
25 quickly because a lot of those were people with gemfibrozil.

1 It was fulminate. It was going quickly.

2 And as Mr. Black said, rhabdomyolysis is almost
3 always going to be attributable to the statin if you're on
4 the statin. In fact, the two epidemiology studies that we
5 looked at already, the Graham and Cziraky, had a period, a
6 run-in period where people were not on any drug and they had
7 zero cases in 300,000 patient-years of exposure when no one
8 was on a statin, zero cases.

9 So it's statin -- if you're on a statin and you
10 have rhabdomyolysis, it's very clear, not 100 percent clear,
11 but very highly likely that the statin caused it; whereas,
12 in PacifiCare there was a vague description that the FDA
13 criticized harshly for not being limited to cases that could
14 be identified with any certainty. It was called myopathy
15 and it included a bunch of claims, everything from myositis
16 to renal failure to myalgia, and they threw it all together.

17 And those events are not necessarily linked to
18 Baycol, as Mr. Black -- as Mr. Beck has pointed out. Excuse
19 me, Mr. Beck. They're not necessarily linked, so they're
20 going to be occurring over time.

21 And, in fact, they did. They occurred -- the
22 average time to event is shown in the PacifiCare actual data
23 and those events were going on -- average time was more than
24 six months. The range was a year or more. So it really did
25 matter that the Baycol duration of use was shorter because

1 events were cut out of the numerator.

2 So this is the Posner recommended -- this is what
3 Bayer's head of regulatory affairs recommended, take the
4 never switched folks, adjust for time, and your relative
5 risk is 2.33.

6 Now, I'm not going to go into there was --
7 Dr. Farquhar did believe there was a basis to go further
8 than that and adjust on the basis of some data in the
9 adverse event reports, as Mr. Beck pointed out. That's in
10 his report.

11 But in his supplemental report he said, look, set
12 that aside for the moment. Just do what Dr. Posner said and
13 here's what you get. You get a statistically significant
14 excess of doubling of the risk in spite of all of the
15 failings of PacifiCare.

16 And then you see Graham, as I was just mentioning.
17 They used person-years of treatment. They did not use
18 number of events over people. They used person-years of
19 treatment so that there was an adjustment for time and then
20 they reported the risk as 10-fold greater based on
21 person-years of treatment.

22 Same with Cziraky. They used person-years of
23 treatment and calculated their incidence rates to get the
24 relative risk of 6.7.

25 And this is what Dr. Farquhar showed as the risk

1 doing the Posner recommended analysis.

2 THE COURT: Would you go back to the last two.

3 You went so quickly that I --

4 MR. ARBITBLIT: I'm sorry, Your Honor?

5 THE COURT: The last two.

6 MR. ARBITBLIT: Yes, sir. The point here is that,
7 as we've been saying, as Dr. Posner said, as Dr. Farquhar
8 carried out, adjustment for time is the standard way of
9 doing relative risk because you're looking at incidence
10 rates, not mere percentages of people with events. Time is
11 a very essential part of incidence. It's part of the
12 definition of "incidence," that it's a specified period of
13 time.

14 So these published authors, Graham and I believe
15 it's Chang and Staffa from the original publication in *New*
16 *England Journal* were on that paper with him, they used
17 person-years of treatment, which is what Dr. Farquhar did
18 when he analyzed PacifiCare. That's not dreamed up. It's
19 standard practice.

20 And so they didn't even report incidence in terms
21 of a percentage of events over people. They only reported
22 it this way, with a denominator based on an adjustment for
23 time.

24 Likewise with Cziraky in *The American Journal of*
25 *Cardiology*. It's the largest published study of a claims

1 database using the methods espoused by Dr. Strom in his
2 pharmacoepidemiology textbook. You take the database, you
3 record the events, and you calculate an incidence rate based
4 on patient-years of exposure that is adjusted for time. And
5 this is what they found.

6 And this is new, but it's confirmatory, Your
7 Honor. We believe that this simply confirms that
8 Dr. Farquhar did the right thing and he did what the peer
9 reviewers would have asked if PacifiCare had submitted its
10 article -- an article to a topflight journal instead of
11 presenting an abstract at a conference.

12 Is that clear enough, Your Honor? Is there
13 anything further you would like me to address?

14 THE COURT: Go ahead.

15 MR. ARBITBLIT: Thank you.

16 I know Mr. Black addressed the FDA caveats. They
17 apply to the data alone. They do not apply to the relative
18 reporting ratio analysis. Mr. Beck showed that slide. It
19 only mentioned AERs. It did not mention using a denominator
20 based on IMS data.

21 FDA officers have made such comparisons, including
22 the one we just talked about by Chang and Staffa, and they
23 have used it to make those comparisons. Yes, they have had
24 the caveats, but they've also made their conclusions that
25 risk is evident; and they've been cited by the recent

1 literature as saying that's equivalent to an epidemiology
2 study in terms of the evidentiary value.

3 And here are those criteria that make it valuable,
4 same class, same indications, similar population, marketed
5 at approximately the same time. And that certainly applies
6 to Lipitor, only a six-month difference in marketing.

7 And there's the quote from the 2006 article that
8 there's a high level of evidence in circumstances of the
9 Baycol case. That doesn't say that you would always use
10 adverse event reports, Your Honor, but you can't make the
11 generalization that Defendants choose to make here, which is
12 that they are never usable, they are never reliable. That's
13 not how science works. It's not all either/or.

14 You have to look at the circumstances. You have
15 to look at the totality of the evidence. You have to look
16 at whether there's consistent evidence from clinical trials,
17 which there is. You have to look at consistent evidence
18 from the epidemiology studies, which there is.

19 And then you see that the relative reporting ratio
20 study is right in line with those and you also see that it
21 meets these criteria and you see that the relative reporting
22 ratios are enormous and not otherwise readily explained.

23 I have already discussed everything that's on this
24 slide, so I will move along.

25 The FDA actually did use it to make the

1 comparisons in August 2001, but I am going to move on past
2 that. I don't need to address it given the interest of
3 time.

4 This is simply the declaration showing that it was
5 peer reviewed initially.

6 There's a statement in the Bayer brief that I did
7 want to correct. The underlined text is what was omitted
8 from the brief so that the text actually said, "The
9 reporting rate is a crude measure of the number of reports
10 received by the FDA."

11 But the actual statement in the Staffa article is
12 with the underlining, "The reporting rate is the number of
13 fatal cases divided by the number of prescriptions dispensed
14 and is a crude measure of the number of reports received by
15 the FDA relative to the extent of the use of an agent in the
16 U.S. population."

17 Now, sure, there are still caveats about that, but
18 you can't just leave out that last part. You can't leave
19 out the fact that it's relative to use, because that's where
20 you get your denominator. That's what differentiates a
21 relative reporting ratio from raw adverse event reports with
22 no denominators that don't allow any comparisons under any
23 circumstances.

24 So more than an artifact, that's not mentioned in
25 the briefs.

1 We've talked about Psaty, we've talked about Bays,
2 and we talked about that (indicating) already.

3 Now, here's something we haven't talked about yet
4 that I want to hit head on. There's an assertion that
5 Dr. Farquhar failed to take into consideration the higher
6 adverse event reporting rate for new drugs. He did take
7 that into account. He made the same comparison to Lipitor
8 that Dr. Staffa and many others have made.

9 Now, Mr. Beck introduced an FDA document from 2000
10 that's never been peer reviewed to suggest that Baycol was
11 in the middle of the pack during the first initial time of
12 marketing, but that's been rejected in the peer-reviewed
13 literature.

14 The new drug effect and publicity effect on
15 relative reporting rates are negated by an actual analysis
16 of trends, and that's in the FDA Officials Chang and Staffa
17 article "Pharmacoepidemiology and Drug Safety" wherein they
18 say, "Sub-analysis of reporting rates for each statin for
19 the first three years of marketing only and for the 19-month
20 period immediately preceding the withdrawal of cerivastatin
21 revealed the same relative patterns seen in the overall
22 analysis." And that should say, "Emphasis added," Your
23 Honor. I apologize for that oversight.

24 The point is, though, that they looked at the
25 trends and they saw the same relative patterns. And they

1 are doing that specifically because they're aware of
2 people's concern is this a new drug reporting effect. And
3 they're saying, no, it's not. The relative patterns were
4 the same.

5 And why did they look at that 19-month period
6 before Baycol withdrawal? If you follow back to December
7 1999 from August 2001, what you come to is December 15, 1999
8 when Bayer first sent out "Dear Doctor" letters saying that
9 there's a problem with co-use with gemfibrozil. So that's
10 when you might start the clock running to see whether
11 adverse publicity might be playing a role.

12 But what they're saying is we looked at that and
13 it didn't. So what we have from the Defense is speculative.
14 It's saying here's what might happen, you might get bad
15 publicity in some other case affecting the reporting rate.
16 But you didn't get it here. You did not get it here because
17 they looked at it and it didn't change it.

18 So here's another example of selective quoting of
19 the deposition. Yes, it's true that Dr. Farquhar had not
20 done adverse event report/IMS analysis, but what he said at
21 his deposition is this:

22 "I really would like to add that, if I may, that the
23 general principles of epidemiology that were set in motion
24 in that analysis are the same as those that I have used in
25 many other circumstances."

1 Now, as lawyers, as judges, as doctors, we're
2 always faced with slightly different circumstances, but we
3 use our experience and we apply it to the case at hand.
4 This is a gentleman who has been practicing as an
5 epidemiologist and physician for 50 years.

6 It's not that this is rocket science to take the
7 data from the FDA MedWatch and put it over denominators.
8 All he had to do was tell Dr. Ahn which terms to look for,
9 which he did. So you plug in the terms and it spits it out.

10 And you'll see in other testimony that this is
11 exactly what had happened. He didn't just hand it off, as
12 Mr. Beck suggested. He testified, "We were going at it
13 together," with Dr. Ahn. That's right out of the
14 transcript.

15 And then there's an extensive discussion, it goes
16 on for five pages where Dr. Piorkowski was grilling
17 Dr. Farquhar about who is Dr. Ahn and what did you do. He
18 was a trusted in-house biostatistician who's worked with him
19 on past projects. Dr. Farquhar directed and instructed
20 Dr. Ahn as to what terms to search in the database.

21 Now, there was a highly technical clip that was
22 pulled about what kind of coding. Well, I don't think you
23 need to know what kind of coding is done to know what to
24 tell your biostatistician to search for.

25 And then you see that actually they did it

1 together.

2 "Just imagine that I am standing here and he's there and
3 there's his computer. He and I have worked out the program.
4 And he's the one that presses the button and gets the
5 compilation of data. Okay?"

6 That's not a handoff. That's a ministerial
7 function of carrying out Dr. Farquhar's directions.

8 "So you were telling him what terms to look for?

9 "Right."

10 Dr. Farquhar did this analysis with someone
11 pushing the button to help him get the data.

12 Now, there was a challenge to the meta-analysis.
13 Well, it's important to respond to that briefly in two ways.
14 First of all, the meta-analysis was not necessary to show
15 the greater risk because each of the five sets independently
16 showed greater risk; and that's stated in the report.

17 Yes, there was overlap, but they didn't show
18 Dr. Farquhar saying that they were sufficiently distinct to
19 furnish an adequately different database.

20 And they didn't mention that there are three
21 analyses that Dr. Farquhar presented, one for
22 rhabdomyolysis, one for myopathy, and a separate one for
23 myalgia alone, that were all based on the single database;
24 no overlap, no meta-analysis, one database.

25 And what you'll see in that is relative risk for

1 Baycol versus other statins of 42 for rhabdomyolysis, 19 for
2 myopathy, and 8.0 with a P-value of less than 1 in 10,000
3 possibility that that result is due to chance when you
4 compare Baycol to Lipitor for myalgia.

5 Now, whether the disease endpoints are defined the
6 same or not, as Mr. Black pointed out, that comes -- and as
7 Mr. Piorkowski pointed out in the deposition -- that comes
8 out in the statistician's wash.

9 "It's important to say that as long as the same methods
10 are being used for drugs in the same class, that one
11 presumes that one is coming out with comparable
12 inaccuracies, if you will, for each of them.

13 "Is there an epidemiological way of saying it all comes
14 out in the wash?

15 "Well, it all comes out in the statistician's wash."

16 And Dr. Farquhar was using the same methods here
17 that were peer reviewed and accepted not only in *The New*
18 *England Journal* letter to the editor, but in the subsequent
19 full publication.

20 So, yes, there are uncertainties, but do they
21 explain a ratio of 8 to 1, 19 to 1 or 42 to 1? No, they
22 don't explain that. And the P-values confirm that that's
23 reliable.

24 And another comparison here just based on the
25 single database shows that actually the peer reviewers said

1 it was even worse for Baycol than Dr. Farquhar. So if you
2 want to analyze whether Dr. Farquhar was biased against
3 Bayer, well, the evidence doesn't support that.

4 We're using the same reporting ratio method. They
5 both used FDA MedWatch adverse events as the single source
6 of the numerator. They used somewhat different definitions,
7 which led to somewhat disparate numbers of events.

8 The Chang definition in the published article
9 included not only rhabdomyolysis, but a CPK over 10,000.
10 Dr. Farquhar's search did not have the CPK limiter, it was
11 just for rhabdomyolysis. It's similar, but it's more
12 inclusive.

13 So the number of events, if you see in the last
14 paragraph, Dr. Farquhar and Dr. Ahn pushing the button to
15 get the number of cases came up with pretty darn similar
16 numbers for Baycol, 495 vs. 479 in the published article.

17 As to Lipitor, it was more disparate, but it was
18 going in the same direction. 109 according to
19 Dr. Farquhar's definition without the CFK. 51 for -- excuse
20 me. The 109 came from Chang. They found -- no, I'm sorry.
21 109 came from Farquhar, which favored Baycol because it led
22 to a higher reporting rate for Lipitor.

23 But on the prescriptions they were both using the
24 IMS data, that's the standard source, and they both came
25 out almost identical, the exact same number for Baycol and

1 6 million off for Lipitor, over the course of several years
2 of marketing.

3 So what happens here is that Chang's Table 4 shows
4 that Baycol versus Lipitor is 4.29 over .03, which is a
5 reporting ratio of 143; whereas, Farquhar's reporting ratio
6 is 57.5 and there's a P-value that is significant.

7 So they used the same methodology. Dr. Farquhar
8 had a slightly different case definition that captured
9 more cases, but there's nothing inconsistent about these
10 results.

11 If anything, the fact that Dr. Farquhar's ultimate
12 finding of the relative reporting ratio there was lower than
13 what the peer-reviewed article said negates any argument
14 that he concocted this in a biased effort to sink Bayer's
15 ship. It's a single database. It's not a meta-analysis.
16 It's a peer-reviewed methodology.

17 Likewise on the free samples. Your Honor, that's
18 an interesting point, but the point that again comes out in
19 the statistician's wash is that Lipitor is made by Pfizer.
20 They were giving out free samples too.

21 During the lunch hour I Googled that and found
22 that they had something like 7.3 million samples in their
23 first year. And I am not going to represent that I have
24 precise data for each year, but the point is that Defense
25 has not introduced any evidence that sampling was

1 differentially related to Baycol versus Lipitor.

2 So if the IMS data didn't capture samples, then it
3 didn't capture Lipitor samples either. So, again, it comes
4 out in the wash. If you've got a 16 times or a 50 times
5 reporting ratio for Baycol, there's no way that that's going
6 to be explained by the marginal difference in how many free
7 samples were given out by Pfizer as opposed to Bayer if, in
8 fact, Bayer outdid Pfizer in the free sample department,
9 which there's no evidence of.

10 So, again, uncertainties affect them in roughly
11 the same manner and there's no reason to throw the
12 analysis out. It's been peer reviewed using identical data
13 sets.

14 Pierfitte, Bayer says that it shows widely
15 disparate reporting rates, but the authors say that the
16 differences remain low and reinforces the credibility of
17 calculations and comparisons made in this context, in the
18 context of similar drugs, similar class.

19 Let's see. In the Hamilton-Craig article --
20 again, supporting from another source -- 88 per million
21 versus 2 per million reporting rates for a European database
22 where the reporting is mandatory, not voluntary. So 44
23 times higher. Consistent.

24 FDA officials have written about the use of even
25 individual adverse event reports so much that there's

1 stronger evidence with denominators. I think I'm going to
2 skip over this.

3 I do think that it's worth looking at, if Your
4 Honor has any interest in seeing, that there are methods for
5 looking at individual case reports, which we didn't need to
6 do here. But if you have rechallenge evidence, which we do
7 have and we've submitted one, and supportive cases, even
8 from small numbers of individual events causation can be
9 addressed with clusters, that we have clusters of cases.

10 We have the baseline rate is close to zero, as I
11 was saying earlier, so that if you have a cluster of cases,
12 that becomes more meaningful.

13 This proportional reporting rate methodology, I'll
14 address it briefly. Dr. Wiholm, who unfortunately passed
15 away a couple of years ago, was a regulator from Europe who
16 came to the United States and was working as the head of the
17 Division of Epidemiology at Merck until he died in 2005 and
18 he authored this chapter in Dr. Strom's textbook.

19 Dr. Farquhar didn't make up the proportional
20 reporting ratio method and, again, it's not used as a strong
21 foundation by Dr. Farquhar or by Plaintiffs. It's merely
22 another consistent piece of evidence.

23 The purpose of a proportional reporting rate is
24 that since all the events are reported for each drug in the
25 same time frame, you're not looking at anything that could

1 be influenced by a publicity effect or a new drug effect.

2 And so it came out the same and there's a recent
3 peer-reviewed study that we have submitted using the same
4 method. Now it's been peer reviewed for another statin that
5 validates the choice to use that as one part of an overall
6 analysis.

7 The Meridia case is distinguishable. There was a
8 PRR there, but it was the only adverse event analysis
9 presented, not simply a consistent additional analysis.

10 The court criticized the failure to submit the raw
11 numbers, which could make the analysis misleading, but here
12 Dr. Farquhar has submitted the raw numbers showing hundreds
13 of cases, thousands of total adverse events in the
14 denominators that make it transparent to the Court and the
15 parties as to what is being compared and still finding that
16 rhabdomyolysis was a much higher percentage of the total of
17 adverse events.

18 That's what proportional reporting rate does. If
19 you want to see whether one drug has more of that type of
20 event as a percentage of all the adverse events, it's
21 considered by Dr. Wiholm to be acting in a fashion similar
22 to relative risk. Dr. Farquhar followed that methodology to
23 the letter and it's in Dr. Strom's textbook.

24 So, again, general causation here is based on many
25 admissible elements, including clinical trials that we've

1 discussed, scientific consensus up through the latest
2 publications, and epidemiology studies, in addition to the
3 reporting ratio studies.

4 And I would be happy to entertain any questions if
5 you would like, Your Honor. Otherwise, I'm happy to sit
6 down also.

7 THE COURT: You saw your red light come on.

8 MR. ARBITBLIT: I should have, but --

9 THE COURT: It just came on.

10 MR. ARBITBLIT: Thank you. Sorry, I didn't know.
11 I was blocking it with my computer.

12 THE COURT: It just came on.

13 MR. ARBITBLIT: My co-counsel were too polite to
14 tell me. Either that or they liked it. I don't know.

15 MR. LOCKRIDGE: Could we have ten minutes, Your
16 Honor, for Dr. Austin? I know we've run over a little bit.

17 MR. ARBITBLIT: I would be happy to waive some of
18 my time on the muscle people if that would make a
19 difference.

20 MR. BECK: Your Honor, I have no objection if they
21 want to take ten minutes on Dr. Austin. I would like a few
22 minutes to -- just a few minutes to respond.

23 THE COURT: You will have a few minutes to
24 respond.

25 MR. BECK: Okay.

1 THE COURT: You may.

2 MR. LOCKRIDGE: Thank you, Your Honor. It will be
3 Mr. Black.

4 MR. BLACK: Your Honor, again I prepared a
5 PowerPoint, but Mr. Arbitblit has anticipated many of the
6 things I was going to address and I think if I could
7 approach and just give you the paper copy and call the
8 Court's attention to --

9 THE COURT: Do you have a copy for my law clerk
10 too?

11 MR. BLACK: We will get a copy for your law clerk.
12 In fact, you can take this one. I can do this from memory.

13 MR. BECK: Can I have one?

14 MR. BLACK: We do have a third copy.

15 While we're waiting for that, this is a point that
16 relates to both Dr. Farquhar and Dr. Austin with regard to
17 the coding and interpreting, the coding of the adverse event
18 reporting data and Dr. Farquhar was accused of not
19 understanding how it was coded.

20 Dr. Strom didn't know how it was coded either.
21 This prominent pharmacoepidemiologist, the editor of the
22 treatise of *Pharmacoepidemiology*, Bayer's expert, didn't
23 know how the data was coded either.

24 As a matter of fact, he didn't know how to access
25 it at his deposition. He said, oh, it was very difficult to

1 do that. You have to get all these -- put in a special
2 request and get the disks. That wasn't true. You could buy
3 the data for like a thousand dollars at the time. Now you
4 can download it from the Internet for free.

5 Dr. Strom didn't know how to do that, didn't know
6 how to access it, didn't know the beginning of how the
7 coding was done. And yet he works with it because he works
8 through assistants, just as Dr. Farquhar did. So I think
9 that's the reddest of herrings.

10 The proportional reporting ratio, Mr. Beck made a
11 big deal about the fact that Dr. Austin did a proportional
12 reporting ratio analysis. Well, he did, but that wasn't the
13 principal focus of his work and I think Mr. Arbitblit
14 explained how that was some additional analysis we did
15 that -- or had the experts do that corroborates the other
16 work that they did.

17 The one point that I specifically want to address
18 about Dr. Austin relates to this accusation that he somehow
19 just made up the 30 percent figure to increase the relative
20 risk. He didn't just make it up.

21 He explained very clearly in his report where the
22 number came from and slide 28 in the PowerPoint that I
23 prepared, which is I think page 14 of the handout because
24 there were two slides per page, explains what he did.

25 The effect of misclassification of the cases, the

1 magnitude of that effect depends on what percentage of the
2 cases are misclassified and what the actual relative risk
3 is; and he showed that in a table in his report.

4 And then based on work that he had already done,
5 correcting for duration -- and Bayer doesn't dispute his
6 correction for duration of use. That's undisputed. He knew
7 already that Baycol was the worst of the statins. The
8 correction for duration, which he had done, which isn't
9 disputed, established that Baycol was the worst of the
10 statins.

11 And then he had also taken a look at the adverse
12 event reporting data and that gave him some idea for a
13 ballpark estimate of what the actual relative risk would be
14 and he used that to come up with an estimate of 1.26 for the
15 multiplier. So that's 26 percent.

16 And then he did exactly what Mr. Beck says
17 scientists ought to do. He goes and he says, well, that's
18 my hypothesis. Now how can I corroborate that? How can I
19 check that out?

20 And he says, you know, in the PacifiCare study --
21 we're talking PacifiCare now, we're talking about his
22 re-analysis of PacifiCare. He said they went and looked
23 separately at those cases that were diagnosed in a hospital
24 setting where you would think that the diagnosis is going to
25 be more precise and accurate and so -- this was only done

1 for the rhabdomyolysis cases. This was a limited number of
2 cases.

3 But he says, you know, if you compare the
4 diagnosis in the hospital where it's going to be accurate,
5 you won't get misdiagnosis and you compare that to the
6 rhabdo cases that came from outside the hospital setting,
7 why then you multiply by a factor of about 16 or 17, 16 or
8 17, not 1.3.

9 And then he said, well, given that magnitude of a
10 correction factor, when I go and take a look at the data, it
11 seems very, very conservative to me to use a correction
12 factor of 1.3 or 30 percent.

13 So he tested his hypothesis. He verified it. He
14 had an explanation for where it came from. It was not
15 something just plucked out of the air.

16 And I would only add on that that Dr. Farquhar
17 went and made the corrections that Dr. Posner, Bayer's
18 in-house doctor, had suggested making and he came up with a
19 higher correction to the PacifiCare report than Dr. Austin
20 did.

21 Dr. Austin's corrections were conservatively low
22 and they were well explained and they certainly weren't
23 based on just assuming the result that he wanted and then
24 reaching it, and that was the one point that I wanted to
25 make sure that I hope I've clarified on Dr. Austin.

1 If the Court has any questions, I'd be happy to
2 entertain them.

3 THE COURT: No. Thank you.

4 MR. BLACK: Thank you, Your Honor.

5 THE COURT: Thank you.

6 MR. BECK: Your Honor, let me -- I want to show a
7 few things here, but while I'm doing that, just on the
8 topics that Mr. Black just covered, on the coding and the
9 AERs he said that, well, our famous Dr. Strom who wrote the
10 book didn't know the codings for the AER system.

11 But, of course, our expert, Dr. Strom, wasn't
12 trying to re-analyze the AERs and wasn't trying to do a
13 meta-analysis and use the AERs for purposes that they should
14 not be used. And so he had no occasion to try to get in and
15 figure out what all the coding was about, unlike somebody
16 who does purport to re-analyze the AERs.

