STATE of OHIO,
SS:
COUNTY of CUYAHOGA.

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IN THE COURT OF COMMON PLEAS

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JOHN T. MURRAY, et cetera, et al.,

Plaintiffs,

vs.

Case No. CV 2018 905172
Judge John P. O'Donnell

RITE AID of OHIO, INC.,et al.,

Defendants.

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Zoom deposition of **WILLIAM C. BECKER, M.D.**, a witness herein, called by the Defendants James Gallagher, M.D. and Gallagher & Gallagher, M.D.S., LLC, for the purpose of cross-examination, pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, RPR, Notary Public in and for the State of Ohio, taken at Versagi Court Reporters, Brendan Place, North Olmsted, OHIO, on **MONDAY**, **NOVEMBER 1, 2021**, commencing at 2:31 p.m., pursuant to Notice of Deposition.

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(NO DEPOSITION EXHIBITS MARKED)

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(for objection and word index, see appendix)

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WILLIAM C. BECKER, M.D.

of lawful age, being first duly sworn, as hereinafter certified, was examined and testified as follows:

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CROSS-EXAMINATION

BY MR. GROEDEL:

Q Doctor, can you please state your name for the record.

A William C. Becker.

Q Dr. Becker, my name is Marc Groedel. I represent Dr. Gallagher. I'm going to ask you some questions today about the opinions that you hold in this matter.

I assume you have been deposed before?

A Yes.

Q So because we're doing this via Zoom, we might have a few glitches along the way. I would just ask that to the extent that you can, wait for me to finish my question before you start giving your answer, and I will try to do likewise. If at any point in time, though, I end up interrupting you inadvertently before you finish your answer, please let me know, okay?

A Okay.
Q You understand that my purpose here today is to explore and have you identify all of the standard of care criticisms you have of Dr. Gallagher; you understand that?
A Yes.
Q I assume you understand that you're under oath and you understand the implications of that oath, correct?
A Correct.
Q Where are you now?
A I am in New Haven, Connecticut.
Q Is anybody with you in the room?
MR. ABRAMOWITZ: I am.
Q Who is with you?
A Mark Abramowitz.
Q Is anybody else with you in the room?
A No.
Q If I ask a question that you don't understand, will you let me know?
A Yes.
Q If you answer a question, I'm going to assume you understood it and answered it truthfully; fair enough?
A Fair.

Q If you need to take a break for any reason, let me know, I'm sure we'll be able to accommodate you. The only thing that I would ask is if there is a question pending, you answer the question and you can then go ahead and take the break. You can take a break for any reason; understood?
A Understood.
Q All right. Very good. Doctor, I have a copy of the report that you wrote in this case that's dated November 27, 2020; is that the only report that you have written in this case?
A That's the final report.
Q Are there any other reports that you have written?
MR. ABRAMOWITZ: Objection.
Q You can answer.
A No.
MR. GROEDEL: Mark, are you the screen?
MR. ABRAMOWITZ: I'm on this screen here. Can you see me, as well?
MR. GROEDEL: I just wasn't sure if you were hooked in as well.

MR. ABRAMOWITZ: I'm turning here to the right, that's why I might not show up.

MR. GROEDEL: Very good.

BY MR. GROEDEL:

Q Doctor, you have identified a number of materials that you reviewed in your report of November 27. Have you reviewed any additional information since writing your report?

A No.

Q Is there any other information that you have requested that you don't have that you think you need to have in order to testify at trial?

A No.

MR. ABRAMOWITZ: I also sent him the expert reports, all the expert reports, all the defendants.

Q So you've received the expert reports that were authored by physicians who are testifying on behalf of the defendants?

A Yes.

Q Do you know any of those physicians either personally or by way of reputation?

A No.

Q While you were reviewing the materials for this case, did you prepare any notes of any

kind?
A No.
Q Doctor, your business address is what?
A It is there on the top of my report. It should be 950 Campbell Avenue, West Haven, Connecticut.
Q What sort of building, is that a hospital, is that a free-standing office building, what is that?
A That's a hospital.
Q Is that where your main office is located?
A Yes, that's correct.
Q Who is your employer?
A I have two employers. VA Connecticut Health System and Yale School of Medicine.
Q So what are your responsibilities as an employee of the VA Connecticut Health Care System?
A I am the Medical Director of a clinic and I run a number of research studies.
Q What are your responsibilities as an employee of Yale?
A To run other research studies.
Q What you just told me, does that encompass all of the professional work that you do?