17 And on this adjustment, the 30 percent adjustment
18 that Mr. Black was just talking about where he said it
19 wasn't just made up, it was interesting to listen to his
20 description of the methodology, if he wants to call it that,
21 used by their witness.

22 He said, well, he starts with the knowledge that
23 Baycol is the most toxic and he also can look at the AERs
24 and see a relationship there. So he's taken the AERs to
25 adjust data in an epidemiological study.

1 And then he says, well, he went to the
2 hospitalization data and he used this factor of 16 or 17
3 times. It so happens that that comes from gemfibrozil. So
4 he's using data that comes from the situation where Baycol
5 is used along with gemfibrozil.

6 And then he says I kind of put all that together
7 and I put it on my forehead and I say 30 percent is
8 conservative and that was the scientific methodology. It
9 was not a computation of any sort. It was someone who,
10 according to their lawyer, started with a presupposition and
11 then set out to prove it and came up with a plug number that
12 sure enough proved it.

13 Now, Your Honor, I have a few things I do want to
14 cover.

15 On the AERs, none of the things that they showed
16 you says that you can use AER data to make reliable
17 comparative risk determinations from one drug to another.
18 None of them said that and that's what they've used it for.

19 I want to look at a couple of the things that they
20 showed you. This is from the FDA. They say this is, you
21 know, the recent guidance from the FDA. In yellow is what
22 Mr. Black -- I'm sorry. I think it was Mr. Arbitblit. I
23 got lost. Whichever one -- it was Mr. -- whoever was
24 talking about the AERs. And I apologize. They both covered
25 some of the same stuff. Mr. Black.

1 Yellow is what he said is real important and he
2 read, "Comparisons of reporting rates" -- and this comes
3 from his slide 62 -- "Comparisons of reporting rates,
4 particularly across similar products or across product
5 classes prescribed for the same indication." So that's what
6 he quoted. And then -- so he said the FDA blesses the use
7 of this.

8 And then the FDA goes on in the green, which he
9 left off his slide, to say, "However, such comparisons are
10 subject to substantial limitations in interpretation because
11 of the inherent uncertainties in the numerator and
12 denominator used. As a result, FDA suggests that a
13 comparison of two or more reporting rates be viewed with
14 extreme caution and generally considered exploratory or
15 hypothesis generating. Reporting rates can by no means be
16 considered incidence rates for either absolute or
17 comparative purposes."

18 And that's exactly what they've done by coming
19 up with these relative reporting rates is they've used
20 it the way that the FDA has said, again, you should not use
21 it.

22 Then, Your Honor, they also showed you the Staffa
23 letter to the editor several times and here this is -- I
24 just did this a second ago, but the yellow is the sentence
25 that this time it was Mr. Arbitblit reading.

1 And he said that when we quoted the yellow
2 sentence we left out some of the phrases in our brief and he
3 wanted you to look at the whole yellow sentence, which says,
4 "The reporting rate is the number of fatal cases divided by
5 the number of prescriptions dispensed and is a crude measure
6 of the number of reports received by the FDA relative to the
7 extent of the use of an agent in the U.S. population."

8 He said it's so important to put that last part in
9 about the U.S. population and then he stops. And then the
10 rest of the note in green says, "Rigorous comparisons
11 between drugs that are based on these data are not
12 recommended since many factors can affect reporting and an
13 unknown number of cases may not be attributed to the drug or
14 reported to the FDA. Reporting rates are not incidence
15 rates."

16 So, again, the Staffa letter has the same
17 cautionary note about the use of AERs. And I should say,
18 Your Honor, that Staffa, as with everything else they did,
19 has to do with rhabdo, not with myalgia.

20 They referred to Psaty. That's an article written
21 by experts being paid by the Plaintiffs' lawyers and they
22 repeated the Plaintiffs' lawyers arguments. Again, it had
23 to do with rhabdo, not myalgia.

24 They showed you a document that came from our
25 files, somebody named Mr. Niemcryn. Let's see here. I'm

1 messing this up. They showed a table from Mr. Niemcryk and
2 let me see if I can find what they showed. Here it is.
3 They showed you this table and said, well, the folks inside
4 Bayer did exactly the same thing that Dr. Farquhar did.

5 What they didn't show you, though, is what
6 Mr. Niemcryk said about this kind of data, that they look at
7 it to see whether there's a signal or not to see whether it
8 should lead us to go out and do an epidemiological study.

9 And he cautions when he uses the data in the
10 appropriate way. He says the interpretation of these data
11 is not straightforward. Data from adverse event reporting
12 can be heuristic, identifying potential relationships that
13 should require further exploration. However, estimates of
14 disproportionate risk cannot directly be generated by these
15 reporting systems.

16 So of course what Mr. Niemcryk does is he
17 acknowledges the limitations that the FDA keeps repeating,
18 exactly the opposite of what their expert did.

19 Mr. Arbitblit mentioned that I said, gee, there
20 are clinical trial data and then I forgot to talk about it
21 in my opening remarks. Myalgia is what we're left with now
22 and there is clinical trial data on myalgia.

23 All of the statin manufacturers reported the
24 incidence of myalgia that occurred during the clinical
25 trials that led to the approval of their statins. And what

1 happened was that -- and it's all in the labels for all of
2 the different statins.

3 And in terms of absolute terms, how many people
4 got myalgia per, you know, thousand patient-years or
5 whatever, Baycol was the second lowest of all the statins.
6 And in terms of comparing it to placebo, Baycol versus
7 placebo was the second lowest of all of the statins when it
8 came to myalgia.

9 And that's very important because the myalgia
10 data -- almost everything that was shown to you has to do
11 with rhabdo and then there was one little part where
12 Mr. Arbitblit showed some data that had to do with myalgia.

13 All of that data was Baycol versus placebo. None
14 of it, not one speck of the data that he showed you was
15 Baycol versus other statins. Not one speck of data that he
16 showed you or that's been identified by their experts says
17 that there's any difference in terms of the reported myalgia
18 from Baycol versus other statins.

19 And there's no study saying that there's a
20 statistically significant difference between Baycol and
21 other statins when it comes to what we're concerned about
22 with the remaining 1,700 cases, not rhabdo, but myalgia.

23 And he had slide 21, Mr. Arbitblit, talking about
24 myalgia and the language that he kind of glossed over that
25 was on his slide said, quote, no data on the long-term group

1 with regard to myalgia is noted. So once again we get back
2 to rhabdo, not myalgia, and again true in every single
3 article that they showed you.

4 Mr. Ismail will discuss later this afternoon the
5 mechanism question about whether this is all part of one
6 continuum and how the argument they're making this morning
7 contrasts with what they're saying in connection with some
8 of their other experts.

9 Lastly, Your Honor, on PacifiCare, there was no --
10 they say the Posner recommended analysis. Dr. Posner of
11 Bayer did not recommend the analyses that were done by their
12 paid experts here years later. He did not suggest those
13 calculations.

14 But what was interesting to me was they then segue
15 from the PacifiCare to Graham and Cziraky and a whole series
16 of other publications. And again, Your Honor, every single
17 one of those had to do with rhabdo. None of them had to do
18 with myalgia, which, as I said, was true for all of their
19 articles.

20 Thank you for your indulgence here, Your Honor.

21 MR. ARBITBLIT: May I have one moment, Your Honor?

22 THE COURT: I'll give you one minute.

23 MR. ARBITBLIT: Can I just use this? Is that
24 possible?

25 THE COURT: Yes.

1 MR. ARBITBLIT: Do I have to plug something in or
2 do I have to push a button or call someone that knows?

3 MR. BECK: This counts against his time, right?

4 THE COURT: It does.

5 MR. ARBITBLIT: Phil, do you know how to do it?

6 MR. BECK: Yeah, I do. Dennis.

7 MR. ARBITBLIT: I just wanted to point out, Your
8 Honor, that something I mentioned but didn't have time to
9 show during the presentation was, in fact, myalgia in
10 Dr. Farquhar's analysis. These are the adverse event data,
11 but what he did was look at -- let me make sure I have got
12 that --

13 THE COURT: You can touch the screen. It's a John
14 Madden screen. No, not that screen, but the monitor.

15 MR. ARBITBLIT: Thank you. I wanted to make sure
16 that the heading is correctly shown here. This is for
17 myalgia alone using the same methodology with the caveats,
18 and I think I was careful to say that the caveats do apply,
19 but that the rates are so much higher that other
20 explanations are not likely.

21 And what you see is that for every statin,
22 including Lipitor, the one marketed closest in time, the IMS
23 data relative reporting ratio for myalgia was statistically
24 significantly greater at rates of 8, 7 times, 27 times,
25 9 times, 10.7 times, and a total of 8.5 for all statins the

1 myalgia rate was higher. I did mention that, but I didn't
2 have a chance to show this document that's attached as
3 Exhibit 9 -- Exhibit 8-B to Dr. Farquhar's supplemental
4 rebuttal report.

5 Yes, over time it became apparent that myalgia was
6 going to be a focus and so he said, well, since Dr. Strom
7 mentions myalgia, I will go look at the data and see. Let
8 the chips fall where they may. I will just use that term, I
9 will tell Dr. Ahn on the same study using myalgia, and
10 that's what it showed.

11 And as far as the clinical trial data, I didn't
12 gloss over anything. They just didn't add anything to the
13 data from those long-term studies, Your Honor. So the
14 short-term studies give everything they have.

15 Thank you, Your Honor. I appreciate it.

16 THE COURT: All right. What's up next?

17 MR. ISMAIL: Your Honor, we have a collection of
18 arguments based on five experts all geared to the muscle
19 injury. We would like to take a break now. These are
20 experts Boulton, Mayer, Richman, Zizic, and Carlson that I
21 would like to address for efficiency purposes in one
22 argument.

23 THE COURT: Mr. Ismail, you're talking about,
24 what, an hour?

25 MR. ISMAIL: Yes.

1 THE COURT: And response on that is going to be
2 what?

3 MR. HOPPER: Your Honor, as Mr. Beck talked about
4 or at least we did with Katie earlier, I have to leave here
5 to catch a plane at 5:00. Mr. Arbitblit was going to go
6 first on Dr. Richman after Tarek finishes and then if I can
7 go again, if that's fine with you.

8 MR. ISMAIL: Sure.

9 MR. HOPPER: If that's acceptable to the Court.

10 THE COURT: How much time?

11 MR. HOPPER: I need about 20 minutes for each of
12 those at the most.

13 MR. LOCKRIDGE: We would like about an hour and a
14 half, I think, if we can, to respond to all of their
15 experts -- all of their motions on the muscles, if we may,
16 Your Honor.

17 MR. BECK: Your Honor, we have a few other
18 motions. If they take more time than we do, I don't know
19 if we are going to get through all the other ones today.

20 MR. LOCKRIDGE: My expert just told me an hour is
21 fine anyway, Your Honor. So I guess we can live with an
22 hour, Phil.

23 MR. HOPPER: You are taking an hour and a half?

24 MR. ISMAIL: I am taking one hour for five
25 motions.

1 MR. HOPPER: We'll take one hour, Your Honor.

2 THE COURT: Do we need to break now?

3 COURT REPORTER: Yes.

4 THE COURT: The boss says yes. We'll take a
5 15-minute break.

6 (Recess taken at 2:35 p.m.)

7 * * * * *

8 (2:50 p.m.)

9 **IN OPEN COURT**

10 THE COURT: First off, congratulations, Counsel,
11 for being named in the top 40 under 40.

12 MR. ISMAIL: Thank you, Your Honor. That's all I
13 wanted to address today. Thank you.

14 Good afternoon, Your Honor. As I indicated before
15 the break, I did want to take as a group the five experts
16 and our related motions relating to muscle issues. As you
17 saw from the briefing, there's considerable overlap both in
18 the argument and the scientific data relied upon in support.
19 So rather than repeat it five times, I thought we could do
20 it all at once. And the experts again are Drs. Mayer,
21 Richman, Boulton, Carlson, and Zizic.

22 And what I want to address collectively is their
23 opinion, which each give as their own opinion, that Baycol
24 is the most toxic statin but not repeating the discussion
25 we've had today, their opinions as to a statin myopathy that

1 is permanent that does not resolve upon discontinuation of
2 the medicine, and lastly their opinions regarding the
3 appropriate methodology by which you can diagnose a statin
4 myopathy.

5 And if I have time at the end, I may -- there's a
6 couple of straggler issues as to unique experts, and if I
7 can get to those I will. Otherwise I'm happy to rest on the
8 papers for those issues.

9 As I indicated, each of the experts that I just
10 mentioned opine as their own opinion that Baycol was the
11 most toxic statin. And whatever the Court resolves with
12 regard to the appropriateness or not of adverse event data
13 for that comparison, none of these experts by their own
14 qualifications and experience pass Daubert muster to give
15 that opinion in their own right.

16 And Mr. Arbitblit and Mr. Black to some extent
17 gave a lengthy presentation of their view of the evidence on
18 the comparative safety issue. None of that, other than the
19 adverse event data, is relied upon by these five muscle
20 experts.

21 And I'm going to play, Your Honor, just straight
22 through some deposition testimony from Dr. Richman, Boulton,
23 and Carlson which shows the limited basis upon which these
24 experts rely to give their opinion on Baycol.

25 "Are you aware of any data supporting the conclusion

1 that Baycol had a higher risk of myotoxicity other than
2 spontaneous adverse event data?"

3 MR. ISMAIL: This is Dr. Richman, Your Honor.

4 "No, I'm not.

5 "Your opinion regarding the comparative muscle toxicity
6 of Baycol versus the other statins is based entirely upon
7 reporting rates of adverse events, correct, postmarket?

8 "Yes."

9 MR. ISMAIL: Dr. Carlson.

10 "Other than the medical articles that you cite in
11 paragraph 8 and paragraph 46, do you have any other basis
12 for the opinions that you set forth concerning the relative
13 toxicity of Baycol versus other statins?

14 "Let me see which -- these are representative of the
15 papers that I would have read that indicate a higher
16 incidence of myopathology in Baycol treated patients.

17 "Okay. Do you know that many of these -- well, do you
18 understand that all of these references in paragraph 8 and
19 paragraph 46 are all based on analyses of spontaneous
20 postmarketing adverse event reports?

21 "Yes, I am.

22 "You do understand that?

23 "Yes."

24 MR. ISMAIL: So what we have, Your Honor, is a
25 group of experts that relied not upon the data that you

1 heard today presented by the attorneys, but rather solely on
2 or in substantial part upon the spontaneous adverse event
3 data.

4 I don't want to repeat our position on the
5 unreliability of that data, but a threshold question under
6 Daubert is one of qualifications and experience. An expert
7 must pass that hurdle before questions of reliability and
8 relevance get addressed.

9 And here none of these experts have in their
10 professional or academic experience the qualifications that
11 would allow them to utilize this data to give a comparative
12 safety opinion.

13 Dr. Zizic is a rheumatologist. Dr. Mayer is a
14 physical rehabilitation medicine specialist. Dr. Richman is
15 a neurologist. Dr. Boulton is a geriatrician. Dr. Carlson is
16 a doctor specializing in physiology.

17 None have done any research on statins. None have
18 ever written or studied or published in the area of
19 comparative drug safety. None are epidemiologists or
20 biostatisticians. And each have a lack of professional
21 expertise utilizing this data.

22 First this is Dr. Mayer, one of the experts
23 subject to our motion, and this is his testimony as to his
24 experience.

25 "Have you ever made any analysis into spontaneous

1 adverse event reports associated with prescription drugs?

2 "That's a role of the FDA to do. That's not -- I'm not
3 an FDA officer, obviously.

4 "Is the answer to my question, no, you have not?

5 "No, I have not."

6 MR. ISMAIL: Again Dr. Mayer.

7 "Would you agree that there are a number of potential
8 biases that impact the relative reporting rates of
9 spontaneous adverse events?

10 "Yes.

11 "Have you made any effort to assess the relative
12 reporting rate of spontaneous adverse events with statins by
13 controlling for biases that are part of the data?

14 "No.

15 "Have you in any context for any drug made any
16 investigation into biases that affect adverse event
17 reporting?

18 "No.

19 "Have you done a literature review, either in this case
20 or for any other exercise, to determine what others have
21 said about biases in spontaneous adverse event reporting?

22 "I have read commentaries and editorials, et cetera,
23 about cerivastatin, but in terms of doing a formal review,
24 no.

25 "Are you aware of any guidelines the FDA has put out

1 regarding whether spontaneous adverse event data can be used
2 to show the relative safety profile of drugs?

3 "I'm not aware of that.

4 "Prior to your expert report in this case, have you ever
5 written a safety assessment of a drug based on its
6 spontaneous adverse event rate?

7 "No."

8 MR. ISMAIL: Your Honor, we went through the
9 caveats document and the Plaintiffs reference some
10 guidelines of the FDA and the proper use of this data, and
11 we have debated today whether those guidelines and caveats
12 preclude or not the use of the data.

13 But here we have an expert who bases his opinion
14 on that data and is not even aware of the guidelines put
15 forth by the FDA or the debate that we have already had
16 today regarding the FDA's commentaries about how to use its
17 own data.

18 Dr. Richman has similar gaps in his professional
19 experience. This is his testimony.

20 "My question was: You are not an expert in how to use
21 the FDA's adverse event database to compare the safety of
22 drugs in a class, correct?

23 "I think I'm a reasonable expert for this.

24 "You've never done it before, have you, Doctor?

25 "No."

1 MR. ISMAIL: So here we have a doctor who has
2 never done the analysis that he did in this litigation and
3 he considers himself expert enough to do the analysis.

4 And the case law has commented on this question of
5 qualifications, that the court need not accept an expert's
6 say-so that he is qualified to do an analysis for the
7 purposes of litigation and instead the case law requires the
8 court and the parties to go further and see whether, in
9 fact, the expert does have a background that is relevant.

10 And the cases talk about does an expert -- is his
11 opinion in litigation a natural progression or outgrowth of
12 the work that he or she has done outside the litigation, is
13 he doing outside the courtroom what he purports to be an
14 expert in inside the courtroom.

15 And Dr. Richman wants the Court to accept him as
16 an expert in epidemiology and comparative safety analyses,
17 but by his own admission he's never done it before being
18 retained as an expert in this case.

19 One more clip from Dr. Richman on the same point,
20 Your Honor.

21 "How did Dr. Staffa calculate the number of cases of
22 fatal rhabdomyolysis?

23 "From the adverse event reporting mechanism.

24 "Do you know what the general scientifically accepted
25 methodology is for using the FDA's spontaneous database to

1 make comparisons between drugs in a class?

2 "This would seem to be a very good one.

3 "Is that the first one you've read?

4 "Yes.

5 "Have you ever read a text on pharmacoepidemiology?

6 "No, I haven't."

7 MR. ISMAIL: Again, Your Honor, we have an expert
8 who wants to rely for his opinion on Dr. Staffa's letter and
9 he wants to give the opinion that it's a good analysis for
10 the purposes of comparative safety determinations and yet,
11 as you just saw, that's the first one he's ever read before.

12 He does not have the qualifications to enable him,
13 just as the other muscle experts do not have the
14 professional experience that enable them, to make
15 comparisons between Baycol and the rest of the statin class.

16 And the Plaintiffs' response to this -- and let me
17 show, Your Honor, the opposition on Dr. Carlson's motion.
18 So this is the Plaintiffs' memorandum in opposition to our
19 motion on Dr. Carlson.

20 And on this question of Dr. Carlson's lack of
21 expertise they write, No one can be an expert in all areas.
22 Such a rule would ignore the modern realities of medical
23 specialization, quoting from cases that have been cited by
24 both parties in this case.

25 And continuing on to the next paragraph, they go

1 on to describe how, gee, in medical science doctors and
2 scientists often collaborate to reach a sort of joint effort
3 with respect to conclusions that they're coming to in their
4 research.

5 And we agree that witnesses cannot be expected to
6 be experts in everything, but the consequence of that is not
7 to excuse their lack of experience on the question of
8 qualifications.

9 The Steering Committee wants to take Dr. Carlson's
10 and Dr. Mayer's and Dr. Richman's lack of expertise as an
11 excuse for their lack of qualifications under Daubert. The
12 cases that they're citing here excluded the testimony of the
13 experts because they were not qualified.

14 So to say that, gee whiz, you can't expect
15 everyone to be an expert in everything, that is true, but
16 the consequence is not that therefore we don't examine their
17 qualifications. The consequence is that the opinions and
18 the experts are excluded as to those issues in which they're
19 not qualified to render opinions.

20 And that is the fundamental disagreement here as
21 to these experts who admittedly do not bring to this
22 courtroom their professional and academic expertise on the
23 question of comparative drug safety, but instead want to do
24 it here for the first time.

25 And just briefly, Your Honor, Drs. Mayer and

1 Zizic, two other experts on this comparative safety, in
2 addition to relying upon the adverse event data purported to
3 give an opinion on pharmacology.

4 And just to refer the Court here to testimony that
5 we cited in our brief, this is Dr. Mayer's deposition and --
6 Dr. Mayer in his deposition and I believe in his report, if
7 you look there, beginning at line 15.

8 "You pointed me to, for example, bioavailability as
9 support for the testimony that Baycol was more dangerous,
10 correct?

11 "Yes.

12 "You're not aware of any study making that connection,
13 correct?"

14 He goes on to say, "I said I couldn't cite a specific
15 study making that connection because that's not my area of
16 expertise that I focused on in my review for this report."

17 And then continuing on, we get to the nub of it
18 with Dr. Mayer at page 263, line 10.

19 "Is it fair to say, Dr. Mayer, that you are not
20 qualified to give statements about comparative safety based
21 upon a drug's bioavailability?

22 "That is fair to say."

23 So here we have a witness who by his own admission
24 is not qualified on his own expertise to give an opinion
25 about comparative safety based on pharmacology grounds, just

1 as he is not qualified on adverse event grounds to give
2 comparative safety opinions.

3 Dr. Zizic, and I won't take the time here to show
4 the testimony, but there's a lengthy passage which we cite
5 in our papers in which he disclaims prior experience as a
6 pharmacologist, prior research or publications on statin
7 pharmacology.

8 And, again, he doesn't come here as an expert in
9 pharmacology. He's a rheumatologist. And he cannot
10 bootstrap his opinion on comparative drug safety by for the
11 first time in this court becoming an expert in pharmacology
12 and rendering opinions that he say support his fundamental
13 opinion that Baycol is the most toxic statin.

14 Now, Your Honor, I wanted to turn to the second
15 topic, unless the Court had areas you wanted me to address
16 there --

17 THE COURT: Go ahead.

18 MR. ISMAIL: -- and that is this question of
19 permanent injury.

20 And I'm sort of in an odd situation here because
21 Mr. Arbitblit about an hour ago stood here and said we're
22 not claiming in this litigation that a patient can have -- a
23 patient who does not have a demonstrated increase in CK can
24 have a permanent muscle related injury.

25 And that is contrary to a vigorous debate in the

1 papers that had been submitted to this Court under the
2 Daubert analysis and what their own experts have said in
3 their depositions and reports themselves.

4 And so the question is: Is there a permanent
5 myopathy in which a patient can have muscle symptoms persist
6 after discontinuation of the statin even in the absence of
7 an elevated CK?

8 And on that question, Your Honor, here we are
9 through Phase -- or in the middle of Phase III and IV in
10 discovery where we're getting case-specific expert reports.
11 We have patients today in this MDL claiming that they've
12 never had rhabdomyolysis, they don't have an elevated CK,
13 and they're claiming in 2006 and 2007 a permanent injury.
14 And so -- Baycol has been off the market for five years.

15 And so what we have is a concession, so to speak,
16 from the Plaintiffs that we're not claiming that those
17 injuries exist and yet we have experts in this case,
18 including the experts the PSC has brought, claiming that
19 there is this permanent class of myopathy for patients who
20 do not have an elevated CK.

21 So I don't want to convince the Plaintiffs that
22 they're advancing a position that they're really not and I'm
23 not trying to create an opinion that they're disclaiming
24 here before the Court, but we're here on an MDL-wide Daubert
25 analysis and we're mindful of the fact that these cases may

1 be remanded for trial and we have expert reports and expert
2 depositions from these five individuals who are describing a
3 permanent injury even in the absence of an elevated CK.

4 And so what we think is appropriate to address
5 here, notwithstanding the comment this morning or this
6 afternoon, is to show the Court that there is no basis in
7 science for an opinion that there's this permanent injury
8 absent an elevated CK.

9 And just to go to the point that I was making,
10 Your Honor, their own experts comment -- this is
11 Dr. Richman.

12 "If a patient presents to you with normal CK and
13 complaints of muscle pain and weakness and they're also
14 taking a statin, okay, and you remove the statin and the
15 pain and weakness do not go away, does that tell you
16 anything about the likelihood that the statin is causing the
17 patient's muscle problems?"

18 Dr. Richman says, "No."

19 And there's other examples in reports and in the
20 briefing here that the Plaintiffs have submitted that
21 they're holding out hope that there's this type of disease
22 that's a statin myopathy that does not involve an elevation
23 of CK that can be permanent after discontinuation of the
24 statin. And that's what we're attacking here on Daubert
25 grounds. It is that opinion that we're seeking to exclude

1 as unreliable and not recognized in medical science.

2 And I have other examples I was just jotting down
3 while Plaintiffs were finishing their discussion of
4 Dr. Farquhar. It's in their opposition to Drs. Boulton,
5 Mayer, Dr. Richman where they have briefed before this Court
6 that there is a permanent statin myopathy, not a permanent
7 rhabdomyolysis. They specifically want this Court to accept
8 that there's a permanent statin myopathy, and that is what
9 we're attacking here.

10 And I would like to begin, Your Honor, with a
11 discussion of the Leathers case, which is what was briefly
12 mentioned this afternoon by counsel. Your Honor, we have --
13 this is a case that came up out of the Northern District of
14 Georgia in 2006. It is a claim by a former Lipitor patient
15 for a permanent myopathy in the absence of elevated CK.

16 So it's the same class of drugs, it's the same
17 alleged injury, and it's the same motion that we have
18 brought here and that opinion was challenged under Daubert
19 grounds by the manufacturer of Lipitor in that case.

20 And the Plaintiffs have tried to distinguish the
21 Leathers case under various grounds and this is their
22 opposition to Dr. Zizic -- excuse me -- their opposition to
23 our motion on Dr. Zizic.

24 And I'm going to go through each of these
25 purported areas to distinguish the Leathers case, but none

1 of them is what counsel said this afternoon is the principal
2 distinguishing feature and that is somehow the plaintiff in
3 Leathers was alleging an injury that they're not alleging
4 here. That's not what they told the Court in their papers.

5 So I'll be addressing what they actually submitted
6 here and what their experts have said to make sure that in
7 this MDL-wide Daubert proceeding we do get what we believe
8 is the focus on this statin -- permanent statin injury that
9 they've alleged up until today.

10 And what they alleged here to distinguish the
11 Leathers case, first of all, they say the court in Leathers
12 found the expert was not qualified. That's one of their
13 points to distinguish the Leathers case.

14 And to the contrary, the court in Leathers
15 found -- although the court had reservations about the
16 plaintiff's expert there, the court specifically found the
17 expert at issue in the Leathers case was qualified on the
18 area of myopathy and permanent injury.

19 So the first point to distinguish Leathers is not
20 true, that the Leathers court did accept that expert as
21 qualified.

22 The second ground that they've raised to
23 distinguish Leathers is that the plaintiff there did not
24 address general causation, and that also is not true. The
25 court found that the expert submitted articles and argument

1 in support of his specific causation opinion and the court
2 took that reasoning as their support for general causation.
3 So the court specifically addressed general causation in the
4 context of a proffered opinion, which is exactly what we're
5 seeking to have this Court do here.

6 Now, the third ground that they have brought or
7 have alleged to distinguish Leathers is that the
8 manufacturer of Lipitor has not challenged -- has challenged
9 general causation; whereas, Bayer has not. And that also is
10 not true.

11 And in the Leathers case the court noted
12 defendants freely admit that physicians have long been aware
13 of certain muscle related adverse events that have been
14 associated with statin drugs, quoting from the defendant's
15 submissions to that court.

16 So there is no difference because it has long been
17 the case, as Bayer has long recognized and warned of, that
18 certain muscle related adverse events have been reported and
19 are associated with all statins, including Baycol.

20 There's no point of disagreement or distinction
21 between what Bayer has conceded, if you want to use that
22 term, and what the manufacturer of Lipitor did in the
23 Leathers case.

24 And the last point that they made to distinguish
25 Leathers is that, well, that drug -- that case involved

1 Lipitor, this case involves Baycol, and you should disregard
2 the Leathers opinion because of that simple distinction.

3 Your Honor, that's also a false distinction and
4 the reason is this. Each of these experts that I'll be
5 talking about relies on non-Baycol statin literature in
6 support of their permanent myopathy opinion.

7 There's the Phillips article. I'll be getting to
8 each of these articles in detail, but they are in every one
9 of the briefs. Your Honor has seen them. Phillips,
10 Hildebrand, Argov, all these literature that they say
11 support their Baycol opinion is based in whole or in part on
12 other statin research.

13 And their clinical experience that they keep
14 talking about in support of their motions, very few of them
15 and some of them had no experience with Baycol-induced
16 rhabdomyolysis, but they had experience with other
17 statin-induced rhabdomyolysis.

18 So the PSC cannot have it both ways. They cannot
19 cite to this Court non-Baycol statin literature in support
20 of the permanency opinion and at the same time say this
21 Court should ignore Leathers because it involved a
22 non-Baycol statin. Either the research is supportive
23 because the opinion is the same or it's not.

24 And so they bring to this Court these non-Baycol
25 medical articles but want this Court to ignore the

1 non-Baycol case law, and we believe that is just an
2 illogical and unsupported position to take.

3 So now that I have gone through the areas that I
4 found that they have tried to distinguish Leathers, the
5 holding which the court reached in the Leathers case is
6 aptly stated in this called-out section of the opinion:

7 The statin side effect recognized in the medical
8 community is a temporary one that ends when the patient
9 stops taking the drug. Plaintiff attempts to extrapolate
10 this temporary side effect to establish general causation of
11 a much more serious, permanent illness.

12 That is the holding of this court after it went
13 through the purported scientific support for the plaintiff's
14 general causation and specific causation opinion in the
15 Leathers case.

16 We understand that the Leathers case is a district
17 court holding not binding here, but I will go through, Your
18 Honor, why we believe that opinion is correct and the
19 similarities between the evidence presented here and that
20 which was at issue in the Leathers court.

21 Baycol, Your Honor, was a medicine that was used
22 by some 6 million patients worldwide. The Plaintiffs have
23 not cited to this Court a single report of a permanent
24 muscle injury from a patient who did not have an elevated CK
25 or other objective indicia of serious muscle disease, none,

1 not a report in a clinical trial, not a report of a patient
2 in an epidemiological study, not one of these adverse event
3 reports that they have relied upon to such great extent in
4 this litigation.

5 Nor have they cited any such report for any of the
6 other statins either, and that's -- those are a class of
7 medicines that have been used by greatly in excess of
8 6 million patients worldwide and yet there is no report of
9 such a patient in the medical literature.

10 And it's not just our say-so, Your Honor. This
11 is what their own experts have admitted. First is
12 Dr. Carlson.

13 "Are you aware of any case reports that document a
14 muscle function impairment more than six months after the
15 acute statin-induced injury has resolved?

16 "Most of them have been more short term in terms of the
17 frame of reference. And, again, I don't know whether these
18 reports would indicate that complete resolution has occurred
19 or if they just didn't go any further.

20 "Okay. So are you aware of any studies that document
21 impairment of muscle function after statin-associated injury
22 greater than six months after discontinuation?

23 "No, if you use the six months, I'm not aware of any."

24 MR. ISMAIL: Dr. Richman.

25 "Are you aware, sir, of a single article describing a

1 patient having normal CK and have muscle symptoms persist
2 following discontinuation of the statin?

3 "Not that I can come up with right now, but it doesn't
4 seem as an impossibility.

5 "Are you aware of a single article describing the
6 possibility that a patient with normal CK can have muscle
7 pain or weakness persist following discontinuation of the
8 statin?

9 "No, I'm not aware of any article that does that --

10 "Have you --

11 " -- that states that. But in terms of my own opinion,
12 I could conceive of circumstances where it would be a very
13 significant possibility.

14 "Have you ever treated a patient in your clinical
15 practice who had normal CK and had muscle symptoms persist
16 following discontinuation of the statin?

17 "I actually want to go back just one second. I mean, it
18 relates to sort of the very first things we talked about in
19 my testimony, that the CK level depends on the timing, of
20 course, and that's always the proviso that I, you know,
21 would want to put in there. But in terms of a patient that
22 I've taken care of that was taking statins, had muscle
23 symptoms, normal CK, and then the statin was discontinued
24 and the symptoms continued, no, I haven't treated a patient
25 like that."

1 MR. ISMAIL: Dr. Mayer.

2 "Are you aware of any medical literature that would
3 support the notion that in patients with normal CK during
4 the statin use, that muscle symptoms can persist following
5 discontinuation of the statin?

6 "I'm not aware of any literature that states that."

7 "Now, Dr. Mayer, are you aware of any medical research
8 that would support the notion that a patient with normal CK
9 can have muscle symptoms persist after the discontinuation
10 of a statin?

11 "I don't know that anybody has studied that at this
12 point.

13 "So you're not aware of any such research?

14 "That's correct."

15 MR. ISMAIL: I want to show now, Your Honor, to
16 show the juxtapose, what was at issue in Leathers to what
17 the Plaintiffs' own experts have testified here.

18 So this is Dr. Mayer's testimony that I just
19 showed you the video clip of, Your Honor, and the question
20 was aware of any medical research that would support the
21 notion that normal CK -- a patient with normal CK can have
22 muscle symptoms persist. And the question had to do with
23 statins in general, that there's no statin related research,
24 let alone Baycol specific research, on this point. And he
25 acknowledges that there is no such medical research out

1 there.

2 If I can manage to do this, Your Honor, I want to
3 put to that side Dr. Mayer -- and you saw similar citations
4 from the other experts I just showed you -- with the opinion
5 in Leathers.

6 So this is the district court's opinion in the
7 Leathers case and the district court is citing Dr. Firth,
8 the expert who was at issue in that case and giving the same
9 opinion that we're seeking to exclude in this litigation.
10 And what was significant to the Leathers court is remarkably
11 similar testimony to what Dr. Mayer and Dr. Richman and
12 Dr. Carlson just gave.

13 "Are you aware of any peer review studies or reports
14 that would show with any kind of statistical reliance that
15 people who take Lipitor who have no CPK elevations and have
16 muscle pain and weakness have a continuing disability --

17 "No.

18 "-- for myopathy after, you know, months or years?

19 "I've seen no studies that address that."

20 This is the basis for the district court's
21 exclusion of this opinion in Leathers. And, of course,
22 Dr. Mayer gave remarkably similar testimony here, as did the
23 testimony of the other experts I just showed you.

24 So we have as a basic proposition the Plaintiffs'
25 own experts acknowledging an absence of medical research or

1 literature in support of this myopathy permanent injury
2 opinion.

3 So each expert has gone out and has pulled up
4 medical articles that they say are support for the permanent
5 injury hypothesis and each of the articles -- experts rely
6 on an article by Dr. Phillips, who at one time was a
7 Plaintiffs' expert in this litigation and was dropped before
8 his deposition. But for the purposes of this permanency
9 opinion, they talked about this article as support for this
10 idea of a permanent injury.

11 And what Dr. Phillips actually says -- back up one
12 second. This is a case study of four patients, only one of
13 whom had ever taken Baycol. So then going back to my
14 comment about it's a false distinction with the Leathers
15 case to say that, gee, that involved Lipitor and here we're
16 talking about Baycol, they're relying on the Phillips
17 article even though most of the patients there were not
18 taking Baycol.

19 But in any event, so we had four case reports,
20 case studies in the Phillips article and there was no
21 elevation of CK. And Dr. Phillips said, well, these
22 patients had subjective reports of pain and weakness and I
23 biopsied them and I found some objective evidence of
24 myopathy.

25 But as to this question of permanency,

1 Dr. Phillips noted these patients -- these symptoms
2 normalized when the patients received a placebo and the
3 pathologic abnormality, so the biopsy study, reversed upon
4 discontinuation of statin therapy.

5 So here we have one of the articles they're
6 relying upon where in point of fact every one of the
7 patients had their symptoms resolve upon discontinuation
8 of the statin.

9 The Hildebrand article, which at first was an
10 abstract when we deposed all these individuals a couple of
11 years ago and has since been published as an article, the
12 Court has been provided by both sides the actual final
13 article.

14 Hildebrand was a study of 45 patients, again, the
15 majority of whom never took Baycol but other statins, but
16 nevertheless they rely upon it for their permanency opinion
17 in this case.

18 In Hildebrand, of the 45 patients studied,
19 patients with statin-associated myopathy experienced
20 full resolution of muscle pain on cessation of statin
21 therapy.

22 And Dr. Zizic, one of the experts of the
23 Plaintiffs here, admitted as much in his deposition. That
24 (indicating) is not Dr. Zizic's deposition, but that
25 (indicating) is.

1 So down here he is asked, "So, again" -- and this
2 is after some questioning where Dr. Zizic identifies the
3 Hildebrand study as support for the permanent myopathy
4 theory.

5 "So, again, Hildebrand, because we do not know, provides
6 no evidence that you can have prolonged statin therapy
7 leading to permanent muscle damage or progressive myopathy
8 in patients with normal creatine kinase levels?"

9 I apologize, Your Honor, I lost -- oh, there it
10 is.

11 "THE WITNESS: Correct."

12 So there's the answer to the question I just
13 showed. Dr. Zizic acknowledges that the Hildebrand study
14 does not support the permanent myopathy theory for patients
15 who do not have a demonstrated elevation in CK.

16 The England study, which is another piece of
17 literature each of their experts relies upon, it's, as you
18 can see from the title, the study of Zocor and Pravachol,
19 again non-Baycol statins -- and these are 15 patients -- a
20 study of their claims of muscle pain and weakness.

21 And as to these patients, all symptoms and signs
22 resolved on cessation of the drugs and then reoccurred in
23 patients who were rechallenged, which means the symptoms
24 came back when they were again given the statin.

25 And this is the material that they cite in their

1 reports and their depositions in support of the permanent
2 myopathy theory and what I want to show, Your Honor -- so we
3 have seen three examples of literature that they are relying
4 upon in which, contrary to the assertions of the Plaintiffs
5 and their experts, every single patient had a resolution of
6 symptoms after they were removed from the medicine.

7 And so going back to the Leathers case, so here is
8 the court's analysis in Leathers. So the court is now
9 analyzing the medical articles submitted in support of the
10 permanent myopathy theory and the court notes, well, in the
11 very articles that you're submitting here in support of your
12 opinions we see things like symptoms resolve completely upon
13 statin discontinuation or repeated muscle biopsy performed
14 three months after discontinuation of statin therapy
15 revealed complete resolution.

16 And interestingly here, Your Honor, the court is
17 talking about the Phillips article. You can see that by
18 actually going to Phillips itself. So here the court is
19 saying in the very articles you're citing here, all the
20 patients resolved.

21 And if you look at the quotes, interestingly, the
22 court is talking about Dr. Phillips' observation of his own
23 patients. So here we have the patient's muscle symptoms and
24 hip weakness improved three months after she discontinued
25 statin therapy, repeated muscle biopsy performed three

1 months after discontinuation of statin therapy revealed
2 complete resolution of the abnormal lipid stores.

3 Each of these patients studied in the Phillips
4 report had complete resolution of the statin myopathy, the
5 very same observations the Leathers court found in support
6 of its opinion to preclude the opinion.

7 And the PSC's response to all of this is, well,
8 gee, the Phillips article and the Hildebrand article and all
9 the other citations that we have in support of our theory,
10 even though all the patients resolved, had their symptoms
11 resolve, it's actually not inconsistent with our theory for
12 various reasons.

13 And so here (indicating) this is I believe
14 Dr. Boulton's opposition and he is talking about the
15 Hildebrand article, which we just showed. There's nothing
16 in this report to contradict Dr. Boulton's opinion.

17 The PSC has -- the burden here is upside down.
18 They've cited these articles in support of the permanent
19 myopathy opinion and none of them, not one, did the patients
20 have a permanent myopathy.

21 And they say, well, we can distinguish our own
22 articles and say that it's not fatal to our opinion, but
23 that's beside the point because they have the burden to
24 support their theory here.

25 And the fact that every single patient in these

1 articles who had normal CK had a resolution of the symptoms
2 is fatal to their claim that there's a reliable basis in
3 medical science in support of a permanent myopathy theory,
4 the same way the Leathers court found similar admissions in
5 the articles there to be supportive of the preclusion of the
6 opinion.

7 Since the depositions were taken, Your Honor,
8 additional articles have come out. The PSC has described
9 them in their briefs. I'll note that none of their experts
10 submitted supplemental declarations relying upon these
11 articles.

12 And if these new articles really were the saving
13 grace for their opinions here, one might expect that we
14 would see a supplemental expert report relying on these
15 medical articles.

16 And the reason why we don't is because they're
17 just like all the others with respect to this permanent
18 myopathy and, in fact, none of them support the theory
19 that's advanced.

20 In the interest of time I will just show a couple
21 of them. One of them is this article called -- written by a
22 Dr. Dobkin. This is an article that apparently came out
23 after their experts were deposed and submitted reports. And
24 this is a study of 18 patients. None were taking Baycol.
25 And each of their -- and, again, these are articles they

1 identify as support for their permanent myopathy opinion.

2 By three months off statin all -- they're talking
3 about all 18 patients -- recovered 5/5, which is the
4 measurement of strength there in that case. By three months
5 off statin all recovered 5/5 proximal strength, again noting
6 that each of the patients in that study fully recovered from
7 the statin -- the alleged statin myopathy.

8 And I'm not going to go now, Your Honor, to each
9 of these articles. We've distinguished them in our papers.
10 Actually not even distinguished them. We embrace them in
11 our papers because the patients there did not suffer
12 permanent myopathy, those who had normal CK or other --
13 absent other indicia, objective indicia, of a muscle injury.

14 So here we don't have any clinical data in
15 support. The very research they cite to this Court
16 demonstrates the opposite of the conclusion they want the
17 Court to reach. And their experts have admitted that they
18 haven't found such a patient in the medical literature that
19 they're advancing as a theory in this case.

20 And for all those reasons we believe the
21 Leathers court got it right and for reasons that are
22 remarkably similar to the way the record has developed in
23 this case.

24 Your Honor, I wanted to turn to the third topic,
25 which was the question of diagnosis, absent any issues you

1 wanted to me to address on --

2 THE COURT: Go ahead.

3 MR. ISMAIL: -- the permanency.

4 Several of the Plaintiffs' experts have given
5 opinions in the context of general causation on what it
6 would take to diagnose a statin-induced myopathy, and I want
7 to take these together because I believe they suffer from
8 the same methodological flaws amongst them.

9 And I'm talking now about Dr. Richman's
10 retrospective diagnosis opinion, Dr. Boulton's clinical
11 criteria that he outlined in his expert report for how to
12 diagnose a myopathy.

13 And it applies to the other experts as well to the
14 extent Dr. Carlson and Dr. Zizic, they hint at a diagnostic
15 criteria, although they don't spell it out in their reports
16 like the others do, but the opinion, whether shared by all
17 of them or not, is what we're seeking to exclude here under
18 Daubert.

19 All the studies that they have talked about, the
20 Phillips, the Hildebrand, the Dobkin, begin as their
21 starting point an affirmative diagnosis of myopathy. All
22 those studies begin with some contemporaneous objective
23 indicia of myopathy, not vague reports of aches and pains
24 analyzed months later. We're talking CPK elevations, EMGs,
25 electromyograms, muscle biopsy, quantitative strength

1 testing, objective criteria to diagnose a myopathy.

2 And that's what the medical profession has
3 identified as the only reliable basis upon which to diagnose
4 a statin-induced myopathy. A couple of the experts have
5 come up with alternatives.

6 This is Dr. Boulton, his expert report. So up here
7 in his expert report he acknowledges that typically there's
8 objective indicia of myopathy, CK increase or EMG, the
9 electromyogram, or abnormal biopsy results.

10 But then he goes on in his report to say even
11 without these objective findings, the presence of moderate
12 cerivastatin-induced myopathy can be deduced in persons
13 meeting three clinical criteria.

14 So we are now deducing a myopathy after the fact
15 absent objective evidence that a myopathy actually exists
16 and we're talking about subjective reports of pain or
17 weakness, a temporal association. And this third point is
18 interesting in light of counsel's comment this afternoon.

19 So the predicate here, we have patients who have
20 no objective evidence of a myopathy and Dr. Boulton is saying,
21 well, you can still diagnose a statin myopathy if you can
22 show these three factors.

23 The third one is the symptoms either diminish or
24 persist. So we have patients who don't have a demonstrated
25 elevation of CK and Dr. Boulton is saying you can still

1 diagnose a myopathy even if the symptoms persist, which is
2 not what I heard from counsel this afternoon as to what
3 they're claiming in this MDL, but instead is what Dr. Boulton
4 is asserting is a diagnostic criteria.

5 So Dr. Boulton is asked in his deposition, now that
6 he has staked out this opinion, Can you show me where your
7 criteria are used in the medical literature to deduce a
8 statin-induced myopathy? He answers, No.

9 Then he's asked, and I am going to show this
10 longer passage from his deposition, why it is that this
11 clinical criteria that he's advancing in this litigation
12 does not appear in the medical literature.

13 "What was the purpose of you coming up with your three
14 criteria?

15 "Yeah, just very briefly, to create some guidance for
16 clinicians in being able to determine whether a person has
17 moderate to severe statin-induced myopathy.

18 "Have you communicated your criteria to any other
19 treating physician?

20 "No. It's all stayed within this context here.

21 "Well, how is it going to be useful to other physicians
22 if you don't communicate it?

23 "It's a process, you know, it's -- in the future it may
24 be useful to other clinicians. Right now I haven't
25 submitted it for publication and I wouldn't because I

1 haven't gone through the rigorous process that I mentioned
2 to you. This is a first step, you write it down, you put
3 together the evidence as best that the evidence seems to
4 indicate, and then you get perspectives from other people.
5 And once you've debated it all out, then you submit it for
6 publication. This is too preliminary."

7 MR. ISMAIL: So Dr. Boulton states that the clinical
8 criteria in his expert report is too preliminary to be
9 subject to publication in a medical journal, which, of
10 course, is one of the questions, again, under Daubert, has
11 the clinical -- has the opinion been accepted, generally
12 accepted, has it been subject to peer review. He doesn't
13 think it's even firm enough to be put through a peer review,
14 let alone pass peer review.

15 And there's a comment from Judge Posner, I
16 believe, that the law should not lead science. Instead it
17 should lag it. And that passage has been cited in this
18 circuit and others as one of the things to consider under
19 Daubert.

20 And here we have an expert who wants to give his
21 opinion a test run here. It's too preliminary for other
22 doctors and for publication, but he thinks it's good enough
23 to bring here because he wants to air it out and get some
24 views from others.

25 That's the opposite of what should happen under

1 the Daubert analysis. The opinion must reach general
2 acceptance before it's submitted to a jury to give a basis
3 for a verdict, not the opposite. You don't put it through a
4 test run here, see how it does, and then go publish it in an
5 article later.

6 Now, Dr. Richman -- I'm not exactly really sure
7 where Dr. Richman ended up with his diagnosis opinion. We
8 describe in length in our motion that he talked about in his
9 deposition this concept of retrospective diagnosis of
10 rhabdomyolysis, and the Plaintiffs respond that Dr. Richman
11 did not mean for his testimony to be so interpreted.

12 This is their opposition on Dr. Richman where he
13 is talking about retrospective diagnosis of rhabdomyolysis
14 even in the absence of an elevation of CK and acknowledging
15 that he did testify to that at his deposition in response to
16 questioning.

17 But then they say here that Dr. Richman intended
18 his, I guess, future testimony to be interpreted that in the
19 absence of a timely CK level measurement, a retrospective
20 diagnosis could be made on the basis of some combination of
21 the factors in the constellation of symptoms he described.

22 Whether it's exclusively upon one factor or on a
23 constellation of factors, we've cited to the Court where
24 Dr. Richman has admitted this concept of retrospective
25 diagnosis of rhabdomyolysis he's never seen before in the

1 literature, he's never seen that phrase before, he's never
2 written about that concept before his expert report in this
3 case.

4 So whether it's on one factor or on three factors,
5 the point of the matter is this is something that he has
6 come up with for the first time in this litigation rather
7 than something that has been put through and accepted by the
8 scientific community.

9 I'll point out as well, Your Honor, that this --
10 well, I guess in the interest of time I will move on rather
11 than show the clip, but we have shown the Court other
12 examples from Plaintiffs' own experts.

13 THE COURT: Let's see the clip.

14 MR. ISMAIL: This is Dr. Mayer, Your Honor. We
15 are talking again about this question of diagnosis and
16 Dr. Mayer has given an opinion -- I'm going to show you
17 Dr. Mayer talking about what it takes to diagnose muscle
18 cell destruction, myopathy, in a patient.

19 "In terms of being able to affirmatively diagnose muscle
20 cell destruction in a patient, you need to do one of four
21 things, either test for elevated CK, do a biopsy, do an EMG,
22 or do a quantitative strength test; is that correct?

23 "Those are probably the four primary ways we could
24 diagnose it, yes.

25 "Is there another way?

1 "I think those are probably the four best ways of
2 diagnosing muscle disease, yes.

3 "Is there another way?

4 "Not that I can think of off the top of my head."

5 MR. ISMAIL: So this is Plaintiffs' proffered
6 expert on muscle diseases stating as his opinion there are
7 only four generally accepted ways to diagnose a myopathy and
8 they're all contemporaneous objective criteria, not
9 retrospective diagnoses, not can we deduce it from the
10 presence of three clinical factors, none of which have been
11 accepted in the medical literature.

12 And to the extent that Dr. Richman and Dr. Boulton
13 and others are suggesting a different criteria for
14 diagnosing a statin myopathy, it is inconsistent with the
15 generally accepted view in medical science.