A I do additionally teach medical students and residents as part of both of those roles.
Q Both as an employee of VA Connecticut Health and the Yale School?
A Correct.
Q We have been provided with a copy of your CV. Did you bring a copy of that with you?
A Yes.
Q The CV that I have is 24 pages and the last article or reference is number 126; is that an up-to-date CV?
A Yes.
Q Are there any changes, additions, corrections that you believe you need to make?
A I don't believe so.
Q So what I would like to do now is talk to you a little bit or have you tell me a little bit about your current practice, what it entails professionally.
A My clinical practice is running a multi-disciplinary pain clinic at the VA Hospital, where we help individuals, we treat individuals with chronic pain, which sometimes also have opiate addiction.
Q Well, is that the extent of your clinical

practice?
A I also serve as a teaching attending physician on the inpatient hospital wards for four weeks a year.
Q Where is that at?
A At West Haven VA.
Q So your clinical practice entails running the pain clinic, and then serving as an attending on the inpatient service several weeks out of the year?
A Yes.
Q So do you see patients in an outpatient basis, in an office basis?
A Yes.
Q Describe for me when you see patients on an outpatient basis.
A That's the multi-disciplinary pain clinic runs in an outpatient setting.
Q How many days a week do you work at that outpatient clinic?
A One.
Q What day of the week is that?
A Tuesday.
Q So on Tuesday what are you doing during that day?

A I am seeing patients and discussing patients with my colleagues, making treatment decisions and implementing them.
Q About how many patients do you believe that you see in direct care on a hands-on basis on that Tuesday?
A Usually approximately 12 to 20.
Q What do you do on Monday?
A The research studies that I am involved with.
Q What actually is entailed with these research studies? What are you doing?
A Well, every research project has pretty standard set of phases from designing the research, writing up the manuals of procedures, then carrying out the research, collecting data, analyzing data, and then publishing the data. So with approximately ten projects ongoing, variety of those in a different stage of completion, basically seeing them through at their various stages to completion.
Q On that Monday are you providing any clinical care to patients?
A If there is a phone call that it is urgent that no one else is able to help with, I will

sometimes get involved in a clinical case, but that's not necessarily scheduled and could or could not be the case on any given Monday.

Q Fair to say then that the vast majority of your time on Monday is spent with handling your research projects as opposed to actually seeing patients?

A Correct.

Q So what do you do on Wednesday?

A Research projects.

Q Same thing that you were doing on Monday?

A Correct.

Q And the same limited, if any, involvement with actual hands-on clinical care?

A Correct.

Q What do you do on Thursday?

A Research projects.

Q Same thing as Wednesday?

A Yes.

Q What about Friday?

A Friday we do have a team, a clinical team huddle that lasts an hour, and we make sure that there were -- if there were any events that happened since our Tuesday clinic that need to be addressed, we decide who is going

to manage them; but other than that hour clinical huddle, I'm also working on research projects.

Q If it's an eight hour day, one hour is spent with that team clinical huddle that discusses patients who are seen in the clinic?

A Yes.

Q And the remainder of that day is spent with the research that you have already described?

A Yes.

Q Do you have any professional responsibilities on either Saturday or Sunday?

A Well, I'm generally catching up with grant writing and writing up manuscripts, but there are no structured hours doing that.

Q And the same would be true on Sunday?

A Correct.

Q So I assume there is no hands-on clinical care that you provide on either Saturday or Sunday?

A Correct. Unless it's during my four weeks of inpatient hospital work.

Q What percentage of your professional time would you say is involved handling administrative responsibilities for the various projects that you are involved in?