16 Your Honor, on the question of mechanism, which I
17 will turn to next, there's this question of -- first of all,
18 the Plaintiffs have stated that, gee, none of their experts
19 have postulated different mechanisms that work for statin
20 injuries.

21 And this is Dr. Richman's deposition and he's
22 asked, Do statins cause a muscle injury that -- sorry that
23 the photocopy is faded here -- that does not involve muscle
24 cell death? As the Court is aware, the hallmark of
25 rhabdomyolysis is death of skeletal muscle and the spilling

1 of its contents in the blood. And he's asked, Do statins
2 cause a muscle injury that does not involve muscle cell
3 death? And he says, Yes, without question.

4 And Dr. Zizic similarly is asked in his
5 deposition, It is your opinion that you can have myalgia in
6 the absence of cell death, muscle cell death? And he says,
7 Certainly.

8 So getting -- not to again repeat much of the
9 discussion this morning, but you have this syndrome of
10 rhabdomyolysis, which as its definition is muscle cell
11 death, and then you have experts saying, well, you can have
12 a statin-induced injury that is not muscle cell death.

13 And so the question of whether you can use
14 analyses of rhabdomyolysis to give the opinion of the lesser
15 injury of myalgia, pain and weakness, their own experts are
16 saying we believe that there's this syndrome out there that
17 does not involve death of skeletal muscle.

18 And they can call it a continuum in terms of
19 severity, but by their own admission there's no generally
20 accepted view on how statins cause myopathy or
21 rhabdomyolysis. They acknowledge that there's not a
22 generally accepted view on mechanism.

23 So how can they say that there is a single
24 mechanism that would account for muscle cell death injuries
25 and nonmuscle cell death injuries when they don't know what

1 mechanism is causing either of them?

2 But the point of the matter is it is a different
3 endpoint, one that is not indicated by a death of skeletal
4 muscle. And that's the point that we've made in our
5 comparative safety challenge.

6 And I know Mr. Beck put as a placeholder that I
7 would comment here on this question of what's the mechanism
8 for myopathy. They acknowledge that there is no generally
9 accepted mechanism of myopathy, but they also acknowledge
10 and it's their position in this litigation that there is a
11 syndrome of muscle disease that is indicated by death of
12 skeletal muscle and they believe there's a syndrome of
13 myopathy in which there's no death of skeletal muscle. And
14 that's the point that we've been making.

15 And, Your Honor, as to mechanism, Dr. Richman in
16 his report and his deposition stated that he believes that
17 Baycol is more likely to enter the cell membrane. There's a
18 long discussion of that in the papers. Dr. Richman has
19 expressed that opinion. Dr. Zizic has expressed that
20 opinion, I believe.

21 And I just wanted to point out on this question of
22 mechanism what it is that we're talking about. Dr. Richman
23 says -- what he says in his report -- excuse me. I meant to
24 show the Plaintiffs' opposition here.

25 So this is their own papers on Dr. Richman. It

1 says, Dr. Richman discussed in detail his opinion that
2 Baycol affects cell membranes differently from other statins
3 and the basis for that opinion.

4 Question: By whatever mechanism statins injure muscle
5 is true for all statins, correct?

6 And he says, I can't agree with that statement.

7 And then he says, At the very simplest level, the
8 ability of statins to get into the muscle cells differ and
9 Baycol being the most effective in getting into the muscle.

10 So he is now coming up with this pharmacology
11 opinion on mechanism. Well, the Plaintiffs promised that he
12 would explain in detail his opinion and all he did was
13 say -- point to an article by Dr. Davidson and the sole
14 basis for Dr. Richman's opinion is the statement the
15 myotoxic potential of statins may not be a class effect and
16 he takes that one clause and he shoves it into a mechanism
17 opinion.

18 And he's asked at his deposition to confirm that,
19 contrary to his supposition. Can we agree that Dr. Davidson
20 does not describe a muscle injury unique to Baycol? First
21 he goes back and reviews the article again. Yes, I would
22 agree with that, he says, but I think you still have to keep
23 in consideration the fact that muscle cell death is an
24 endpoint which you can get through different pathways.

25 So he has come up with a mechanism opinion in

1 this case, Dr. Richman, on the basis of an article in which
2 there's absolutely no discussion of that point.

3 And we get back to what is at work here on
4 Dr. Richman's opinion and others, and that's the classic
5 exclusion of the say-so of an expert. The analytical *ipse*
6 *dixit* of the expert is not a sufficient basis to admit the
7 opinion as a reliable and accepted opinion in the published
8 medical research or really a permissible leap from the
9 existing theories that are out there.

10 Your Honor, my light has flashed and I will stop
11 here.

12 THE COURT: How much more do you have?

13 MR. ISMAIL: Well, I was going to point out and
14 just direct the Court to some other issues and that is we --

15 THE COURT: Because this is a very important area,
16 I want both sides to cover this area thoroughly.

17 MR. ISMAIL: I have finished my discussion of the
18 muscle issues. But as to these experts, and I won't take
19 the time to argue it, we've pointed out that some of these
20 experts give ethics, state of mind opinions. And I'm happy
21 to address that case law in connection with Dr. Raskin and
22 others --

23 THE COURT: All right.

24 MR. ISMAIL: -- but I wanted to make sure that's
25 pointed out.

1 And we also point out that Dr. Boulton has come up
2 with a labeling opinion in his deposition and we point out
3 where he disclaims any professional expertise on labeling to
4 enable him to give such an opinion.

5 Those are not common across the five and I don't
6 intend to take up more time today, but wanted to point them
7 out. Thank you, Your Honor.

8 THE COURT: Can we just take a stretch break?

9 (Recess taken at 3:55 p.m.)

10 * * * * *

11 (4:00 p.m.)

12 **IN OPEN COURT**

13 THE COURT: Let's continue.

14 MR. ARBITBLIT: Your Honor, with your permission,
15 since Mr. Hopper has to travel and I'm going to be doing
16 some lengthy presentation as part of the response to
17 Mr. Ismail, with the Court's permission I would like to take
18 just about five minutes to quickly respond to some of the
19 points and try to narrow whatever issues the Court needs to
20 address on a global basis for the experts and then allow
21 Mr. Hopper to address his specifically and then come back to
22 Dr. Richman, for whom I'm principally responsible. It's a
23 little confusing and I would rather not do it that way, and
24 we won't if you think it's too confusing.

25 THE COURT: Let's have Mr. Hopper go.

1 MR. ARBITBLIT: Thank you, Your Honor.

2 THE COURT: And then you will have a chance to
3 respond.

4 MR. ARBITBLIT: Thank you.

5 MR. HOPPER: Good afternoon, Your Honor. I
6 realize it's getting late in the day. Not to take anything
7 away from my brother, his accolades and his accomplishments,
8 it would be just tremendous just to note --

9 THE COURT: You are always a star in my --

10 MR. HOPPER: To get some congratulations for
11 making it to 50, Your Honor, would just be wonderful --

12 THE COURT: Congratulations.

13 MR. HOPPER: -- after all this.

14 And also in the interest of time, Your Honor --

15 THE COURT: So you'll know how I feel later on
16 this year when I make it to 60.

17 MR. HOPPER: And I have great respect.

18 And in the interest of time, Your Honor -- I
19 appreciate you working with the PSC on the schedule -- I'm
20 not going to use the PowerPoints, but I would like to hand
21 them up and you can look at them now or later.

22 As Your Honor knows, I'll be defending against
23 Bayer's challenge to Dr. Chad Boulton to exclude his
24 testimony as an expert witness for the PSC. Your Honor,
25 Dr. Boulton's testimony comes squarely within the ambit of

1 Rule 702 and more than satisfies the standards set forth in
2 Daubert.

3 Briefly, Your Honor, since Mr. Lockridge has
4 already effectively covered Daubert and Rule 702 this
5 morning, I don't want to belabor that, but for the record,
6 Dr. Boulton and as to his testimony, I only want to touch on a
7 few key points raised by Mr. Lockridge.

8 As Dick mentioned, the rules and the case law are
9 very clear that this Court is given wide latitude when
10 applying Daubert in the context of expert testimony. As
11 Your Honor knows, in its role as a gatekeeper the district
12 court exercises its authority by ensuring that an expert's
13 testimony rests on a reliable foundation and is relevant to
14 the task at hand.

15 In short, Your Honor, as I said that I would be
16 brief here and I'm going to continue to do that, a trial
17 judge in applying Daubert and the standards of 702 and
18 104(a) must make a preliminary assessment of whether the
19 expert's testimony and underlying reasoning or methodology
20 is scientifically valid and can properly be applied to the
21 facts of the case.

22 If the testimony is found to be scientifically
23 valid and is proper for the facts of the case, the testimony
24 is deemed admissible and to meet the Daubert standards as
25 codified in 702, reliability and relevance.

1 Without equivocation, Your Honor, we'll show with
2 the remaining presentations on the various muscle experts
3 that each of these experts and in specific Dr. Boulton's
4 testimony meets the Daubert and 702 standards with a plumb.

5 Your Honor, I listened carefully -- before I get
6 into Defendants' arguments, I want to point out one thing
7 very specifically. I listened very carefully to what
8 Mr. Ismail had to say and quite honestly, to my utter
9 amazement, he miscited the law. He miscited the law, Your
10 Honor.

11 In the holding in Daubert the holding states, and
12 I'm pointing to pages 2792 through 99, The Federal Rules of
13 Evidence, not Frye, provide the standards for admitting
14 expert scientific testimony in a federal trial. Mr. Ismail
15 cited to Frye. There's no general accepted standard.

16 Listen, if Your Honor would, to what the court
17 wrote. Frye's general acceptance test was superseded by the
18 Rules' adoption. The Rules occupy the field. Nothing in
19 the Rules as a whole or in the text and drafting history of
20 Rule 702, which specifically governs expert testimony, gives
21 any indication that general acceptance is necessary or is a
22 necessary precondition to the admissibility of scientific
23 evidence. Moreover, such a rigid standard would be at odds
24 with the Rules' liberal thrust and their general approach of
25 relaxing the traditional barriers to opinion testimony.

1 There's no general acceptance standard here any
2 longer. That's long gone. What we're looking at now and
3 what this Court is entrusted to do by the Supreme Court in
4 Daubert is to play the gatekeeping role and to examine the
5 methodologies and the underlying reasoning of the experts
6 who are proffering their opinions.

7 Defendants have attempted two rather weak
8 arguments, I would add, to disqualify Dr. Boulton in
9 particular. First they claim that Dr. Boulton's clinical
10 criteria as the basis for his opinion lacks scientific
11 foundation, and second they claim that Dr. Boulton's opinions
12 regarding persistent myopathy are not supported by the
13 scientific literature and that further he has no background
14 or expertise qualifying him to make these opinions.

15 Mr. Ismail focused a great deal of attention on a
16 few things and I want to take those one by one. In
17 particular he focused on the AERs and he put up there for
18 the Court to see various deposition clips and cuts that they
19 sort of cherry-picked out of all of the depositions.

20 And they did that, Your Honor, because they want
21 to pin this entire validity of our experts -- apparently
22 they do -- on the AERs. They have a few other touchstones
23 too, but in particular the AERs.

24 And if that's all it was about, Your Honor, I
25 suppose we could probably pack our bags and go home because

1 that's why doctors do consults with each other, that's why
2 we have all of this collection of experts. That's
3 consistent with the practice of medicine. That's why
4 doctors share information with each other. That's why they
5 have grand rounds in the hospital, so they can collaborate
6 with one another.

7 That's the importance in why we have assembled
8 these world-renowned experts from Harvard and Stanford and
9 Johns Hopkins, Ph.D.'s, M.D.'s, 29 years experience,
10 clinical experience, for Dr. Boulton.

11 If you think about it, it just makes common
12 sense -- if you're going to market a drug in the way that
13 Bayer did, largely to a population of elderly people,
14 wouldn't it make sense to have a geriatrician's opinion
15 included in the mix? Of course it would.

16 And wouldn't it make sense if the effects of that
17 drug, the side effects of that drug, in fact, were going to
18 affect the human muscular system, that you would want to
19 have the opinion of a physical medicine rehabilitation
20 expert? Of course, in Dr. Mayer.

21 Dr. Boulton actually has impeccable credentials and
22 he is well qualified to testify. They didn't want to spend
23 any time on the credentials. I heard what Mr. Beck said
24 earlier this morning, but it is interesting to note that
25 they didn't.

1 And I think perhaps they didn't because these
2 experts stand very, very firmly on their credentials and
3 their opinions emanate from considerable experience,
4 knowledge, training, and recognition in their field.

5 Dr. Boulton, for example, in addition to his M.D.,
6 he also has an M.P.H. in epidemiology. He knows what he's
7 talking about when he looks at these studies. He did a
8 residency in geriatrics at Brown University and he has an
9 M.B.A. as well.

10 He has 29 years, as I've said, of clinical
11 experience in the field of geriatrics as a geriatrician
12 working with the elderly, a high percentage of the Baycol
13 market, as I mentioned.

14 He has conducted significant research at the
15 prestigious Johns Hopkins School of Public Health, which has
16 been his researching clinical base for many years. He's
17 received and conducted NIH grants that span 17 years with
18 his most recent grant application receiving a peer-reviewed
19 score placing it as one of the top 1 percent of research
20 grant applications in the country.

21 Defendants say Dr. Boulton is not qualified to
22 render his opinions because he has no experience with
23 statins. Well, he has no experience -- he was honest. I
24 mean, all of our experts have been honest and candid with
25 the Court on these depositions.

1 When asked about the AERs he said, I don't hold
2 myself out as an FDA expert. We have an FDA expert. We
3 have a neurologist. We have muscle experts. We have a
4 geriatrician. We have a geriatrician for important reasons
5 and as I move on, Your Honor, I know the Court will see that
6 the methodologies and the foundations for his opinions are
7 rock solid.

8 Dr. Boult's credentials as a researcher and
9 practitioner in geriatrics makes his testimony highly
10 relevant to the Baycol litigation and precisely for that
11 reason -- I have already stated Baycol was prescribed to an
12 elderly population -- you want to have Dr. Boult's opinions
13 into the mix.

14 The objective is to make certain that an expert,
15 whether basing testimony upon professional studies or
16 personal experience, employs in the courtroom the same level
17 of intellectual rigor that characterizes the practice of an
18 expert in the relevant field. That's directly from Kumho
19 Tire, Your Honor.

20 To be admissible the opinion must be reasonably
21 based on good science. The analogies, inferences, and
22 extrapolations connecting the science to the testimony must
23 be of a kind that a reasonable scientist or physician would
24 make in a context outside of litigation. And that's -- as
25 Your Honor knows and is familiar with in the progeny of

1 cases, that's from Joiner.

2 Daubert nor 702 requires an expert to do specific
3 research. He doesn't have to be an expert in statins or do
4 standalone research on statins in order for his opinion and
5 his clinical experience to weigh in on his opinion.

6 Dr. Boulton, however, does prescribe statins.
7 25 percent of his patients take them. He's examined and
8 evaluated patients with muscle complaints, many of whom he
9 has taken off statins and many of whom are recovering from
10 muscle disorders and neurological complaints. That's what a
11 geriatrician does. As Dr. Boulton testifies in his
12 deposition, he teaches and instructs residents and medical
13 students on muscle disorders and diseases.

14 Dr. Boulton would be prohibited ethically and
15 probably legally, in fact, as well from conducting any
16 research on patients taking Baycol because of the removal of
17 the drug from the market. How could we possibly expect him
18 to reach some gold standard that Defendants argue must be
19 met by putting Baycol to a test? He wouldn't even be
20 allowed to do that.

21 But that doesn't mean under the current case law,
22 Your Honor, or even under the practice of medicine as we
23 know it and as doctors practice it that he cannot
24 extrapolate.

25 It was pointed out that all the various articles

1 and all the various studies that were relied upon, it was
2 pointed out by Defendants and even Dr. Boulton said it, it is
3 preliminary.

4 Well, that's the iterative process, Your Honor,
5 that scientists and doctors do and what they undertake,
6 thesis, antithesis, hypothesis. And it's valid, it's solid,
7 it's rock solid, and it's been the bedrock of the scientific
8 method. A clinician adheres to that. A clinician like
9 Dr. Boulton follows that process. He knows that it's
10 evolving.

11 And he's not going to say something that's not
12 true, but he knows that he can extrapolate. He knows he can
13 take those arguments and the inferences from those studies
14 that my colleagues have cited and you'll hear more about and
15 extrapolate from those to his opinions. And that's what
16 Daubert requires, Your Honor, and that's the scientific
17 method at its best articulation, I believe.

18 Dr. Boulton's practice and experience as a clinician
19 qualifies him as an expert because his opinions and the
20 clinical criteria he set forth are based upon scientifically
21 valid reasoning and methodologies, as I've stated.

22 Dr. Boulton is not basing his opinions on
23 speculation and conjecture. Dr. Boulton's development of
24 clinical criteria are based upon sound clinical reasoning
25 and judgment and diagnostic protocols taught to and

1 practiced by medical doctors.

2 I made a note when Mr. Beck was talking because he
3 actually pointed out an important element of the scientific
4 process when he said that the scientific method involves
5 having a written protocol that lays out in advance the data
6 one will be following.

7 Dr. Boulton has been trained as a medical doctor to
8 follow those kind of protocols and here they are, Your
9 Honor, here are the kind of protocols that doctors follow.
10 They include patient history, symptomology, environmental
11 and occupational history, they like to look at that, past
12 and present patient medical records, the physical
13 examination, diagnostic tests.

14 These are precisely the protocols that Dr. Boulton
15 has used to develop the clinical criteria in his report.
16 Dr. Boulton is not speculating at all. He's following a
17 scientifically valid professional rigor that a clinician
18 would be expected to follow.

19 Defendants have actually misrepresented
20 Dr. Boulton's opinions with regard to the development of
21 clinical criteria. Dr. Boulton testified that these criteria
22 need to be viewed within the big picture. These criteria do
23 not exist in a vacuum.

24 These are the points that he makes in his report,
25 Your Honor, which we submitted with our papers. They need

1 to be used in connection with a history and a physical exam
2 to perform a differential diagnosis.

3 As the Court knows, Your Honor, this has already
4 been discussed. An order that this very Court issued
5 requiring Plaintiffs to submit a case-specific expert report
6 that includes a differential diagnosis has already been
7 undertaken in this court.

8 We're not in disagreement with that. It's
9 precisely what Dr. Boulton has testified to already. The
10 criteria he set forth in his report are for that purpose and
11 for all practical purposes that's a nonissue.

12 The rigor and the methodology that Dr. Boulton used
13 in the development of these criteria, Your Honor, is well
14 settled within the annals of medicine and meets without
15 equivocation the reliability prong of Rule 702, as required
16 to substantiate an expert's opinion.

17 Dr. Boulton's testimony further meets the standards
18 set forth in Daubert and codified in Rule 702 because
19 they're well-grounded in scientific methodology and
20 procedure.

21 Daubert vs. Merrell enunciated in dicta, Your
22 Honor, an important principle for a district court's
23 Daubert/702 inquiry when the court wrote, and I think this
24 is in a footnote, number 12, The inquiry we envision by 702
25 is a flexible one. Its overarching subject is scientific

1 validity and thus the evidentiary relevance and reliability
2 of the principles that underlie a proposed submission. The
3 focus must be on the principles and methodology, not on the
4 conclusions they generate.

5 Dr. Boulton not only extrapolated from his clinical
6 experience, but he extrapolated from peer-reviewed
7 literature. And this practice is exceedingly well-founded
8 and the Court will find authority for this practice, of
9 course, in Joiner, one of the seminal cases in the Daubert
10 progeny, as Your Honor knows.

11 Dr. Boulton based his opinions for general causation
12 on medical and scientific literature. He based it on
13 epidemiological data. He's an epidemiologist. He's trained
14 in that. He's based at one of the most prestigious public
15 health schools in the world. He's more than qualified to
16 examine epidemiological information.

17 He looked at toxicological data, he looked at case
18 reports, and he relied on his training and his clinical
19 experience as a doctor. It's not just about the AER, Your
20 Honor, as Defendants claim.

21 These same factors have been described amply and
22 the Court will find further instruction in the Reference
23 Guide, which I know Your Honor is familiar with, on
24 Scientific Evidence. There's ample authority for the way
25 that Dr. Boulton approached his opinion.

1 I don't want to take any more of the Court's time
2 to review again all the various studies cited. The lawyers
3 on both sides have presented those. But for the record,
4 Dr. Boulton reviewed the Phillips article, the Hildebrand
5 article, Argov, England, Hansen, and Soininen. These
6 articles supported the opinions offered by Dr. Boulton at the
7 time he wrote his report and provided his deposition
8 testimony.

9 And I think in addition my colleague,
10 Mr. Arbitblit, has previously detailed why we don't believe
11 that the Leathers case is instructive. I'm not going to,
12 also in the brevity of time, go over that as well.

13 But I do, however, Your Honor, want to focus for
14 just a few moments on this methodology and on the reasoning
15 underlying Dr. Boulton's opinions since that's the focus and
16 the subject of the Daubert inquiry and that's what this
17 Court will be looking at.

18 The Supreme Court's decision in Daubert, Your
19 Honor, references several *amici curiae* submitted to the
20 court at the time of Daubert. Importantly, those *amici*, in
21 the court's own words, express a view that science is not
22 absolute when it said, Of course it would be unreasonable to
23 conclude that the subject of a scientific testimony must be
24 known to a certainty. Arguably, there are no certainties in
25 science.

1 And in quoting from an *amici* that the court wrote,
2 Indeed, scientists do not assert that they know what is
3 immutably true. They're committed to searching for new,
4 temporary theories to explain as best they can phenomena.

5 That's exactly what Dr. Boulton set up in his
6 deposition. That's exactly the candor that he used in
7 answering I believe Mr. Ismail's question when he was
8 examining. He's taking it up to the door. He's using the
9 scientific method to get to the next step. And that's
10 exactly what Dr. Boulton has done to formulate his opinions,
11 Your Honor.

12 In particular he structured his opinion that
13 Baycol causes persistent myopathies in some people, not in
14 everyone and perhaps even not in most, Your Honor, but that
15 doesn't exclude certain people. And as a practitioner and
16 as a clinician and someone who looks at this day in and day
17 out, he knows that it's not the entire population, there are
18 exceptions even after CK declines to normal.

19 It's consistent with the scientific literature we
20 submitted to the Court, consistent with our experts,
21 consistent with Defendants' experts, Mr. Dorfman, who
22 Mr. Arbitblit is going to address, and consistent with the
23 scientific methodology underlying the etiology of disease.

24 Etiology, as Your Honor knows, refers to the
25 various levels of underlying abnormality that have led

1 substantially to the next higher level of abnormality, of
2 disease, or of diagnosis. This chain or this web of
3 causation is considered what in science is well-settled as
4 the pathogenesis or the pathophysiology of a disease.

5 While the annals of medicine are replete with a
6 discussion on this topic, for most medical doctors this
7 underlying process for diagnosis and causation is often
8 intuitive. They're trained in it. They know it. They
9 understand what they're looking at.

10 As a clinician they're well-grounded in the art
11 and the science of clinical reasoning, which I previously
12 discussed and which have been more than adequately
13 substantiated as being scientifically valid.

14 Since we began this case many years ago now, Your
15 Honor -- and I know you know I've been involved in the
16 expert discovery phase significantly -- I've been scratching
17 my head over Mr. Beck's bright-line distinction between
18 rhabdo and nothing else.

19 And quite honestly, not as a medical doctor, not
20 as a scientist, but even as lawyer, that makes no sense to
21 me because in fact, Your Honor, it doesn't square with
22 pathogenesis, it doesn't square with pathophysiology, and
23 with that web or that continuum that our experts have
24 referred to so carefully and so adroitly.

25 That's what makes sense. That's what makes sense

1 to doctors. It's why they do consults. It's why it forms
2 the basis of the scientific method, because they know that
3 it's not a bright-line distinction that it's just simply
4 Baycol -- excuse me -- that it's just simply rhabdo or
5 nothing at all.

6 With respect to muscle disorders, Dr. Boulton's
7 testimony is well-founded on this scientific principle when
8 he discussed a continuum that I referred to or a severity or
9 a progression of disorders ranging from myalgia or, as
10 Mr. Beck has called them, the aches and pains. He likes to
11 refer to them as that.

12 But it doesn't just start there and then leap to
13 rhabdo. That doesn't square with medical science and it
14 doesn't square with reality. There's myositis and myopathy
15 it progresses to over various stages to rhabdo.

16 This pathophysiology of muscle disorders is
17 scientifically valid, it's well-settled methodology within
18 the practice of medicine, and it's referred to. And I can
19 give the Court cites to that, if the Court wishes, now or
20 submit them later in an effort to save time, but the same
21 authors of the medical literature we cited relied upon this
22 same type of method as the basis of their opinion.

23 It also lays the scientific foundation for
24 Dr. Boulton's opinion that persistent myopathies may occur in
25 some patients at levels of disorder lower than rhabdo after

1 taking and stopping Baycol.

2 Conversely, however, Defendants' argument that
3 Baycol causes mild toxicity only at the level of
4 rhabdomyolysis is not scientifically valid and should be
5 considered for purposes of Daubert and Rule 702 treatment,
6 Your Honor.

7 If one examines the medical literature carefully
8 of this bright-line distinction, I would say if anything is
9 junk science, Your Honor, not to use that term casually or
10 flippantly, if anything is junk science, saying it's rhabdo
11 or nothing is. That just doesn't square with reality, Your
12 Honor.

13 But there are many other examples in addition to
14 the science of myopathology that I can point the Court to
15 that follows this same pattern of etiology. For instance, a
16 heart attack may be due to a sudden block, a sudden blockage
17 of a coronary artery, but that heart attack may be due to
18 genetics or diet or lifestyle, a sedentary lifestyle, and
19 smoking. These factors may contribute to the buildup of
20 plaque in the artery, which in turn may slowly build up or
21 break loose to cause the heart attack.

22 It's not just bad lifestyle and then all of a
23 sudden heart attack. There's a progression. There's
24 stages. There's steps in between. The doctors know that.
25 The literature supports that.

1 Why would myopathology, why would someone looking
2 at muscle disorders follow any different regimen or any
3 other different professional rigor? They don't and they
4 wouldn't. And our experts have opined to that over and over
5 again.

6 But we've had to listen to this mantra from
7 Mr. Beck that this bright-line distinction is simply the
8 order of the day and that everything revolves around CK.
9 That's not the only factor, Your Honor. That's not what
10 doctors would conclude.

11 And you've heard not only our experts testify, but
12 it squares with the practice of medicine that's not the only
13 way to diagnose here in a myopathy situation. There's a web
14 of causation here of all types of indicia.

15 They want to try to peg us down into CK. They
16 want us to realize and take something that is dynamic and
17 make it static. But that doesn't square with reality, Your
18 Honor, and our doctors have testified to that because they
19 know it's true.

20 THE COURT: Mr. Hopper, I love to hear you speak,
21 but I got an eye from Mr. Beck that he knows that you're
22 going to be able to catch your plane and I suspect that
23 Mr. Beck wants to get on his plane.

24 MR. HOPPER: All right, Your Honor.

25 MR. BECK: I'm staying until tomorrow, Your Honor.

1 I hope that he keeps going, especially about these heart
2 attacks, because I'm --

3 MR. HOPPER: You've had your chance. I'm happy to
4 wrap up, Your Honor.

5 THE COURT: No, no. I'm just telling you --

6 MR. HOPPER: Dr. Boulton's opinions and testimony
7 should be --

8 THE COURT: You've been going for a half hour.

9 MR. HOPPER: I'm happy to wrap up. Dr. Boulton's
10 opinions and testimony should be admitted. They should be
11 because they meet the requirements set forth in Rule 702 and
12 they meet the test of Daubert and its progeny.

13 I thank you for your time today.

14 THE COURT: Thank you.

15 MR. ISMAIL: Your Honor, in light of Mr. Hopper
16 potentially having to leave, would you like me to respond to
17 that while he is here?

18 THE COURT: Yes, you may.

19 MR. ISMAIL: Just a few minutes, Your Honor.

20 MR. LOCKRIDGE: Well, Your Honor, if I can
21 interrupt here. We have a couple of more people for our
22 hour that would like to still respond.

23 THE COURT: I'm getting going. I've got my second
24 wind.

25 MR. HOPPER: I would like to think I helped that

1 along, Your Honor.

2 THE COURT: So we can go until 9:00, 10:00
3 tonight.

4 MR. LOCKRIDGE: That's fine, Your Honor. My point
5 is I think we get a full hour, so we would like to --

6 THE COURT: Don't worry about your time.

7 MR. LOCKRIDGE: All right.

8 MR. ISMAIL: Briefly.

9 On the question of the standard under Daubert, I
10 don't think Mr. Hopper's characterization of our position is
11 a fair one. Under Daubert the court must determine whether
12 the expert's opinion is reliable.

13 And the Supreme Court identified general
14 acceptance as a factor, not dispositive, one of the factors
15 to consider. We certainly address that in connection with
16 some of their experts' opinions.

17 Some of the other factors include whether it has
18 been subject to peer review. Dr. Boulton's opinion was
19 pointedly not submitted to peer review and he said it
20 couldn't be submitted to peer review. So he fails that
21 standard as well as the general acceptance standard.

22 The other two of the four nonexclusive factors
23 identified in the Daubert case law by the Supreme Court
24 itself in Daubert:

25 Whether the theory has been tested. And certainly

1 there's a lot of research in this area and they haven't come
2 up with any that identify Dr. Boulton's clinical criteria as
3 being correct.

4 And whether there's a known error rate associated
5 with it. And of course inasmuch as there's no research on
6 this standard that he's come up with in the litigation, of
7 course there's no error rate that has fallen out of that
8 clinical criteria.

9 So analyzing these four factors together or in
10 isolation, the opinion is not reliable.

11 And I know Mr. Hopper did a lot of talking about
12 what experts are allowed to do, they're allowed to
13 extrapolate, they're allowed to rely, they're allowed to
14 even make certain leaps of logic, but he didn't identify any
15 research that supports Dr. Boulton's opinion on permanency or
16 diagnosis. He said he looked at case reports, he looked at
17 peer-reviewed articles, but he didn't identify any that
18 actually say what he says in this case.

19 And there's an analytical gap here, Your Honor,
20 that is simply too great. You have a set of case reports
21 that talk about resolved muscle symptoms and then you have
22 experts who say there's a permanent condition that we're
23 advancing in this litigation. That is not a reliable
24 opinion for the purposes of Daubert.

25 And with respect to -- and I guess we have heard

1 the nub of the disagreement on comparative safety opinions
2 from Dr. Boulton and others.

3 As Mr. Hopper indicated, the whole point that
4 doctors frequently get consults for opinions upon which
5 they're not expert in and doctors collaborate, the
6 consequence of that is not to excuse the Daubert standard on
7 qualifications, but to exclude the opinion.

8 If they're admittedly not expert in the area and
9 they would have to go get a consult to give in their
10 professional capacity, then they can't give the opinion here
11 and that can be left for another expert who does have the
12 qualifications. And so it's not an excuse to circumvent
13 Daubert. It is a basis to exclude them under Daubert.

14 And with that, I will await Mr. Arbitblit's
15 discussion, I suspect, of the medical literature and hold my
16 comments until he's done.

17 THE COURT: Thank you.

18 MR. ARBITBLIT: Your Honor, I just need a moment
19 to set up and I would like to pass the PowerPoint hard copy
20 forward with the Court's permission.

21 THE COURT: I'm sorry?

22 MR. ARBITBLIT: I would like to provide the hard
23 copy of the PowerPoint --

24 THE COURT: Oh, please.

25 MR. ARBITBLIT: -- to the Court and defense

1 counsel.

2 THE COURT: How much time will you need for this?

3 MR. ARBITBLIT: Your Honor, I'm at your disposal.

4 If you were serious about a second wind, I can tell you as
5 much as you would like to hear about muscle -- I have
6 certainly been studying it and trying to make it as clear as
7 possible.

8 I can try to go through it quickly if you prefer,
9 but I certainly would appreciate your indulgence in terms of
10 trying to get at some of the subtle issues. So it's
11 entirely at your pleasure. If you wanted me to say a time,
12 I would say half an hour.

13 THE COURT: Thirty minutes.

14 MR. BECK: Turn on his yellow light.

15 MR. ARBITBLIT: Mr. Beck, what was that?

16 MR. BECK: I said turn on his yellow light,
17 please, Your Honor.

18 MR. ARBITBLIT: Will someone please tell me if
19 it's --

20 THE COURT: The yellow light will come on with ten
21 minutes to go. Mr. Zimmerman is in charge of telling you
22 when the yellow light comes on.

23 MR. ARBITBLIT: Have I started?

24 THE COURT: It will reflect on the back of his --

25 MR. BECK: Here, I'll do this for you.

1 THE COURT: And your 30 minutes does not include
2 setup time.

3 MR. ARBITBLIT: Thank you, Your Honor. In my case
4 that's a real benefit.

5 THE COURT: If I can suggest something. You know
6 your topic extremely well and one thing I do not like about
7 PowerPoints is when someone puts something up and I'm
8 looking at it and it flips through -- you've given me this
9 to digest once I leave the bench. Let's hit the highlights.
10 Whether or not you need the PowerPoint or not, I don't
11 think -- I prefer to listen to you just like I listened to
12 Mr. Hopper and Mr. Ismail. It's easier for me to do that.
13 But when you flip the PowerPoint up, my eyes at this ancient
14 age do not adjust quickly to what's on the screen and I'm a
15 slow reader and so I end up getting a migraine headache.

16 MR. ARBITBLIT: I'll try to certainly avoid that,
17 Your Honor, and only use the PowerPoint if there is some
18 special reason to do so.

19 THE COURT: I appreciate that.

20 MR. ARBITBLIT: Okay. So with that, Your Honor,
21 briefly, Dr. Richman is a professor of neurology and a
22 former department chair at the University of
23 California-Davis with a specialization in muscle disease,
24 particularly a disease called myasthenia gravis.

25 He is familiar with and qualified to interpret the

1 scientific literature. He's been a principal investigator
2 in numerous clinical trials, as shown in his CV. His
3 methodology was reliable and included over 180 articles that
4 he reviewed, including those as to the consensus we
5 described earlier and which we won't go into any great
6 detail other than to say what he said about it when we come
7 to it, and his experience in treating muscle disease,
8 medical records review.

9 And I would like to just try to, again, not repeat
10 what I did this morning, but to refocus on what I think has
11 been to some degree ships passing in the night between what
12 the Plaintiffs' experts are saying and what the defense
13 counsel are hearing.

14 At times I see the defense counsel asking
15 questions trying to elicit opinions and then in the course
16 of the exchange it's not clear what the expert meant, and
17 sometimes what I see happening is that opinions are being
18 challenged that were not in the reports and I'll give you an
19 example of that.

20 Dr. Richman's report, which -- I'm very familiar
21 with it because he is the expert that I worked most closely
22 with out of the muscle experts. I'm familiar with what he
23 said at his deposition and his report and what's in our
24 papers in opposition to the motion.

25 He never said that a myopathy that has always had

1 a normal CK can be permanent. He said just the opposite.
2 He said that a normal CK myopathy is at the mild end of a
3 spectrum of injury and that it stops and it reverses when
4 you go off a statin.

5 It's been asserted that he's part of a group of
6 people who are saying that there can be a permanent myopathy
7 where there's never been an elevation of CK and no breach of
8 the muscle cells. He never said that. It's not in his
9 report. His report at paragraph 16 says the opposite. It
10 says that it reverses.

11 So it's very important that we not attack a straw
12 man, that we try to focus on what the expert's real opinions
13 are and whether the literature supports those opinions, not
14 those that are attributed to them.

15 And I would say that to some degree that may be
16 true with Dr. Boulton, but I'm not as familiar with his
17 report. I did not work with him personally and so I'll
18 mostly be focusing on Dr. Richman, but in that context I'll
19 try to make comments that I think are generalizable.

20 Now, there was a point that was made by Mr. Ismail
21 which is valid, that there are many individual cases that
22 the Court is concerned about that remain in this MDL and
23 that there are case-specific reports coming up.

24 And so what is the interplay between what happens
25 here and those people? Well, obviously there is an

1 interplay. That's why we have MDLs. But that doesn't mean
2 that this group speaks for all of those lawyers. It means
3 that our experts and I speak for myself in working with
4 Dr. Richman and knowing his opinions.

5 And I speak for co-counsel with whom I have met
6 and discussed this do not feel that the literature supports
7 a permanent myopathy where the CK has never been elevated
8 and we do not take that position.

9 To the extent that it may have been stated in a
10 deposition, it may well be that some of our experts feel
11 that could be the case. They may have testified to that in
12 their deposition because someone asked them their opinion.

13 But is there scientific literature that passes
14 Daubert to support it? I don't think so. And so in my
15 opinion and Dr. Richman's opinion, more importantly, he
16 never said that. He said that it reverses.

17 So that's the mild end of the continuum, but
18 there's no doubt that there's a continuum. Dr. Dorfman on
19 the other side -- and I'll read his quote to you when we get
20 there -- said that there's a continuum of injury. In his
21 own report he meant to refer to that and said it quite
22 specifically.

23 So when we talk about a no elevation CK injury, we
24 have to be very careful what we mean by that. Do we mean a
25 case where the CK was tested and found normal? If so,

1 that's an easy case. There's no scientific literature
2 supporting that there could be a persistent myopathy off
3 statins. It's reversible. That's what the literature says.

4 On the other hand, the easier case on the more
5 extreme end is where the CK is tested and it's found
6 abnormal and there it's crystal clear that there's a
7 continuum of increased CK that is consistent with physical
8 damage.

9 The CK is not the disease. It's the marker. When
10 the muscle cells die due to exposure, the cell walls are
11 gone and the contents go into the bloodstream. When the
12 exposure stops, the muscle cell deaths stop and the body
13 does its normal job of clearing out what isn't supposed to
14 be there.

15 Ten days to 14 days later, in most cases, the CK
16 is gone. And so does that mean that the patient has
17 recovered? Not necessarily because the marker is not the
18 disease.

19 Now, there was a lengthy exchange between
20 Mr. Ismail and Mr. Richman where I believe Dr. Richman was
21 trying to explain his opinions about that and I don't think
22 that they were -- I think they were ships passing in the
23 night because I have great respect for Mr. Ismail and his
24 intellect and I just can't imagine that he believes that
25 Dr. Richman was saying one thing when he had said the

1 opposite in his report.

2 He never said if -- so the distinction is on the
3 low end CK is tested and it's normal. No claim for
4 permanency or persistence. When you stop the statins, it's
5 gone. That's what our experts say.

6 Is someone else out in the MDL going to say
7 something different? Probably, but I can't stop that. I
8 can't -- I won't be putting forth an expert to Your Honor
9 who would support that statement, but I don't know what all
10 the experts are saying in all the cases nor what the basis
11 is. I just know what I know from reviewing the literature
12 and working with these experts.

13 So then you have CK elevated; and when you have CK
14 elevated, you have people defining rhabdomyolysis in
15 different ways. Some people will say it's ten times normal
16 with symptoms. Some people will say it's five times normal
17 with symptoms. Everyone agrees that rhabdomyolysis is the
18 severe end of the spectrum.

19 And we have testimony from Dr. Dorfman, the
20 defense neurologist, that basically agrees with Dr. Richman
21 that in a small minority of cases people who have severe
22 rhabdomyolysis can have a permanent injury because the
23 extent -- two factors that influence the time of recovery,
24 the extent of injury and the ability to regenerate. Because
25 the injury, again, is not the CK elevation. The injury is

1 the muscle destruction.

2 So what happens when a muscle is destroyed is that
3 it has to regenerate and there are many factors that affect
4 the ability of an individual to regenerate muscle tissue,
5 primarily age; secondarily, concomitant disease conditions
6 and specifically those that affect the blood supply to the
7 regenerating muscle or the nerves that are connected to the
8 muscles at synapses and without which the muscles cannot
9 regenerate as effectively.

10 Now, I do -- when we get to that I do want to show
11 you what Dr. Dorfman said about that because it's very clear
12 that individual host factors completely preclude a blanket
13 definition of when CK myopathy ends when you've got an
14 elevation.

15 If it's really bad and a very severe injury, you
16 can get fibrosis, you can get scarring. Those are the
17 things that Dr. Richman testified to. Those are the things
18 that Dr. Dorfman testified to.

19 And those unlucky few that get that, they have
20 permanency or they have a substantial risk of permanency and
21 in some cases it is permanent. That's in the literature.
22 It's in the Woodrow article, which is cited in Dr. Richman's
23 report, which I read that particular sentence to Dr. Dorfman
24 and he agreed with it. He said, yes, in those very severe
25 cases it can be permanent.

1 Well, how does that happen? It happens because
2 the ability of the muscle to regenerate is exceeded. So
3 some of the regeneration happens through fibrous tissue and
4 scar tissue that create permanent disability.

5 And so that's the very extreme and it's only in a
6 few cases. And given what's been said earlier, probably
7 there aren't cases like that left, but there are some
8 rhabdomyolysis of varying severity that are still left in
9 the MDL.

10 So what's in the middle? In the middle there are
11 cases with elevated CK, and probably the best source of
12 information on that is the Hansen article that's been
13 submitted by both sides, which at the time of Dr. Richman's
14 deposition was only in abstract form and involved a smaller
15 population. This is at the University of Wisconsin where
16 they went through medical records.

17 And of interest in the Hansen study, the authors
18 said that what they were doing was a retrospective study.
19 So the idea that a retrospective diagnosis of whether
20 someone had a statin-associated myopathy, the idea that
21 that's crazy or concocted is just not accurate.

22 When any expert in litigation is attempting to
23 diagnose what happened to a person, there's an element of
24 looking through the retrospectascope. That wasn't the
25 treating doctor who was there examining the person at the

1 time. You're doing the best you can with the records you
2 have.

3 And your differential diagnosis, as Hansen points
4 out, and I'll go through the list of what they did, but very
5 important to Hansen is that -- and with all due respect to
6 Mr. Ismail, he said that all of the literature involved an
7 objective measure of the underlying statin myopathy. That's
8 not true.

9 The Hansen article specifically said that in 8 of
10 the 45 patients that they looked at, they had normal or
11 unknown CK. And what was the reason for that? They --
12 here's what they say, and this is submitted to Your Honor
13 with our materials.

14 THE COURT: Are you on one your slides?

15 MR. ARBITBLIT: Okay. I can do that, yes, sir.

16 THE COURT: Just tell me what page.

17 MR. ARBITBLIT: It's at slide 38. There's a
18 series -- as long as we are talking about Hansen, perhaps I
19 could go through a little bit of what the Hansen article
20 was.

21 Starting at 37, 45 patients -- actually what they
22 did was they went through about 400 records. They looked
23 through a large database of people who had diagnoses that
24 are listed in a dictionary of diagnoses and from that they
25 identified people who might have a statin-associated

1 myopathy. And so they looked at everything available to
2 determine whether they probably did.

3 And from that larger group they selected 45 and
4 those are the 45 who became the subjects of the study. And
5 for those 45 they state that it provides a spectrum of
6 observations, a spectrum. That's another word that's
7 interchangeable with "continuum" in the literature. Some
8 people say "spectrum," others "continuum." Dr. Dorfman said
9 both. The study provides a spectrum of observations ranging
10 from mild muscle pain to acute rhabdomyolysis. That's at
11 2675. So it's a peer-reviewed study.

12 And what they said was that 57 percent resolved in
13 one month, 34 percent resolved between one and six months
14 and they don't get more specific than that, and 7 percent
15 resolved by 14 months after stopping statin use. This is
16 the largest study I'm aware of that gives you the spectrum
17 not only of the condition, but of the recovery time. And
18 it's not one size fits all. It's affected by who the person
19 is, how fast can they regenerate.

20 Clearly their CK went back to normal in 10 to 14
21 days. Maybe a little bit longer or a little bit shorter in
22 some cases. But that's what CK is, it's a marker. So if
23 someone is out at six months or the 7 percent who resolved
24 somewhere between six and 14 months, those people long ago
25 had normal CK. But did they have a persistent myopathy?

1 Yes, they did, according to the peer-reviewed literature.

2 Now, Dr. Richman relied on the abstract of this at
3 his deposition, which had just been published and had
4 similar findings but different numbers because it was a
5 smaller study.

6 And I believe he said at the time that 24 percent
7 had not resolved by nine months and 76 percent had. I think
8 those were the numbers as of the time of the abstract that
9 preceded the full publication. But the idea is the same.
10 Not everybody is the same. People are different, their
11 ability to regenerate is different; and that's what this
12 article shows.

13 Now, of interest in the Hansen study is that
14 these -- while they do provide a spectrum of observations,
15 the spectrum is on the low end, which is probably because
16 the distribution of injuries is more mild cases than severe
17 cases. That's typically what you would expect.

18 But if you look at slide 39, you'll see that the
19 category that -- they used what they called the American
20 College of Cardiology statin clinical advisory --

21 THE COURT: Let's go back.

22 MR. ARBITBLIT: Yes, sir.

23 THE COURT: Your second PowerPoint -- second
24 bullet point -- no, your third bullet point on page 37,
25 peer-reviewed study supports Dr. Richman's opinion that the

1 statin myopathy can persist after CK returns to normal.

2 MR. ARBITBLIT: Yes. And is there a particular
3 question about that? The point being that the CK is back to
4 normal in 10 to 14 days, but the muscle pain does not
5 resolve for up to 14 months. So the CK is normal, but the
6 condition continued.

7 And what I want to make clear by persistent is
8 that it doesn't mean permanent. No one is suggesting in
9 Dr. Richman's opinions or any that I know of and I'm not
10 suggesting that persistent is the same as permanent. It
11 means that it persists after CK returns to normal for some
12 period that the literature describes as, in this range of
13 cases in severity, resolved by 14 months.

14 But in that small window of the most severe cases
15 that Dr. Dorfman and Dr. Richman both agree do take place
16 you can have a permanent injury, but only with this very
17 severe rhabdomyolysis.

18 THE COURT: Okay.

19 MR. ARBITBLIT: So if you -- let's go through 38
20 where we first started, please, Your Honor, and what's
21 important here is that the authors performed a retrospective
22 study and that passed peer review.

23 They used medical records to ascertain these
24 cases. They did what they called focused medical record
25 review of the outpatient and hospitalized patients with

1 muscle related diagnoses.

2 And then here's the sentence that led me to this
3 slide is they included patients with a normal or unknown CK
4 level because recent evidence supports the entity of
5 statin-associated myopathy with CK levels within the
6 reference range.

7 The reference range meaning normal, which for this
8 laboratory I believe they said that it was about 170
9 something for women, who have less muscle mass so they have
10 less normally dying muscle cells to contribute to their
11 upper limit of normal, and somewhere in the low 200s, I
12 believe, for men who have more muscle mass.

13 But the point is in this article what they did was
14 looked at medical records of patients with normal or unknown
15 CK. And so that means that these people are supportive of
16 the idea that you can diagnose a statin-associated myopathy
17 without having a CK test, either because you can have it
18 while you're in the normal range or that you can have it
19 without knowing what it is by using the other available
20 information to make that determination.

21 So we'll get to those diagnostic criteria in a
22 moment -- they're at slide 40 -- from the Hansen article,
23 but going on to 39, I wanted to point out that this was the
24 milder end by and large, that they had 37 patients for whom
25 CK was tested and the median CK was only 328 and the low was

1 36.

2 So even the median, the most common value where
3 there's half above it and half below it, was not that far
4 above normal and yet it was sufficient for them to be
5 diagnosing that these folks had statin-associated myopathy
6 that could continue after their CK returned to the normal
7 range.

8 And for 8 they didn't have that information, but
9 they made their diagnosis on other bases. And importantly,
10 they didn't just do that on their own. They made reference
11 to a consensus statement of one of the leading medical
12 bodies in the country.

13 The American College of Cardiology statin clinical
14 advisory document terms are referenced in the Hansen article
15 as a source for a categorization of statin myopathy from
16 rhabdomyolysis to a myopathy and finally -- a myopathy with
17 three times normal or greater -- and then finally
18 Category 3, myopathy with muscle pain and weakness or an
19 unknown normal or mildly elevated CK level at less than
20 three times the upper limit of normal.

21 So that's the bottom end of the continuum and
22 that's where 34 of the 45 cases were that were nevertheless
23 persistent for these time periods of one month, six months,
24 fourteen months for 7 percent of them.

25 And so 13 of the 45, that's about a quarter of

1 them, were within the reference range, they were normal, and
2 yet they had statin-associated myopathy. So what does that
3 do? It supports the idea that there is an entity of normal
4 CK myopathy.

5 Does that mean it's a different mechanism? I
6 think that's a leap. I don't think that it's implausible to
7 believe that damaged cells precede dead cells, that whatever
8 the mechanism is that's happening -- and I think the
9 mechanism does not have to be known with certainty. We know
10 this is happening. The mechanism should be plausible.

11 And there are plausible mechanisms, two or three
12 of them, in the literature that involve interference with
13 the cholesterol or the ubiquinone or the apoptosis.
14 Whatever -- there are only three that are talked about and
15 they all have some supporters and some detractors and they
16 are all considered plausible.

17 We do not know it with certainty, but that
18 doesn't mean that it's a different mechanism causing
19 damage to cells from the mechanism that's causing death to
20 cells.

21 And the continuum of damage that you see in some
22 of the clinical trial data with elevated CK going up with
23 dose with Baycol, as we saw this morning, supports the idea
24 that there's a continuum of damage.

25 Now, people who have less than three times the

1 upper limit of normal have dead muscle cells. If it's above
2 normal, that's because there are dead muscle cells. They
3 have fewer dead muscle cells than the people above three
4 times the upper limit of normal and all else being equal
5 they'll probably recover sooner. But all else isn't
6 necessarily equal, as we'll see in Dr. Dorfman's and
7 Dr. Richman's testimony.