A I'm not sure if you're trying to separate out the administrative responsibilities of those projects, or that was just meant to mean research in general; but my professional effort is split 20 percent clinical, 80 percent research.
Q The 20 percent clinical, that would involve the Tuesday that you're seeing patients?
A Yes.
Q The 80 percent research is what you already told us about?
A Yes.
Q Are you saying then that you have some administrative responsibilities within that 80 percent research?
A Yeah. I mean, I'm responsible for making sure that the reports get back to the NIH and things are being accounted for in the way they need to, to show productivity, so yes.
Q So limiting your answer to your research responsibilities, what percentage of your time would you say is devoted to administrative functions?
A 20 percent of the research effort.
Q I assume you know what Dr. Gallagher does for

a living?
A Yes.
Q Have you ever worked as a primary care physician like Dr. Gallagher?
A Not in a community setting, no.
Q Well, have you ever worked as a primary care physician at all?
A Yes.
Q In what respect?
A I was a primary care physician at the Philadelphia VA from 2007 to 2009.
Q Would that have been the extent of your experience as a primary care physician?
A No. I was also a primary care physician when I returned to Yale from 2007 to 2012.
Q Anything else?
A No, that's all.
Q So tell me what sort of work you did and where you did it as a primary care physician when you were in Philadelphia?
A I was managing a panel of approximately 800 patients with their adult medical problems full time at the Philadelphia VA.
Q You were employed by the VA at that time?
A Correct.

Q So were you working like in a big office or out of a VA Medical Center? Explain that to me.
A Yeah. Multi physician practice, 15 to 20 full-time internists out of the VA.
Q What about your work at Yale from 2009 to 2012, explain that for me.
A There I was teaching faculty, so I had my own panel of patients; but I was also supervising residents with their panel of patients.
Q Did you actually provide hands-on care to patients while you were at Yale?
A Yes.
Q During that period of time?
A Yes.
Q How often were you doing that, roughly?
A Two and a half days a week.
Q About how often were you providing direct hands-on care to patients when you were working as a primary care physician in Philadelphia?
A Seven half days a week.
Q I'm sorry?
A Seven half days a week.
Q So just tell us a little bit about the pain

clinic that you are working at now. What sort of services does it provide, what type of patients do you see?

A We take referrals from primary care providers throughout VA Connecticut of their patients who are struggling with chronic pain that have not responded well to first line treatment. So we get involved to add diagnostic expertise and to try to match patients with improved treatments to help them do better.

Q Are there physicians besides internal medicine folks that work at this clinic?

A Yes.

Q What are the other specialists that work at this clinic?

A We have a psychiatrist who works with me.

Q Anybody else?

A There are trainees who also rotate through us, physician trainees, some of whom are internists, some are psychiatrists; but the only other attending level physician is a psychiatrist.

Q So this clinic that you have been referring to where you see patients on Tuesdays, there is two attending physicians that work at this

clinic?
A Yes.
Q What's the role of the psychiatrist?
A Well, many of the patients we see have co-occurring psychiatric disorders that's complicating their chronic pain, and she helps weigh in on optimizing their care plans.
Q If you have a patient at your clinic that you think would benefit from medication assisted therapy, such as methadone or Suboxone, do you provide that sort of treatment at your clinic?
A We provide Suboxone. We can't -- well, we are not allowed to prescribe methadone for opiate use disorder, but we do refer patients to the opioid treatment program to do so, but we do provide Suboxone.
Q I assume you don't provide methadone because you got to have special license from the government to utilize that medicine?
A Correct.
Q The psychiatrist that works with you, is that psychiatrist capable of recognizing when a patient has an addiction disorder?
A Yes.
Q An opioid use disorder?

A Yes.
Q Is that a skill that most or if not all psychiatrists have or should have?
A So I heard two different questions. That they have or that they should have. I would say not all of them -- most don't have it, but most should have it.
Q Why do you say that?
A Well, the data shows that a majority of psychiatrists don't feel comfortable diagnosing addiction, but if they're taking care of patients who have mental health issues, addiction is very commonly co-occurring, so they probably should gain comfort with that.
Q Would you agree that most psychiatrists are sufficiently skilled to recognize when a patient might have an opioid use disorder or an addiction disorder?
MR. ABRAMOWITZ: Objection, but can answer.
A Most physicians skilled? Yes.
Q I know you have written a number of articles and have spoken on opioid use disorder. I'm just wondering whether there are any

particular articles, one or more, that you plan on citing to a trial to support the opinions you plan on offering?

MR. ABRAMOWITZ: Objection, but you can answer.

A I have not made any plan to do that, any particular articles.