8 Going to Your Honor's questions about diagnostic
9 criteria and how to -- I know that's an issue of concern and
10 it's an issue that Mr. Ismail addressed, but these are the
11 things that the Hansen authors looked at, at slide 40:

12 Onset, duration, location, and severity of muscle
13 pain. That's part of a clinical history.

14 Inciting drug with dose and duration of therapy
15 before the onset of symptoms for the person taking the
16 statin.

17 The presence of muscle weakness, and that is
18 considered by both experts on both sides to be a matter for
19 objective testing. It's not just subjective, I don't feel
20 well. It's something that trained doctors test all the time
21 and don't consider to have much uncertainty. If it's just
22 someone saying, oh, I hurt, well, that's different than if
23 you have somebody who you know they are on a statin and you
24 do strength testing.

25 These are if they were available. Peak CV values

1 where available, recent thyrotropin test results to see if
2 thyroid condition might be causing muscle symptoms, what
3 therapeutic interventions were done, number of months to
4 resolution of muscle pain and they use the term "months,"
5 and the response to other statins.

6 Then they define "recovery." The time from
7 cessation of the implicated statin to the resolution of
8 muscle pain.

9 So that's a list of the types of things that might
10 be available in particular cases and a doctor trying to
11 figure out what caused a disease is going to look at as many
12 of them as are available. And in different cases that might
13 be enough and in different cases it might not, but it's not
14 a black and white issue where one size fits all.

15 So Dr. Richman's methodology to diagnose statin
16 myopathy is similar to Hansen, at slide 41, and this is from
17 his report and this sets aside all the debating at his
18 deposition, clinical history, lab results, CK tests where
19 available, strength testing to detect muscle weakness,
20 biopsy or EMG may be done but are uncommon and not
21 necessary. They're not commonly done.

22 Biopsy in particular is invasive and painful, and
23 Dr. Dorfman I believe testified that he only did it when he
24 couldn't confirm that it was a statin that caused it and
25 wanted to see if there was some other serious cause.

1 Dr. Dorfman, his testimony at page 89 on slide 42
2 on the differential diagnosis. The most important question,
3 according to Dr. Dorfman, is whether you are taking a statin
4 when your symptoms begin and then the treating doctor
5 suspicion that it might be the statin can lead to stopping
6 the drug and then you form what he called a working
7 diagnosis. And if the enzymes normalize and the symptoms
8 resolve, at that point you have a higher level of confidence
9 that the diagnosis was correct.

10 Now, as far as when that resolves, he testified
11 that he agreed with the idea that it was -- it could be a
12 period of days or it could be months or it could be over a
13 year, and we'll get to that.

14 So Dr. Dorfman similarly testified to similar
15 criteria at a slightly later point. I won't read them.
16 They're too similar to spend the time on.

17 Strength testing, is that objective? Yes, both
18 doctors agree. Dr. Dorfman says:

19 "Can you describe what you're referring to when you say
20 objective evidence of muscle disease?

21 "Answer: I mean primarily weakness of the type that
22 neurologists are trained to evaluate and assess.

23 "And how does that assessment figure in your diagnosis
24 of statin-related myopathy?

25 "Answer: For me to think of the degree of

1 statin-related myopathy as being more than just a minimal
2 degree of severity, I would like to assure myself that the
3 individual, in fact, is manifesting true weakness of the
4 affected muscles and that the limitation is not merely on
5 account of pain."

6 So that is -- he's referring to testing for muscle
7 weakness in addition to pain as an objective criterion that
8 neurologists are trained to carry out.

9 He used the same differential diagnosis for mild
10 conditions with his own patients, mild muscle symptoms, mild
11 elevations, CK and symptoms resolved promptly and did not
12 recur, no other apparent cause, did a clinical exam and did
13 strength testing. So that's one way of doing it.

14 And he did the same thing for the Defense in
15 litigated cases, as he described, in reviewing records to
16 tell them whether he thought those were more likely than not
17 caused by Baycol, which he did determine in two out of
18 three.

19 And he looked at -- this is an interesting quote
20 at slide 46. In coming to those opinions he relied on the
21 totality of the medical evidence that he had available to
22 him concerning these individuals, including their past
23 medical histories, the existence or nonexistence of other
24 disorders that might have played a role in causing their
25 symptoms, and adding an additional laboratory test to rule

1 out alternate diagnostic possibilities.

2 That's a classic diagnostic differential diagnosis
3 description. It's quite similar to the criteria that the
4 Hansen authors used and it's quite similar to what
5 Dr. Richman said.

6 So on the issue of recovery, here are some
7 citations that support what I was saying earlier, Your
8 Honor. There's that the recovery depends on the extent and
9 severity and the variable capacity to regenerate. More
10 severe conditions take longer to resolve all else being
11 equal and regenerative capacity is adversely affected by
12 age, disease states.

13 So then we go to the Woodrow article. Muscle
14 damage from rhabdomyolysis may result in prolonged
15 rehabilitation and permanent disability in a minority of
16 patients, and Dr. Dorfman agreed at page 85 to 86 of his
17 transcript.

18 He agreed -- and here at page 76 to 77 he says why
19 that would happen. Persistent muscle symptoms, the reason
20 for that is the muscles "have been so badly damaged that the
21 regenerative capacity of the muscle has been exceeded and
22 the muscles are compelled to heal not only by regeneration,
23 but also to some degree by scarring or fibrosis and that the
24 scarring of the muscles is a source of persistent symptoms
25 and disability for these people."

1 It's in complete harmony with Dr. Richman's
2 opinion. No dispute. If you've got a severe case, it can
3 be permanent. That's what the experts say. Not necessarily
4 what the briefs say on both sides, but that's what the
5 experts on both sides say.

6 So here are some of the things he testifies to and
7 why that would affect the rate of recovery. And they're
8 very important in this case, Your Honor, because old age is
9 probably the most significant factor in delaying recovery
10 and this is an elderly population of users.

11 It's partly because of age itself and its effect
12 on regenerative power of muscle tissue, but it's also
13 because of the concomitant issues that go with old age and
14 in particular the conditions that go with people who have
15 high cholesterol, for which Baycol would be prescribed.

16 An awful lot of people in that condition would
17 have atherosclerosis. And as we'll see here, Dr. Dorfman
18 says that reduces the blood supply by narrowing the vessels
19 and so you have less blood and oxygenation and slower
20 regeneration.

21 So the elderly are at particular risk of delayed
22 recovery and that's a factor that is case specific, but has
23 to be in the mix of the differential diagnosis of causation
24 and duration.

25 So here's what he says. Satellite cells are

1 needed to regenerate muscle and they're significantly
2 reduced in elderly patients. He agrees with Dr. Richman's
3 report.

4 And that's important due to the advanced age. For
5 example, in the HMO study, PacifiCare, the 19,000 Baycol
6 patients' average age was 67. So -- and that's an average,
7 so many were older than that.

8 "What is your opinion as to the range of times of
9 recovery from statin-related myopathy for [sic]
10 rhabdomyolysis that is less than the full-blown fulminating
11 paralysis renal type failure that you've described a few
12 moments ago?" And that was the kind he said could be
13 permanent.

14 And here's his answer. "I think most people will
15 recover over the course of several months, a few perhaps
16 more quickly and a few somewhat longer, but I think the
17 period of recovery can be measured in months to perhaps a
18 year or longer than that." That's his testimony. That's
19 very consistent with Dr. Richman's report as well and with
20 the Hansen article.

21 Slower recovery for patients with diabetes or
22 atherosclerosis. I asked him whether individual host
23 factors, the condition of the patient affect recovery. And
24 he answered, "Without question" -- that was the first thing
25 he said, "Without question" and then he went on to list some

1 of them. Host factors affect the ability to recover from
2 statin-related myopathy. General health has a large
3 influence on the rate of recovery. Preexisting conditions,
4 diabetic complications, severe atherosclerosis, "which is
5 why the statin medication was prescribed in the first place,
6 if they have other kinds of co-existing disorders, those
7 will tend to slow down the rate of recovery, I think."
8 That's his opinion.

9 And specifically to the diabetics -- and, again,
10 18 percent of the PacifiCare patients were diabetic,
11 18 percent, and Dr. Dorfman is saying those people are
12 particularly at risk of a slow recovery.

13 Why? Because narrowed blood vessels slow muscle
14 regeneration and nerve damage also slows recovery because
15 "the intimate relationship between nerves and the muscles is
16 important for regenerating muscles as well as healthy
17 muscles, so that may play a role also." Atherosclerosis
18 lowers the blood supply, "and if the blood supply is limited
19 to a muscle or a region of the body, I would predict that
20 the recovery from injury would be slower."

21 So these people already had their CK go back to
22 normal within 10 to 14 days, but Dr. Dorfman is explaining
23 why some of them won't get better that quickly. And that's
24 not the same and needs to be clearly distinguished from
25 people who didn't have an elevated CK in the first place.

1 These are people who had elevation and we're talking about
2 how long does it take to get better. It's not 10 to 14
3 days. It's some longer period in some cases.

4 Next, why the elderly have such trouble with
5 recovery. "Any and all disorders, if they are sufficiently
6 severe so as to demand a certain proportion of the body's
7 energies, will restrict energies that are available for
8 regenerating muscles."

9 And so he then said that it's likely that
10 increasing age slows recovery from statin-related myopathy
11 in part because of the increased prevalence of other health
12 conditions and in part because of reduced ability to
13 regenerate muscle tissue due to the loss, significant loss,
14 of satellite cells that are responsible for the
15 regeneration.

16 So there's an example here and it's probably the
17 most severe case I know of, and I wanted to show Your Honor
18 this case as an example of someone out in the real world who
19 took statins with gemfibrozil.

20 In fact, this poor gentleman was an
21 Italian-American and he had a communication breakdown with
22 his doctor and he was on Lipitor and he didn't get off
23 Lipitor when his doctor prescribed Baycol. So he was --
24 admittedly, this is not your typical case, but the mechanism
25 is the same and it stands for some of the same principles.

1 This is the -- I bring this to the Court's
2 attention as an example to point out that permanent injury
3 from statin exposure can occur with rhabdomyolysis where you
4 can see in his chart the CPK, which is the other term for
5 CK, you can see it going down in the course of a month while
6 he's paralyzed for several months of these records.

7 So if you look at the summary, he started Baycol
8 June 29th of 2001 while on Lipitor and gemfibrozil. On
9 July 28th his CK was 137,000 and it peaked at 346,000 a
10 couple of days later on August 1st. By August 27th, a month
11 later, it was 59. His CK had gone down into the normal
12 range. A few days later it was even further down to 37.

13 And those data are blown up at slide 58. You can
14 see when he first got to the hospital 137,000 and then up
15 to 346,000 and then down, down, down because he's off the
16 drug.

17 And so he -- after he got off the drug it
18 continued to rise while the drug was in his system killing
19 muscle cells and then the drug cleared from his system and
20 no longer was killing muscle cells. And so the CK slowly
21 cleared over the course of -- there's some missing dates
22 where they didn't test apparently, but the bottom line is 37
23 within a month.

24 But look what the records say. Just go to page 7,
25 please, Your Honor, if you want to or I'll just read it if

1 you would prefer, but -- well, first at page 5, four months
2 later he's got an objective pathology report of a biopsy
3 that says there's evidence of muscle fiber injury.

4 On January 25, 2002, six months after his CK has
5 been at its peak and gone down back to normal, he's stiff in
6 both lower extremities, he can't bend them, he's got
7 contractures that keep his body from bending. They have to
8 pick this poor guy up and move him like a board and put him
9 on his bed because he can't bend anything. He's got a
10 history of rhabdomyolysis.

11 And then at page 63 you see he was given Baycol
12 for hyperlipidemia and he has quadriparesis, all four limbs
13 won't go, secondary to rhabdomyolysis.

14 So that's the injury that this person suffered.
15 He is stiff like a board at page 8. His CK is normal, but
16 six months later he is stiff like a board. That's just an
17 example to bring to the Court's attention in a graphic way
18 that a person can have a normal CK that has nothing to do
19 with recovery of injury.

20 Now, I don't want to leave the Court with the
21 impression that all people are like that, because they're
22 not. And out of 200 clients that my law firm represented
23 who had claims arising from Baycol, he was the worst one.

24 And did most of them get better? Yes, they did.
25 And did they have a variable course of recovery? Yes, they

1 did. And did some of them get better quickly? Yes. Did
2 some of them have high CK? Yes. Did some have low CK?
3 Yes. Did some of them not have a test? That's true too.
4 Do they have differing levels of ability to prove causation
5 in a differential diagnosis? Probably so.

6 But that's the methodology that Your Honor has,
7 I believe, appropriately endorsed for this litigation and
8 the elements of it are not too far apart between the
9 parties.

10 And I do want to address one issue on
11 qualifications, Your Honor, if I may, and that has to do
12 with Dr. Richman as someone who is able to rely on the
13 literature.

14 Now, the question is does a person have to be an
15 expert in adverse event reports or epidemiology to read *The*
16 *New England Journal of Medicine*, and the answer is no. *The*
17 *New England Journal of Medicine* is a journal for general
18 circulation to about 200,000 doctors who are not
19 epidemiologists, card-carrying or otherwise. They're not
20 FDA specialists, card-carrying or otherwise. They are
21 doctors who read that journal to learn information that's
22 relevant to their practice and that's why the Staffa article
23 was published.

24 If you look at what Dr. Richman actually says
25 about that article -- I'm a little out of order, but I do

1 want to try to find that -- he says that there's a consensus
2 by far of the medical community that accepts the Staffa
3 study as being indicative of a higher risk. And that's what
4 we discussed this morning with the recent articles, in
5 particular the Bays article that calls it a high level of
6 evidence for precisely that point.

7 You don't have to be an expert to read *The New*
8 *England Journal* and know what it means. A doctor reads that
9 and knows that's why it's in there is to tell you that
10 there's this extraordinary phenomenon out there where one
11 drug that's now off the market is 16 to 80 times worse and,
12 hey everybody, you better pay attention to that. It's a
13 significant finding.

14 Beyond that, it's important that Dr. Richman -- I
15 believe his credentials in the area of evaluating drug
16 safety and epidemiologic studies were not fully stated in
17 the defense papers and possibly not in our response.

18 But it should be pointed out that he's published
19 articles that he testified to in his deposition about
20 myasthenia gravis, which is the muscle disorder within his
21 specialization, comparing the safety of drugs based on case
22 series of myasthenia gravis treatment.

23 So this is a person who has got some experience
24 with comparing drug safety based on case series, so he knows
25 what that's about. And he testified -- that's at page 132

1 to 133 of his deposition. And also at 133 he said that he
2 reviewed articles about the adverse event reports.

3 And Dr. Dorfman, the defense expert, stated at his
4 deposition that he does not claim expertise in the field of
5 epidemiology, but that did not prevent defense counsel from
6 eliciting testimony, after the discovery portion of the
7 deposition was over, eliciting testimony from Dr. Dorfman as
8 to the doctor's opinions on the limitations of adverse event
9 reporting databases as well as their advantages and whether
10 such data can be used to generate estimates of
11 disproportionate risk without claiming any expertise in
12 epidemiology.

13 And I believe that it would be appropriate for the
14 Plaintiffs' expert, who does have experience with drug
15 safety comparisons, to at least offer the opposing
16 perspective based on having reviewed the literature and
17 having done drug safety comparisons himself.

18 And I believe I'm done subject to any questions
19 that Your Honor may have.

20 THE COURT: Thank you.

21 MR. ARBITBLIT: Thank you, Your Honor. I
22 appreciate your time and patience.

23 MR. ISMAIL: Is there any further argument from
24 the Plaintiffs on this?

25 MR. ARBITBLIT: Your Honor, I would just

1 incorporate the same arguments as to Drs. Zizic and Carlson,
2 that they're professional doctors, they're capable of
3 interpreting something in *The New England Journal of*
4 *Medicine* and the consensus that arose around it.

5 The consensus that we talked about earlier today
6 has simply confirmed that they were right when they read
7 those articles, that Staffa was right, that no one has
8 questioned it, and that the drug Baycol is off the market
9 for a reason and the reason is it's more toxic.

10 THE COURT: So incorporated. Thank you.

11 MR. ARBITBLIT: Thank you, Your Honor.

12 MR. ISMAIL: May I respond, Your Honor?

13 THE COURT: You may.

14 MR. ISMAIL: Thank you.

15 MR. LOCKRIDGE: Your Honor, while we're setting
16 up, can I pass up Dr. Mayers' documents from --

17 THE COURT: You may.

18 MR. ISMAIL: While that's getting straightened
19 out, Your Honor, I will just begin without the reference to
20 some of the documents.

21 Starting at the end of counsel's comments as to
22 this expertise question, I think the question is fairly well
23 staked out. Dr. Richman is the fellow whose deposition I
24 showed earlier where he said he had never used this data to
25 do comparative safety assessments. Dr. Staffa's letter is

1 the first safety assessment he's ever seen using this data.
2 And so that's the lack of expertise that we're focusing on
3 here. And he's further one of the witnesses who said it's
4 the only data upon which he's basing his conclusion.

5 And counsel stated that, well, gee, Dr. Staffa's
6 letter was in *The New England Journal* and it's a general
7 circulation publication and any doctor can read it. Well,
8 the cases that we've cited both in this district and
9 elsewhere have stated the idea that any doctor can comment
10 on any medical issue, to the extent that ever was valid, has
11 been debunked after Daubert and the specialization that has
12 evolved.

13 So to the extent any doctor can read Staffa, that
14 doesn't mean any doctor satisfies Daubert's requirements for
15 qualifications and expertise. I think the case law bears
16 that out.

17 And as to Dr. Dorfman, he was asked by Plaintiffs'
18 counsel in his deposition about adverse event data. He has
19 no opinion in his expert report in which we've proffered him
20 to make comparisons of drug safety and it's only after he
21 was asked those questions that our lawyer established his
22 view as to the unreliability of the data.

23 So I think it's a little unfair to suggest
24 Dr. Dorfman has affirmatively staked out an opinion on drug
25 safety given that he's a neurologist. We have not asked our

1 neurologist to give an opinion in the area that we've
2 challenged their neurologist from giving an opinion.

3 And counsel spent a great deal of his remarks
4 talking about the potential for permanent injury after
5 rhabdomyolysis and he showed some examples of cases. All
6 those cases, including the ones that he has shown, have
7 settled. They are no longer a part of this MDL.

8 And to the extent that there is a severe enough
9 case of rhabdomyolysis where questions of residual injury
10 can be addressed, to the extent one of those cases ever
11 comes back into this MDL, we can deal with that on a
12 case-specific challenge to any such claim of residual
13 injury. But rhabdomyolysis is no longer really a part of
14 this MDL. Instead we have a thousand, more or less, muscle
15 ache cases.

16 And so there's a great deal of discussion of
17 medical literature, citations to Dr. Dorfman, our expert,
18 where they posit if you hypothesize a severe enough case of
19 rhabdomyolysis, 350,000 CK, can you have some residual
20 injury? That's not what we're dealing with anymore in this
21 MDL. And so what our motion was directed at is the
22 remainder of the cases, not a hypothetical case that's not
23 here.

24 And what we have stated is that when a patient --
25 and then we had the statement from counsel, and I don't know

1 to what extent it's binding on the rest of the PSC since it
2 was only made in the context of Dr. Richman, but the very
3 clear statement if there's no elevated CK, we're not
4 claiming that the system -- the symptoms can persist
5 following discontinuation of the statin. If I have
6 misstated it, somebody can tell me if I have, but that's
7 what I understood Dr. Richman's -- or Mr. Arbitblit's
8 position to be with respect to Dr. Richman.

9 MR. ARBITBLIT: With the Court's permission, I
10 would like to clarify that that was intended to be the
11 position of the PSC and its experts, that if the CK is
12 tested and it's never elevated, that we do not claim that
13 there's a possibility of permanent injury.

14 MR. ISMAIL: So now we have --

15 THE COURT: I think it's been said three times.

16 MR. ISMAIL: So now we have counsel's statement
17 that what he characterized as the easy case, that it's been
18 tested, it's normal, there's no permanent injury, that this
19 group of plaintiffs is not claiming that that type of injury
20 exists.

21 But, of course, we have such reports in this MDL
22 and in part that's what we have addressed our motion to,
23 that under Daubert and as apparently joined by the
24 Plaintiffs' Steering Committee, there is no reliable science
25 on that theory.

1 So then we get to a group of cases where CK was
2 not tested and there is no contemporaneous diagnosis of the
3 myopathy, there's no objective indicia of the myopathy. I
4 am unclear as to whether the PSC thinks there's a permanent
5 injury that results or can be present there, but we have
6 brought in our -- sought in our motion to exclude such
7 theories.

8 If there is no -- it's only in the rarest of rare
9 rhabdomyolysis cases do you have some residual injury, not
10 in cases where you have -- and if a patient's CK is not
11 tested, that patient didn't have rhabdomyolysis; or if that
12 patient's myoglobinuria -- if there's no diagnosis of
13 myoglobinuria, that patient didn't have rhabdomyolysis.
14 Doctors know to make these laboratory tests.

15 So if here we have a patient who after the fact
16 reports I had muscle aches and pains on Baycol and there's
17 no -- and of course the treating physician never drew a CK
18 because these are complaints that arise after the fact,
19 those patients can't claim a statin myopathy that continues
20 months and even years after they've stopped taking Baycol.

21 Just like there's no science to support
22 affirmative normal CK, there's no science to support the
23 idea that we can have this ongoing statin myopathy for which
24 there's no evidence that the patient ever had injured
25 muscles.

1 So in that respect we would extend the PSC's
2 concession to even those patients in which there was
3 no contemporaneous CK or other indicia of myopathy at
4 the time. So we don't need to address the rhabdomyolysis
5 hypothetical here because that's not what's left in this
6 MDL.

7 And I don't want to, again, be ships passing in
8 the night or otherwise try to convince them that their
9 experts have a theory that they've disavowed here, but they
10 have in their expert reports said myopathy may include
11 patients who had no elevations of CK, that's one part of
12 their opinion, and then another part, patients with myopathy
13 can have chronic or residual or permanent disability. So
14 they define "myopathy" to be normal CK and then they define
15 "permanent injury" or "chronic injury" in patients who have
16 a myopathy.

17 So it's not ships passing in the night to worry
18 that there's a theory being staked out here that myopathy
19 can be a chronic permanent injury, and it's to that theory
20 that we brought our motion and responded to every one of
21 their articles and case reports showing all those patients
22 had their symptoms resolved. Even in the Hansen review that
23 we've talked about, every one of those patients had their
24 symptoms resolved. And so it is on that basis that we seek
25 to exclude the theory in line with the Leathers opinion, in

1 line with the concessions made today by counsel.

2 And so in light of that, unless Your Honor had
3 specific questions -- and then on diagnosis, CK isn't the
4 only objective indicia. It's the most common. But we have
5 said in our papers and our expert discussed EMGs or biopsies
6 or quantitative strength tests.

7 So I know this goes back to Mr. Hopper's point
8 that we've attempted to -- I don't know what he said --
9 drill a hole in the ground with CK and put them in it.
10 That's not the only objective indicia of myopathy that
11 exists. There are others.

12 And Dr. Mayer, whose deposition I played much
13 earlier this afternoon, he talked about the four objective
14 indicia, EMG, biopsy, CK, quantitative strength test. So
15 it's acknowledging that those possibilities exist, but
16 understanding that there has to be some contemporaneous
17 proof of the myopathy.

18 Are there any issues you want me to address, Your
19 Honor?

20 THE COURT: Thank you.

21 MR. ISMAIL: How do you want to proceed at this
22 point? There's three more Bayer motions and one Plaintiff
23 motion. I could be relatively quick on the three even
24 though they're -- not a lot of overlap. I could take them
25 seriatim.

1 THE COURT: Why don't you do that. How much time
2 do you need?

3 MR. ISMAIL: Ten minutes a motion, would that
4 bother anyone here?

5 THE COURT: How are you doing down there?

6 COURT REPORTER: Can we take a five-minute break?

7 THE COURT: Let's take a five-minute break.

8 (Recess taken at 5:30 p.m.)

9 * * * * *

10 (5:40 p.m.)

11 **IN OPEN COURT**

12 THE COURT: You may continue.

13 MR. ISMAIL: Thank you, Your Honor. If it's all
14 right with the Court, I would proceed with Dr. Raskin and
15 then since I'm up here and we are already set up, I would go
16 right to Dr. Kapit and Dr. Smith, even though they really
17 don't have anything to do with each other, rather than break
18 down the computers one at a time.

19 THE COURT: I will give you 30 minutes.

20 MR. ISMAIL: Thank you. Dr. Raskin first.

21 Dr. Raskin is a cardiologist, practicing cardiologist, and
22 he gives opinions in three areas, comparative drug safety,
23 labeling, and normative opinions about Bayer's conduct in
24 the context which I'll address it as in addition to his
25 chronology, as he sees it, of the Baycol story, which we

1 believe to be squarely on all fours with the Rezulin
2 decision, which excludes these plaintiff -- excuse me --
3 partisan arguments dressed up as expert testimony.

4 I don't want to spend a lot of time on comparative
5 drug safety. The parties' positions are well staked out.
6 Dr. Raskin stated in his deposition he is relying either
7 exclusively or principally on AER data and he had no prior
8 experience with AER data before being retained as an expert
9 in this case. And for similar arguments that we've made
10 with the last group of experts, we sought to exclude that
11 opinion with respect to Dr. Raskin.

12 On labeling Dr. Raskin gives the opinion that
13 Bayer could have and should have included comparisons of
14 spontaneous adverse event data in its label so that these
15 reporting rate studies that we've heard described today
16 should have been either put in quantitative or qualitative
17 statements in the Baycol labeling.

18 And as to that question Dr. Raskin has no prior
19 experience in pharmaceutical labeling, at least on the FDA
20 regulations issue. He's never helped draft a drug label,
21 never been a consultant to a pharmaceutical company or FDA
22 in regards to drug labeling.

23 And as to his opinion, he stated at his deposition
24 Bayer could have on its own included the spontaneous adverse
25 event data in its label through this mechanism called the

1 changes being effected process by which a company prior to
2 receiving FDA approval changes its drug label. There's an
3 animal in the federal regulatory scheme that allows for
4 this, and he opines that that could have been done.

5 But prior to submitting his expert report in this
6 case, Dr. Raskin never even heard of the changes being
7 effected process and he states so in his deposition at
8 page 90.

9 "Is it the case, sir, that when you submitted your
10 expert report in this case you had not even heard of the
11 changes being effected process?"

12 He said, "No, I just had heard about the 'Dear Doctor'
13 letters.

14 "Was my statement correct?"

15 He says, "Yes, sir."

16 And he flat out admits in his deposition he is not
17 an expert in FDA regulations with respect to drug labeling.
18 He's asked at page 86:

19 "You are not an expert in FDA regulations?"

20 "Answer: That is right."

21 Again at page 105 he's asked:

22 "Do you have any expertise to opine as to whether or not
23 the FDA would have approved a change to the Baycol label to
24 list the number of spontaneous events of rhabdomyolysis?"

25 "No, I don't have any particular knowledge of that."

1 So he's admittedly not an expert in the FDA scheme
2 for drug labeling and yet he seeks to give an opinion on it.
3 His sole basis for his labeling opinion is stated in his
4 deposition, page 91 of his deposition. Let me try it this
5 way.

6 "The sum total of your work to prepare an opinion
7 regarding what label changes Bayer could have made to the
8 Baycol label consisted of reading Dr. Kapit's expert report,
9 who is another Plaintiffs' expert, and reviewing the
10 published Code of Federal Regulations?"

11 And he answers, "Yes."

12 But as to those two issues he states:

13 "When you submitted your report in this case you had
14 neither reviewed the Code of Federal Regulations nor
15 reviewed Dr. Kapit's expert report, correct?"

16 And he answers, "That is correct."

17 So his sole basis for a labeling opinion is
18 Dr. Kapit and the Code, neither of which he ever saw before
19 he submitted his expert opinion in this case.

20 So here we have the antithesis of a scientifically
21 reliable methodology. We have an expert who has staked out
22 an opinion, later tried to backfill support for that
23 opinion, but he never had that support when he reached his
24 opinion to begin with. That is not the scientific method.
25 That is not scientifically valid and reliable methodology.

1 So that's Dr. Raskin on drug labeling and there
2 are cases that we cite that preclude experts -- purported
3 experts from giving opinions on drug labeling who do not
4 have prior professional expertise in FDA regulation of
5 labeling and prior experience in the regulatory process
6 governing pharmaceutical labeling. Dr. Raskin is squarely
7 within that case law.

8 Dr. Raskin also gives an opinion where he states a
9 couple of things with regard to what doctors knew. He
10 says -- he gives the opinion doctors did not know X, Y, or Z
11 about Baycol and he further states I did not know X, Y, or Z
12 about Baycol. So if you would consider those two opinions
13 on their own.

14 First of all, his speculation as to what doctors
15 knew is not an opinion that would pass Daubert muster. It
16 is speculative. It's inherently anecdotal. He's got no
17 surveys of what doctors knew. He's not someone who has
18 written in the area of physician prescribing behavior. He's
19 got this general gestalt about what doctors -- what he
20 thinks doctors knew about Baycol and wants to opine that he
21 doesn't think doctors as a whole knew about certain alleged
22 toxicity.

23 And clearly Dr. Raskin can't testify what a
24 specific doctor knew or didn't know, and that's all that is
25 relevant on issues regarding warnings and learned

1 intermediary.

2 Dr. Raskin's opinion as to what doctors knew in
3 the abstract can't go on the questions of relevance and fit,
4 to use the Daubert terminology, to an individual doctor's
5 assessment of the warnings and risks and benefits of the
6 medicine.

7 And even Dr. Raskin's statements that he
8 personally wasn't aware has no relevance whatsoever to
9 whether other doctors in individual cases were aware.

10 And I think the Plaintiffs have stated in their
11 papers that somehow we confuse that Dr. Raskin is being
12 offered as both an expert and percipient witness. Well, as
13 a -- he has put these opinions about what he knew and didn't
14 know in his Rule 26 expert report, but he's a percipient
15 witness as to what he knew.

16 And one of the standards under Daubert is the
17 opinion has to be relevant to the issue at hand. And what
18 Dr. Raskin knew in northern California is not relevant to
19 what a doctor in Minnesota knew or doctors elsewhere around
20 the country. So as to that basis under Daubert,
21 Dr. Raskin's speculation as to what the community as a whole
22 knew and what he knew simply is not relevant.

23 The last topic on Dr. Raskin is his commentary on
24 what he speculates as to Bayer's corporate state of mind and
25 various normative value, ethical judgments he makes in his

1 testimony and report.

2 I think the Plaintiffs don't dispute the general
3 legal proposition that an expert cannot opine as to his view
4 of the ethics or pass value judgments on a company. There's
5 particularly in the mass tort area a great number of cases
6 that have excluded such opinions. It's in the Rezulin case.
7 The Diet Drugs litigation has resulted in similar opinions
8 excluding experts.

9 But to the extent they agree with the case law, I
10 think they don't agree with the application here and I would
11 like to use an example of where courts have excluded
12 testimony along the lines similar to what Dr. Raskin has
13 done.

14 Here's Dr. Raskin's expert report, and this is
15 just an example. I'm at paragraphs 18 through 21 and this
16 is just one part of a five- or six-page chronology, as
17 Dr. Raskin sees it, of the Baycol story, so to speak.

18 And he talks about what he thinks the documents
19 show was Bayer's knowledge. Bayer was aware of evidence,
20 rather than encouraging an open and honest disclosure about
21 Baycol's risks, clearly these are normative value judgments
22 that he's passing, but even more to this whole idea of can
23 an expert become a party's -- provide a party's closing
24 argument and look at internal documents and put them in a
25 chronology that is selective and spoon-fed and biased in its

1 presentation and call it an expert opinion.

2 And the Rezulin court very clearly shot down the
3 idea that such opinions pass Daubert. This is the court's
4 opinion in the Rezulin litigation, which we have cited in
5 several of our briefs. As plaintiffs' Rezulin historian,
6 therefore, Dr. Gale does no more than counsel for plaintiff
7 will do in argument, propound a particular interpretation of
8 defendant's conduct. And it goes on to exclude the opinion.

9 And earlier in the opinion, earlier in the court's
10 opinion, it describes that this expert, Dr. Gale, just went
11 through internal company documents and came to an opinion as
12 to the chronology of events. And Dr. Raskin, if you go
13 through his expert report, has done the same thing.

14 And whether they call it background or whether
15 they call it the predicate facts upon which he gives his
16 opinion, that is not expert testimony. There is no
17 expertise required there, as the courts found in Rezulin and
18 in Diet Drugs. That is a matter traditionally left to
19 juries and not a matter upon which juries need an expert's
20 guidance.

21 The lawyers can make the arguments and inferences
22 from the internal documents. They don't need an expert to
23 get up and propound an opinion as to what he thinks the
24 chronology shows.

25 Turning then to Dr. Kapit, Dr. Kapit is a former

1 FDA employee who didn't have any prior experience while at
2 the FDA with Baycol. He hasn't practiced medicine in some
3 time and he has no clinical experience with these medicines.
4 He hasn't written on the topics that are at issue in this
5 litigation.

6 One of the areas that we spell out in our motion
7 is an area of preemption of Dr. Kapit's opinions, and I
8 don't want to take the time here to go over all the analysis
9 there. We rely on our papers.

10 But Dr. Kapit states in his deposition that Bayer
11 submitted the adverse event reports, submitted the
12 preclinical and clinical data with respect to Baycol, was
13 not remiss in withholding any data, but he thinks Bayer
14 should have given something to the FDA that it was not
15 required to give.

16 And under Buckman and its progeny, a
17 pharmaceutical company who is complying with FDA regulations
18 shouldn't be in a position to wonder down the line what a
19 plaintiff expert would say or a state court jury would say
20 were its real disclosure obligations.

21 The FDA gets to decide what it wants to receive
22 and how it wants to receive it. That is not for an expert
23 down the line to second-guess and certainly not an issue
24 that a jury can second-guess.

25 And so to the extent Dr. Kapit is purporting to

1 impose on Bayer different disclosure obligations than those
2 that are spelled out by the FDA, such opinions are clearly
3 preempted.

4 Dr. Kapit also has in his report -- and if Your
5 Honor looks to our papers, we seek to exclude his ethical
6 musings about what he thinks of Bayer's conduct. And again
7 the Plaintiffs don't contest the proposition that an expert
8 is not allowed under 702 to give value judgments as to what
9 he thinks of a party's conduct.

10 And Dr. Kapit's report very clearly uses words
11 like "ethical" or "irresponsible" or "inappropriate,"
12 buzzwords that have been consistently ruled out in federal
13 court cases.

14 And the PSC's response is to acknowledge that case
15 law and they state very clearly in their report -- or in
16 their opposition, Plaintiffs agree that the Court should
17 preclude Dr. Kapit from using the word "ethics" and its
18 cognates and go on to concede the case law which precludes
19 such ethical opinions.

20 But where we disagree is what they do next when
21 they say -- this is Plaintiffs' opposition to our motion on
22 Kapit -- A close reading of Dr. Kapit's report indicates
23 that the term "unethical" is often used as a synonym for
24 "irresponsible" or even "reckless." So now we have the PSC
25 being Dr. Kapit's personal thesaurus and wherever he said

1 "unethical" in his report, he really meant to say
2 "inappropriate."

3 So there's two ways to view this rewriting of
4 Dr. Kapit's opinion. On the one hand, the lawyers could be
5 changing the substance of the opinion -- there's no
6 supplemental report from Dr. Kapit, there's no subsequent
7 declaration on this issue from Dr. Kapit -- or that the
8 words "ethical" and "inappropriate" or "reckless" mean the
9 same thing.

10 They're either changing his opinion or they're
11 not. And if they're not changing his opinion, then the word
12 "ethical" is the same substantive opinion as saying it's
13 reckless or inappropriate.

14 And not even the PSC is pretending that they can
15 after the fact go in and rewrite their expert's report and
16 change the substance of the opinion. So what we have here
17 is we're left with the only other alternative, that the word
18 "ethical" is a 100 percent synonym for the words
19 "irresponsible" and "reckless."

20 Well, Daubert excludes opinions, not word choice.
21 If ethical opinions are -- do not satisfy muster under
22 Daubert, as they clearly do not and as Plaintiffs concede,
23 then calling it by another name and conceding it's
24 100 percent the same opinion also has to be excludable. You
25 can't just change the word "ethics" and say, well, he really

1 meant to say "inappropriate," but they're exactly the same.

2 So whether they want to call it "reckless" or
3 "inappropriate," "ethical," or some new word, the opinion
4 itself is what we're seeking to exclude, not the word
5 choice. And very clearly the case law would exclude it.

6 And just to show examples, Your Honor, of what
7 we're talking about on the substance here, this is
8 Dr. Kapit's expert report. He's got a section on Bayer's
9 knowledge of excessive toxicity. Now we have an expert
10 speculating as to Bayer's state of mind and, again, under
11 Rezulin and Diet Drugs such opinions are excludable.

12 Elsewhere in his report Dr. Kapit has examples of
13 irresponsibility generally. There might be one where he
14 thinks irresponsibility specifically, but here's one on
15 generally. And again he's passing value judgments in the
16 sequence of his views as to Bayer's conduct along the way.

17 He's even got an opinion -- he's even got a
18 section of his opinion on Bayer's priorities and the
19 company's strategy for Baycol. So he is an expert now,
20 apparently, who can derive Bayer's priorities with respect
21 to Baycol; and of course he is in no position to do that.
22 There's no expertise that he's bringing to Bayer on that
23 issue. He's just speculating as to what he thinks the
24 priorities are.

25 And then he's got an opinion where he goes through

1 what he says is the history of Baycol and he goes through
2 his view of the story. It's a story, however, of corporate
3 ambitions for profit and prominence that overcame good
4 judgment.

5 It reads less like an expert report and more like
6 he's writing a work for general circulation. He's got his
7 view of the Baycol story. There is no expertise that would
8 assist the trier of fact that he's bringing to that
9 question.

10 And since we haven't had a reference to Vioxx in
11 almost an hour, I will make one now. Dr. Kapit and other
12 experts who have attempted to give state of mind and
13 normative, ethical value and judgment opinion testimony in
14 that litigation have been excluded just like they have in
15 Rezulin and Diet Drugs. So the string of exclusionary
16 rulings in this area that began a few years ago has
17 continued right through this past year.

18 THE COURT: Don't beat a dead horse on this one.

19 MR. ISMAIL: Yes, sir.

20 So then with respect to Dr. Kapit, there's only
21 just one other area and that is the foreign regulatory
22 issues. Dr. Kapit has several references to interactions
23 that Bayer had in other countries and we've sought to
24 exclude that opinion as irrelevant to the issues in the
25 litigation, one of the questions under Daubert, and we have

1 cited several cases that support that very proposition.

2 And the Plaintiffs' response is the foreign
3 regulatory proceedings are relevant as to notice and
4 presumably there will be some time on a motion in limine
5 where we can have this fight as to whether as a matter of
6 evidence these interactions can come in as to notice. That
7 is not for this day.

8 But if the only purpose of these interactions with
9 foreign governments is as to notice, then there's no
10 expertise that Dr. Kapit is bringing to that question. All
11 he is doing now is reciting the facts of the interaction.

12 And so there's no -- it's no different than him
13 doing a Baycol chronology and putting it in a plaintiff's
14 closing argument sense that these are the facts that he
15 thinks give rise to notice.

16 And he wants to talk about Australia and Canada.
17 That's not an expert opinion. Those are just facts that a
18 jury does not need, to the extent they are admissible at
19 all, and we have cited in our papers that other Baycol
20 courts have excluded this very evidence, but that's for
21 another day in the federal court system.

22 But as to the opinion testimony, there's no
23 expertise there. It's just the recitation of facts that a
24 jury can understand and a plaintiff can make the argument
25 and inferences from them.

1 And so that concludes Dr. Kapit and I'll quickly
2 deal with Dr. Smith, who is a toxicologist, not a medical
3 doctor, and Mr. Beck played a portion of his testimony many
4 hours ago.

5 He gives -- he has no prior research experience
6 with statins or Baycol or publications, which is not a
7 dispositive factor to preclude him, but it's relevant in
8 this Court's analysis of his opinions.

9 Dr. Smith states his opinion is that Baycol is the
10 most toxic statin. He relies in part on adverse event data,
11 again, lacking the qualifications there to use that in his
12 analysis, and he relies also on animal and test tube data.

13 And as far as I can tell, he's relying on three
14 studies, the Matsuyama study, the Matzno study, and an
15 internal Bayer in vitro study. Each of these three studies
16 involved high dose either petri dish or animal testing.

17 Dr. Smith does not rely on any human pharmacology
18 testing, as far as I can tell, to give a comparative safety
19 opinion. Instead he extrapolates from super high dose test
20 tube and animal studies to give an opinion about human
21 toxicity.

22 And we have cited case law in the Eighth Circuit,
23 the Glastetter case, and in the Supreme Court the General
24 Electric case which have stated such extrapolations from
25 high dose test tube and animal models to human toxicity does

1 not meet Rule 702.

2 The Plaintiffs do not distinguish these cases.
3 They say instead that there's no per se blanket exclusion to
4 rely on animal or test tube data to give an opinion on human
5 toxicity.

6 And that per se exclusion has never been
7 presented. The Supreme Court or the Eighth Circuit hasn't
8 had to invoke a per se exclusion, but just finding on the
9 facts of those cases that the evidence is not sufficiently
10 reliable.

11 And we don't believe a per se exclusion is
12 something this Court has to reach either, but instead on the
13 facts of this case, just like in all the others, there is no
14 reliable extrapolation that can be made.

15 The Plaintiffs do not cite a case finding solely
16 from toxicology high dose animal and test tube models that
17 an expert can give an opinion on general causation. And
18 what they say instead is -- this is their opposition -- they
19 say, well, gee, Dr. Smith is saying -- does not base his
20 opinion on the extrapolation of the results of high dose
21 animal studies to human. He's actually basing his opinion
22 on a comparison of high dose animal studies between statins.

23 Well, that's a less reliable or greater analytical
24 leap than what the cases have already excluded. You've got
25 high dose animal and test tube studies which courts have

1 said you cannot extrapolate to humans, but he wants to take
2 those on two different statins and then compare them to each
3 other. He's got multiple layers of unreliability in that
4 analysis, far in excess of what courts have already
5 excluded.

6 THE COURT: You've set the trap.

7 MR. ISMAIL: I'm sorry, sir?

8 THE COURT: You've set the trap. Let's see if
9 they can get out of it.

10 MR. ISMAIL: Well, in that case --

11 THE COURT: So save your few minutes to respond to
12 what they've got to say.

13 MR. ISMAIL: Then I will not proceed further
14 there.

15 On mechanism, which we have also sought to exclude
16 from Dr. Smith, he's got the opinion that -- you saw this
17 term "apoptosis" in the motion and in the briefs.

18 Mr. Arbitblit a moment ago said there is no
19 generally accepted view on what the mechanism is for a
20 statin myopathy. Lots of theories have been thrown out and
21 he said there are proponents and detractors for each.

22 Dr. Smith apparently is a proponent of the
23 apoptosis theory, but he admits there's no human clinical
24 data in support, no pharmacology data in support, no animal
25 data in support, no test tube data in support. He admits

1 it's just a theory, and we've provided the deposition
2 citations from his own admissions that it's his theory.

3 However inspired it may be, it is not grounded in
4 scientifically reliable methodology. Instead it's his
5 *ipse dixit*. He says that's the mechanism and he'll be
6 prepared to defend it, but that is all the farther it goes.

7 He also has an opinion that Bayer's metabolism
8 increased the likelihood of its interacting with other
9 drugs. He admits there's no peer-reviewed literature in
10 support of that opinion.

11 And we noted for the Court that Plaintiffs' other
12 toxicologist, Dr. Pang, flatly disagrees with Dr. Smith. He
13 said this dual pathway for drug metabolism for Baycol was
14 not a reason to believe they would have a higher
15 susceptibility to drug interaction.

16 And so, again, it's an interesting theory that he
17 advances, but not one that's been repeated anywhere outside
18 his expert opinion in this case.

19 Lastly, Your Honor, Dr. Smith joins other experts
20 in giving value judgments about Bayer's conduct. And the
21 response from the Plaintiffs was, well, gee, he is only
22 quoting from Bayer's own internal documents; and that's at
23 page 23 of their opposition to our motion on Dr. Smith.
24 That's not a response to pass muster under Daubert. That's
25 a reason to exclude it under Daubert.

1 If all he is quoting is internal Bayer documents
2 and putting them in whatever chronology or drawing
3 inferences from them, that's for a jury to do and that's
4 what the cases have held; and Dr. Smith's attempt to the
5 contrary doesn't pass muster under Rule 702.

6 And with that, thank you, Your Honor.

7 THE COURT: Thank you.

8 MR. ARBITBLIT: Your Honor, Mr. Black will be
9 addressing the Kapit motion and I will be addressing Raskin
10 and Smith. We can go in whichever order you prefer.

11 THE COURT: I will leave it in your hands.

12 MR. BLACK: And then, Your Honor, I can go
13 directly into the motion on Dr. Arrowsmith-Lowe.

14 THE COURT: That's fine.

15 MR. ARBITBLIT: May I provide these and use them
16 as little as possible, Your Honor?

17 THE COURT: Most definitely.

18 MR. ARBITBLIT: There's one for Dr. Smith, two
19 copies, and one for Dr. Raskin, two copies.

20 THE COURT: You've got 20 minutes and the yellow
21 light will come on with 10 minutes to go so you will know to
22 switch gears.

23 MR. ARBITBLIT: I'll start with Dr. Raskin, Your
24 Honor. The interesting issue with Dr. Raskin is that Bayer
25 called him an expert when they hired him, put him on a

1 speakers panel and said you're an expert and we'd like you
2 to help us sell Baycol and promote it to other doctors.

3 And there's, I think, a qualitative and important
4 difference between someone who is simply hired to tell the
5 Rezulin [sic] story as an outsider versus someone who was
6 hired by the company to tell that story to doctors and then
7 found out the story wasn't true and that he was misled and
8 he wasn't told what the company knew.

9 And so it's not simply -- it's an important
10 distinction in this case and an important contribution that
11 Dr. Raskin can make to what, after all, is a story for a
12 jury. It's not just about science.

13 And he is a fact witness. He's a percipient
14 witness. He was there. He was told that Baycol was as safe
15 as other drugs at the same time that Bayer was accumulating
16 data, more and more each month, that it was not telling him.
17 As he was going about the business of preparing to tell
18 other doctors how safe Baycol was, he was not being told
19 that they were having these doubts internally and compiling
20 data that was showing that wasn't necessarily so.

21 Now, Dr. Raskin did testify that he does have some
22 familiarity with adverse event reporting systems. He's
23 not -- he doesn't have to be an FDA expert to testify to
24 that. What he has to do is meet the standard that's in the
25 Diet Drugs case, which is that he is permitted to testify

1 that the label did not match what was known or
2 scientifically knowable. And that also feeds into the issue
3 of state of mind.

4 Now, knowledge is an element of the cause of
5 action or a claim for relief for failure to warn. What was
6 known or scientifically knowable defines the duty of a
7 manufacturer to disclose risk. So the idea that knowledge
8 is a forbidden state of mind for an expert to talk about
9 is -- would make the claim for relief unprovable, so that
10 can't be the standard.

11 When it gets into intent, then perhaps -- then
12 that does cross the line. When it gets into ethics, that
13 does cross the line. But when it's about knowledge, that
14 does not cross the line. That's essential testimony about
15 what was known or scientifically knowable and did it match
16 the label.

17 Now, the position that Dr. Raskin takes and
18 testified to is that on other occasions throughout his
19 experience as a treater and prescriber he had seen examples
20 of companies that did disclose risks based on adverse event
21 reports and that his notion of what a drug company should
22 tell a doctor was based on that experience and as well as
23 reviewing the Staffa article, which we've had enough
24 discussion about whether there's a consensus on that. I
25 won't go into that again, but we think that he was entitled

1 to rely on that.

2 But he was a statin expert. That's why he was
3 asked to be on the panel. He was asked to tell the story of
4 Baycol being as safe as other drugs to other doctors and he
5 is in a unique position factually to say I was not told what
6 they knew; and if I had known, I would not have agreed to be
7 a part of their panel and I would not have prescribed this
8 drug because to me as a prescriber that signal should have
9 been disclosed.

10 Now, there are two very important factors that
11 support him on that. One is -- and this doesn't get talked
12 about much, but it is important and it is in his report --
13 on December 15, 1999 Bayer issued a "Dear Doctor" letter.

14 That "Dear Doctor" letter changed the landscape as
15 far as what doctors were told about Baycol, but it only
16 changed it as to combination use. It said combination use
17 with gemfibrozil is not a good idea, we recommend against
18 it. And that got stronger over time, but that was the
19 initial information to the public.

20 But what hasn't been said often enough but
21 Dr. Raskin does say it is that at the very same time frame
22 the very same data analysis that Bayer was doing of adverse
23 event reports also showed excess risk for monotherapy. That
24 was not said, but it was in the data. It's in the report.
25 It's in the data.

1 Dr. Raskin is entitled to say if Bayer could
2 disclose a risk that they got from adverse event reports
3 that they say are so irrelevant but yet they acted on
4 them -- that was the only basis in December 1999 for that
5 warning, was their internal analysis of the adverse event
6 reports compared to other statins -- and they want
7 congratulations for doing the right thing and warning the
8 community, but if they're going to warn about combination
9 use, what insulates them from warning about monotherapy,
10 which is also shown to be elevated in the same database?
11 Why is Dr. Raskin somehow precluded from testifying they
12 told me about one, why didn't they tell me about the other?
13 He shouldn't be precluded.

14 He testified that other companies had given him
15 the opportunity to do the right thing by giving him
16 information when there was adverse event spikes that showed
17 that there was a potential problem.

18 Now, the other thing that supports him is that
19 Dr. Dorfman agreed with him. And the testimony of --
20 Dr. Dorfman, who also believed that he had received the
21 "Dear Doctor" letter of December 15, 1999 and said at his
22 deposition in September of 2004 that that was the type of
23 information he expected to receive from drug manufacturers,
24 testified as follows: And this is at slide 10 of the Raskin
25 presentation.

1 "Question: Are you suggesting it would be prudent for
2 the manufacturer to let doctors know if they discover a
3 particular signal of higher adverse event reporting even if
4 they haven't yet concluded that the relationship is
5 definitely there?

6 "Answer: Yes.

7 "Question: Would your answer be the same whether the
8 data showed increased reporting rate relative to
9 prescription numbers for Baycol in monotherapy as opposed to
10 this December 1999 letter pertaining to combination therapy
11 with gemfibrozil?

12 "Answer: I don't see why there should be a difference."

13 And frankly, Your Honor, neither do I see why
14 there should be a difference. And the point is that
15 Dr. Dorfman expected that type of information to be
16 disclosed as a treating doctor so that he could make
17 treatment decisions that were based on the knowledge that
18 the company had. Dr. Raskin is entitled to say as well that
19 the label did not disclose what was known or scientifically
20 knowable.

21 And I believe that the report of Dr. Raskin, for
22 example, in the last paragraph, indicated that in summary
23 Bayer did not tell practicing cardiologists or the medical
24 community what it knew about the risks of muscle toxicity
25 associated with Baycol.

1 That goes to knowledge. That's a state of mind
2 that is not off limits. It's within bounds. It's necessary
3 to proving the failure to warn because what has to be proved
4 is that there's something that's known or scientifically
5 knowable.

6 And with that I would like to move on to
7 Dr. Smith, with the Court's permission.

8 THE COURT: You may.

9 MR. ARBITBLIT: Thank you, Your Honor. Now, the
10 issues with Dr. Smith, I'm sorry, I'm going to have to rush
11 through them because they are somewhat more complicated. In
12 fact, even some of the names of the authors are hard to
13 pronounce.

14 But the point is that you don't -- I don't believe
15 that it's a fair interpretation of the law on animal studies
16 that you start with the presumption that they're out. The
17 presumption is the opposite. The Reference Manual says that
18 there is a role to play for animal studies. They are a part
19 of the entire picture.

20 They're not the only evidence of Baycol's greater
21 toxicity. Whether it's Dr. Smith or someone else
22 testifying, there's plenty of evidence in this case about
23 Baycol's greater toxicity.

24 And to exclude someone talking about animal
25 evidence that's within their speciality, first of all, he --

1 I believe that he is entitled to rely on the literature as
2 far as whether he thinks it showed excess toxicity based on
3 Staffa and a few people that cited her with approval as of
4 the time he wrote his report.

5 But in addition to that, this evidence on what the
6 animal studies show is not in isolation. You can't take one
7 expert and say this expert is divorced somehow from the
8 other evidence in the case.

9 If there's evidence in the case of greater
10 toxicity, which there is plenty of evidence that we've
11 talked about today, someone else talking about what the
12 animal studies show is relevant to the entire evidentiary
13 portrayal. And so this is a piece of the puzzle, not the
14 entire puzzle.

15 In addition, I would point out that we've -- first
16 I'll just cite to the Reference Manual at 206 -- 2006, page
17 405 and 569, on the issue of using animal studies. One can
18 usually rely on the fact that a compound causing an effect
19 in one mammalian species will cause it in another species.
20 That's a quote. So the presumption is that it should be
21 permitted, not that it shouldn't.

22 The Bayer documents about the steep dose-response
23 curve are mirrored in the recent literature on -- for
24 example, the Bays article that we talked about earlier that
25 talks about a threshold dose being reached for Baycol at

1 marketed doses at .4 and going way up with .8 that wasn't
2 happening with other marketed doses of other statins. So
3 there's a -- it's not just -- what we're seeing is later
4 research again validating the opinions that Dr. Smith had on
5 this narrow window.

6 Now, as far as human data, well, bioavailability
7 on average 60 percent, much higher than the bioavailability
8 of other statins. That's based on human data. So the
9 assertion that there's no human data in Dr. Smith's report
10 is wrong. He does talk about the human data.

11 And bioavailability is part of what the literature
12 says is a reason -- bioavailability means more of the drug
13 gets into your system where it can do some harm instead of
14 getting excreted where it's harmless.

15 So the literature that we've submitted does
16 include many references to bioavailability as one of the
17 things that could be contributing as a plausible mechanism
18 to the greater toxicity of Baycol for human muscles.

19 Now, another example of recent literature -- and I
20 think this is important because it's the first study as
21 scientists continue to progress and I think supporting the
22 opinions he came to previously -- at slide 11 there's a
23 reference to the Yamazaki article, which is a 2006 study
24 that said in human skeletal muscle cells that cerivastatin
25 was the most potent inhibitor of cholesterol biosynthesis

1 and showed the most cytotoxicity, which means cell killing.

2 So this is human skeletal muscle and that's a
3 scientific advance that confirms what Dr. Smith was saying
4 based on the animal studies. There were no human skeletal
5 cell studies as of the time of his opinion. Now there are.
6 They confirm what he said previously.

7 The narrow safety margin that Dr. Smith talks
8 about is again something that has been confirmed in the Bays
9 article, about going up to a .4 and you have exceeded the
10 threshold dose for toxicity. That's because you have a
11 narrow window between the threshold for efficacy and for
12 toxicity.

13 Good drugs, as Dr. Smith testified, have a large
14 window so that when you are getting what you want out of the
15 drug, you're not risking what you don't want. Bad drugs are
16 too close together where what you need to lower cholesterol
17 is too close to what you have for killing cells.

18 So that narrow window is talked about in Bays,
19 it's talked about in Jacobson, and it is a serious issue for
20 Baycol.

21 Now, on the dual metabolic pathway, well, this
22 is -- I hope I have time to explain this as I would like to,
23 Your Honor, but the situation is if you would like to look
24 and see if this would help at all, it's starting at
25 slide 14, that the issue with drug-drug interaction is that

1 if -- drugs are taken out of the body through various
2 pathways that metabolize them. You take it in and you have
3 to get rid of it.

4 If you don't get rid of it soon enough, it builds
5 up as you keep on taking more of the drug. So that means
6 that your body concentration gets higher and higher and
7 exceeds a threshold dose and then you have cell killing.

8 The problem with Baycol that makes it more
9 susceptible -- and there are examples given in the slide
10 presentation and the biggest one is gemfibrozil itself,
11 which is found to be a special case for Bayer, for Baycol,
12 where it's more toxic with Baycol than with any other drug.
13 And the reason is the dual pathways because, as it's now
14 been published, there's the second pathway.

15 They have these acronyms. CYP3A4 is a very common
16 pathway for four of the statins to be metabolized, but
17 CYP2C8 is crucial, it's called crucial to the metabolism of
18 Baycol, not to the other statins. So if you have another
19 drug that's taking up the CYP2C8 or inhibiting it, then you
20 can't get rid of the Baycol.

21 And that's what they found that gemfibrozil does.
22 It increases the concentration called the area under the
23 curve which measures your systemic exposure over time. It
24 increases it six-fold with Baycol, but not with other
25 statins.

1 And that's an example of confirming what Dr. Smith
2 testified, that if you couldn't see that that was a
3 possibility, it was weak thinking; and he's been proven
4 right.

5 The research shows that CYP2C8 is the reason why
6 gemfibrozil is so bad in combination with Baycol but not
7 other statins, because it's using up the stuff that would
8 get rid of the Baycol, in plain English. If you had more
9 CYP2C8, then you could get rid of the Baycol. If you've got
10 gemfibrozil using it up, then you can't get rid of the
11 Baycol.

12 And so there are examples in here -- now, I do
13 want to talk about Dr. Pang. Again, Dr. Pang had just seen
14 Dr. Smith's rebuttal report on these dual pathways. And if
15 you look at slide 19, the part that was not included in the
16 excerpt provided by defense counsel is that she says she
17 doesn't agree with Dr. Smith, but then she does. She says
18 both things. Well, that's not much of an opposition to his
19 opinion.

20 She says -- and this is the part that was left
21 out -- "But of course if you have two enzymes, the
22 incidences of drug-drug interaction, as Dr. Smith pointed
23 out, become higher because you have two different components
24 that could be interacted with."

25 And that's what's happening with Baycol having the

1 CYP3A4, which interacts with drugs like cyclosporine and
2 many others and causes a higher rate and also with
3 gemfibrozil, which is one of the acknowledged bad
4 combinations. And we cite to the literature that also talks
5 about those interactions at slide 20.

6 Let's see. We acknowledge that Dr. Smith will not
7 testify as to whether Bayer acted ethically, but, again, the
8 issue is that statements in Bayer's documents that they made
9 publicly and that they've made to the FDA are not only
10 relevant to a fraud on the FDA claim, as the Kittleson case
11 points out in this district, statements made to the FDA are
12 evidence of negligence for the main claim of failure to warn
13 the patient and the patient's doctor. A failure to -- an
14 FDA fraud claim means that the individual is trying to claim
15 a private right of action because the FDA was defrauded.

16 And that's not what these plaintiffs are alleging
17 in the Baycol cases. They're alleging, as in Kittleson,
18 their own right under a failure to warn theory and, as in
19 Kittleson, statements to the FDA that are not accurate are
20 evidence of negligence, not evidence of a fraud on the FDA.

21 And so Dr. Smith is entitled to talk about what
22 they said that was contrary to known or knowable scientific
23 information at the time, and that's what he did.

24 Thank you, Your Honor.

25 THE COURT: Thank you.

1 MR. BLACK: Your Honor, if I might approach, I
2 have PowerPoints prepared. In the interest of time I would
3 like to pass both of them up at once.

4 THE COURT: You may.

5 MR. BLACK: I've handed one to counsel as well.

6 With regard to Dr. Kapit on preemption, Your
7 Honor, there's two kinds of preemption at issue. There's
8 preemption of fraud on the FDA --

9 THE COURT: First off, how much time do you need?
10 Ten for Kapit. On your motion how much time do you need?

11 MR. BLACK: I would think five minutes, Your
12 Honor.

13 THE COURT: The yellow light will go on in five
14 minutes. As you can tell, the GSA has turned off the
15 ventilation, so that five minutes may be cut down to a
16 couple of minutes.

17 MR. BLACK: We'll move along, Your Honor. I
18 understand. May I proceed, Your Honor?

19 THE COURT: You may.

20 MR. BLACK: With regard to Dr. Kapit and
21 preemption, there's two kinds of preemption at issue.
22 There's the preemption of fraud on the FDA claims under
23 Buckman. It's in the PowerPoint. It's in our briefing.

24 In the Vioxx litigation Judge Fallon held that
25 Buckman had no bearing at all on the admissibility of

1 Dr. Kapit's testimony, a specific ruling on exactly
2 this point.

3 In this district there have been three rulings all
4 holding that Buckman did not preempt the use of evidence
5 about communications to the FDA to prove claims of
6 negligence or failure to warn.

7 And those cases -- the most recent one is the
8 Medtronic decision in which Chief Judge Rosenbaum said you
9 can't use the evidence solely to show fraud on the FDA, but
10 you can use it to establish a failure to warn claim or other
11 state tort law claims. In 2004 Judge Tunheim in the St.
12 Jude case held similarly and in Kittleson, to which
13 Mr. Arbitblit has already referred, Chief Magistrate Noel
14 similarly held.

15 So that's all I will say on Buckman unless the
16 Court -- unless Your Honor has some questions about that.

17 With regard to Geier, Geier is the idea that
18 regulations establish both a floor and a ceiling. Geier was
19 a case about air bags. And after the Department of
20 Transportation had explicitly rejected a proposed regulation
21 that would require air bags on all cars, plaintiffs go into
22 court and say that a Honda is defective because it doesn't
23 have an air bag. And that's the Geier case.

24 The Supreme Court said, no, under those
25 circumstances, when the agency has explicitly ruled upon the

1 very action that you want the defendant to have taken, then
2 it's preempted. And I don't believe that applies here at
3 all, Your Honor.

4 There's also been a preamble to some rules that
5 came out about a year ago where the FDA was pushing this
6 idea of Geier preemption. The FDA has recently clarified
7 that in a letter brief that was submitted I think it's in
8 the Eastern District of Pennsylvania. It's in the Perry
9 case, Perry vs. Novartis.

10 And what's interesting about that is that there
11 the FDA makes clear that all we're talking about is language
12 that the FDA explicitly rejected or would have rejected.
13 And I don't think either of those applies here.

14 Bayer never went to the FDA and said, Please,
15 please, can we add some warning language about monotherapy
16 myopathy? That was never done. That was never explicitly
17 rejected.

18 And as to the would have rejected, we know what
19 happened when the FDA finally learned. On August 3rd there
20 was a letter sent to Bayer saying we think there's real
21 problems with this drug, and the details I'll leave to Your
22 Honor to read the exhibit yourself.

23 And there was an August 17th memorandum in which
24 the FDA addressed the situation and, among other things,
25 raised serious questions about PacifiCare, raised serious

1 questions about the adverse event evidence, what the adverse
2 event evidence showed about Baycol.

3 So it's pretty clear that the FDA would not have
4 rejected a stronger warning had Bayer proposed it;
5 therefore, you don't have either rejected or would have
6 rejected.

7 And finally on that point, the Perry court, the
8 court to which that letter brief was submitted, rejected the
9 brief. It said we don't accept that argument at all. So
10 even if you accept the brief as the outer limits of Geier
11 preemption, it doesn't apply here.

12 And a number of courts have said -- have not
13 recognized the FDA's argument on that, and it isn't just the
14 Perry court. The majority of courts that have considered
15 the argument have rejected it, and those cases are listed in
16 our briefing or in the PowerPoint.

17 With regard to ethics, I don't want to beat this
18 horse anymore, Your Honor. I don't think -- first of all,
19 Dr. Kapit's report is not going to come into evidence; or if
20 we for some reason wanted to put it into evidence, we would
21 have to redact it and have to agree on some redaction with
22 Bayer. So that's not an issue.

23 And I don't think there would be an issue with any
24 testimony he'd give. He'll be testifying about things
25 like -- as Mr. Arbitblit explained with regard to

1 Dr. Raskin, he would be testifying to things like this is
2 what Bayer did, this is the information Bayer had available
3 to it, this is what I saw other companies do when they had
4 similar information available to them, this is how they
5 reacted; and therefore, I don't think that Bayer acted with
6 what I would typically expect -- within what I would
7 typically expect a pharmaceutical company to do. That's the
8 kind of testimony he's going to give.

9 And in the PowerPoint I've suggested and I think
10 for purposes of today it's about as far as we can go. We
11 are not going to be giving -- we are not going to be
12 eliciting testimony from Dr. Kapit about ethics or state of
13 mind. We'll state that clearly on the record.

14 And I would suggest that Your Honor take the
15 approach that Judge Fallon did in the Vioxx litigation and
16 issue a ruling to that effect and leave the details to
17 objections at trial should the issue arise at trial.

18 That's all I had to say about the ethics. As to
19 the foreign regulatory actions, what Dr. Kapit is relying
20 upon is not only the fact that there were communications
21 from foreign regulatory agencies to Bayer about Baycol, but
22 also relying on the scientific substance of those
23 communications.

24 So to the extent that the Australian Therapeutic
25 Goods Administration is a scientific agency, as the FDA is,

1 and the Therapeutic Goods Administration found that there
2 was an elevated rate of muscle problems with Baycol as
3 compared to other statins, that's scientific information on
4 which Dr. Kapit is perfectly -- or should be allowed to rely
5 and about which he should be allowed to testify.

6 And that's the way he would be using that. So
7 it's both for the scientific findings of foreign regulatory
8 agencies as well as for notice, that information of which
9 Bayer should have taken notice.

10 And that's all that I have to say on Dr. Kapit.
11 If the Court is willing, I'll move on to
12 Dr. Arrowsmith-Lowe.

13 THE COURT: All right.

14 MR. BLACK: I think I will do this in two minutes,
15 Your Honor. This issue is very, very narrow.

16 There were several documents, in particular a
17 document prepared by an individual named Steve Niemcryn, I
18 think I have pronounced that correctly, but also other
19 comparisons of adverse event reporting rates that were
20 conducted by Baycol and never provided to the FDA.

21 I'm not sure they have been provided to the FDA
22 even today, but certainly up through August of 2001, when
23 the drug was taken off the market, that information had
24 never been provided to the FDA.

25 There's a rule that clearly states that you have

1 to report on studies undertaken during a three-month period
2 or one-year period in a periodic safety update report.
3 During the time at issue here it would have been every three
4 months that one of these reports had to be submitted.
5 That's what the regulation clearly states.

6 So you've got this study. Again, we're talking
7 about something that happened two and a half -- two years to
8 a year and a half before the drug is finally off the market
9 Bayer is conducting these studies and during that whole
10 period of time never tells the FDA.

11 Your Honor, that simply cannot be right. It
12 clearly falls within the regulation and Dr. Arrowsmith-Lowe
13 should not be allowed to give testimony to the contrary. I
14 think you've got the documents in front of you and I think
15 you can rule based on that.

16 THE COURT: Thank you.

17 MR. BLACK: Thank you, Your Honor.

18 THE COURT: Short response.

19 MR. ISMAIL: May I make a couple of comments on
20 the three motions that I referenced earlier, very briefly?

21 I have nothing to comment further on Dr. Smith,
22 but as to Dr. Raskin, I think Mr. Arbitblit tried to limit
23 his testimony, but then walked right back into the case law
24 when he says he wants to opine as to what Bayer knew. Bayer
25 didn't tell me what they knew, well, that requires him to

1 speculate as to what he thinks Bayer knew.

2 And they say in their brief Dr. Raskin feels
3 duped. Well, that's not a fact in relevance in any one of
4 these cases. Whether -- Dr. Raskin's personal feelings
5 about what he thinks Bayer knew is not at issue and wouldn't
6 be relevant under Daubert.

7 And just to clarify this suggestion that
8 Dr. Raskin was part of the Bayer family, so to speak. He
9 went to one meeting, never spoke on behalf of Bayer. It was
10 in 1999 in which other cardiologists were invited to
11 participate.

12 And if Dr. Raskin actually wanted to give an
13 opinion about cardiology or lowering lipids or whether he
14 thinks Baycol was a lousy statin or whether he thinks
15 lowering cholesterol isn't really as good as Bayer made it
16 out to be, well, then that would be an area in which he is
17 qualified and an area in which he participated in this lipid
18 conference.

19 But not for him instead to comment about things in
20 which he's admittedly not an expert, what he thinks Bayer
21 could have done and the FDA regulations, comparative drug
22 safety and what he thinks Bayer knew.

23 Lastly, on Dr. Kapit under Geier preemption, FDA
24 had the very data that Plaintiffs say we are obligated to
25 put in the label. We got it from the FDA. In fact, the FDA

1 did its own comparative analyses. Mr. Beck showed it
2 earlier.

3 So this idea that under Geier preemption what the
4 FDA would have done had this information sought to be
5 included in the label, we have conclusive proof that the FDA
6 had the data, had the analyses. Not only did they not
7 require it to be added to the label, they subsequently
8 approved the .8 dose, the doubling of the dose. So this
9 idea that FDA would not -- or would have acted had the
10 information been provided to it is just flat-out wrong.

11 And lastly, I don't want to spend any more time,
12 but if you read Dr. Kapit's report, it is replete with his
13 normative and state of mind hypotheses. And accepting
14 counsel's attempt to put boundaries around it may be very
15 well good in this situation, but we have an expert report
16 that is going to travel on remand and we have an expert who
17 clearly can't give the opinions he wants to give.

18 And Mr. Black saying, well, that's not what I'm
19 going to ask him really doesn't do us any good in this
20 context. What we're seeking to have is the entirety of
21 those opinions excluded on state of mind and ethics and what
22 he thinks a company should have done in similar
23 circumstances.

24 And with that, I am going to turn the
25 Dr. Arrowsmith-Lowe response to Mr. Baum, our colleague.

1 MR. BLACK: I hate to do this at this hour, Your
2 Honor, but just one very brief surreply with regard to what
3 the FDA knew.

4 This is sort of a situation where they told the
5 FDA, they told the FDA. They hid the data. They didn't
6 break any rules necessarily because it's sort of somewhere
7 in the document, but there's no evidence that the FDA
8 considered all that data. And they certainly did not
9 provide the comparative analyses that they had done. The
10 FDA never considered that.

11 If that's the argument on preemption, if the FDA
12 actually had adequate data to reach a decision, then I think
13 what you have is a factual issue that you have to get into
14 in order to deal with preemption; and that's not something
15 we're going to do here today. That requires another hearing
16 on preemption and that would make Dr. Kapit's testimony on
17 how the FDA works and processes information even more
18 relevant and admissible.

19 THE COURT: Thank you.

20 MR. BAUM: Good evening, Your Honor. I'll be very
21 brief in responding to the Arrowsmith-Lowe motion.

22 THE COURT: Good evening.

23 MR. BAUM: I would like to start by focusing on
24 what the PSC does not dispute in its motion.

25 First, the PSC does not dispute that the subject

1 matter of Dr. Arrowsmith-Lowe's testimony is proper subject
2 matter for expert testimony generally. Here we have an
3 undisputed FDA expert interpreting FDA regulations and
4 applying them to relevant issues in the case. I would note
5 the PSC has disclosed its own FDA expert, Dr. Kapit, to
6 opine on the very same matters.

7 Second, the PSC does not dispute that
8 Dr. Arrowsmith-Lowe is sufficiently qualified as an FDA
9 expert.

10 Third, the PSC does not dispute that
11 Dr. Arrowsmith-Lowe employed a proper methodology in
12 reaching her opinion. Here Dr. Arrowsmith-Lowe reviewed the
13 relevant regulations, applied them to the documents at
14 issue, and using her undisputed experience and expertise
15 determined that the documents did not fall within the scope
16 of the reporting requirements. Notably, the PSC -- neither
17 in its motion nor in its argument has the PSC offered some
18 other mode of methodology that would have been more proper
19 in this circumstance.

20 And fourth, the PSC does not dispute that
21 Dr. Arrowsmith-Lowe's opinion is relevant to the issues in
22 this case.

23 So that brings us to the one thing that the PSC
24 does dispute in its motion and that is Dr. Arrowsmith-Lowe's
25 conclusion that Bayer was not obligated to provide the

1 specific data compilations of rhabdo AER data pursuant to
2 Section 314.80.

3 Again, a party's disagreement is not a basis for
4 excluding evidence under Daubert. Daubert itself states,
5 and I'm quoting here from page 595 of Daubert, The focus, of
6 course, must be solely on principles and methodology, not on
7 the conclusions that they generate.

8 Here the PSC has not challenged the principles or
9 methodology used by Dr. Arrowsmith-Lowe in any way. The
10 sole basis of the motion is that Dr. Arrowsmith-Lowe is,
11 quote, simply wrong.

12 Dr. Arrowsmith-Lowe adequately provided her
13 reasoning for her opinion. She stated on pages 187 and 188
14 of her deposition that, first, the sort of data contained in
15 these documents is not the sort of data that allows for
16 reliable conclusions about comparative drug safety. That's
17 the same position as espoused by the FDA in the caveats
18 document we saw earlier today.

19 And second, at page 183 Dr. Arrowsmith-Lowe
20 testified that these data compilations were not studies
21 within the meaning of the regulation cited by Mr. Black.
22 They weren't preclinical or clinical trials. They weren't
23 epidemiology studies. They had none of the indicia of a
24 study in the traditional sense. There was no formal
25 protocols, no inclusion or exclusion criteria, no generation

1 of new data at all. Bayer simply took data mostly from the
2 FDA and put it into a tabular form.

3 By way of contrast, I would point to the
4 PacifiCare study or the Baycol/gemfibrozil interaction
5 study. Those clearly were studies that were initiated in
6 response to adverse experiences. The same cannot clearly be
7 said of the Niemcryk or Sprenger analyses. And in the
8 opinion of the expert in this case, Dr. Arrowsmith-Lowe, it
9 can't be said at all.

10 So simply put, Defendants believe that the PSC has
11 raised no Daubert challenge at all. It's not an adequate
12 basis to disagree with the conclusion. And certainly
13 Plaintiffs are free to cross-examine Dr. Arrowsmith-Lowe at
14 trial regarding this opinion, but it's not a basis, in our
15 opinion, to exclude the testimony.

16 That's all I have.

17 THE COURT: Thank you very much.

18 Anything further? If not, I'll take everything
19 under advisement and next time I might listen to
20 Mr. Lockridge when he says everything should be submitted on
21 the record.

22 MR. LOCKRIDGE: We tried, Your Honor.

23 THE COURT: No, I prefer oral argument and I would
24 not change my ruling on that. I thank you for being patient
25 with me and getting everything done this evening.

1 You should really thank Mrs. Simpson because we
2 start up trial tomorrow at 9:00 and she will have a few
3 minutes to ice her fingers before we get started again.

4 So have safe journeys and it's good seeing you all
5 again and I'll get the order out as quickly as possible.

6 COUNSEL: Thank you, Your Honor.

7 (Court adjourned at 6:50 p.m.)

8 * * *

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10
11 I, Lori A. Simpson, certify that the foregoing is a
12 correct transcript from the record of proceedings in the
13 above-entitled matter.

14
15
16 Certified by:

17 Lori A. Simpson, RMR-CRR
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