Q Recognizing that you're well-versed in the field, as you sit here today, you don't plan on citing to any specific article that you have written to support your opinions at trial; is that correct?

MR. ABRAMOWITZ: Objection, but you may answer.

A I haven't made that plan. I may end up doing that, but as I sit here today, I haven't made a plan to do that.

Q Well, I mean, this is my one and only chance to find out exactly what you're going to say and why you're going to say it prior to trial, so that's why I am asking the question; but without waiving any objection that I might have to what you may end up telling us later on, I would ask that if you do plan on citing to any of your specific writing to support

your opinions at trial, that you let Mr. Abramowitz know as soon as possible so that he can advise the rest of us about that, okay?

A Okay.

Q Thank you. Can you give me an idea as to approximately how many hours you have spent reviewing records, depositions, and other materials in this case?

A Approximately 12 to 15 hours.

Q Do you have any billing records that would reflect what you billed Mr. Abramowitz thus far?

A I do not have them all pulled together at this time.

Q Would you be able to do that for us and send them to him so that he can send them to us?

MR. ABRAMOWITZ: Mr. Groedel, I'll take care of that.

MR. GROEDEL: Thank you.

MR. ABRAMOWITZ: No problem.

Q I want to ask you a few questions about your prior experience in medical malpractice litigation.

Can you tell me approximately how many

other times you have been involved as an expert in a medical malpractice case?

A Three prior times, so this is my fourth.

Q Those three prior times, can you tell me whether they were on behalf of the family or plaintiff bringing the case, or the defendant medical provider?

A Twice with the plaintiff, once with the defendant.

Q Were all three of these cases involving narcotic usage?

A Yes.

Q What's your charge for reviewing records and depositions?

A My charges for case review is $400 an hour, and depositions $500 an hour.

Q Besides this case, have you given a deposition in a medical malpractice case?

A Yes.

Q How many times?

A This will be my third time.

Q The two other times, were they for defendant medical providers or plaintiffs?

A One plaintiff, one defendant.

Q Have you testified in trial before?

A No.
Q What do you charge for trial testimony?
A Looking up my fee schedule here. $5,000 per day, plus travel expenses.
Q You say you got a formal fee schedule?
A Yes.
Q Would you send a copy of that to Mr. Abramowitz so that he can send that along to us; do you have any problem with that?
MR. ABRAMOWITZ: We have no problem with that. We'll get that to you, Marc.
MR. GROEDEL: Thank you.
Q Are you scheduled to testify at the trial of this matter?
MR. ABRAMOWITZ: Objection, but you can answer.
A I have not been scheduled, but I'm willing to do so.
Q Besides this case, are there any other cases that you have reviewed either for the DiCello firm or for Mr. Stombaugh?
A No.
Q To your knowledge, are you on the roster of any company that advertises its ability to find expert witnesses?

A No.
Q I assume you don't advertise your services as an expert witness?
A Correct.
Q How did the DiCello firm find you to review this case?
MR. ABRAMOWITZ: Objection, but you can answer.
A I actually don't know. I don't know.
Q Do you recall how you were contacted, was it by telephone, email, letter, in person?
MR. ABRAMOWITZ: Objection, but you can answer.
A I don't recall.
Q When you were reviewing the records in this case, would I be correct in assuming that you were aware that Mr. Dukeshire had died?
A You would be correct.
Q Would I be correct in assuming that when you were reviewing these records, you knew that he had died from narcotics?
A Yes.
Q Or illicit drugs?
A Yes.
Q We know from the records we received in

discovery that Mr. Dukeshire received narcotics from other physicians before he came under the care of Dr. Gallagher; I assume you were aware of that?

A Yes.

Q Do you know which physicians provided Mr. Dukeshire with narcotics prior to him becoming a patient of Dr. Gallagher's?

A The names of those physicians you are asking?

Q Yes.

A No. I saw them in the record but I didn't commit them to memory.

Q Sure. Well, these were physicians I believe who are affiliated with Family Health Services of Erie County, and you mentioned them as one of the records that you reviewed, correct?

A Yes.

Q Do you believe that any of the physicians that prescribed narcotics to Mr. Dukeshire before he came to see Dr. Gallagher breached the standard of care in providing those narcotics?

MR. ABRAMOWITZ: Objection, but you can answer.

A I don't believe I have a complete set of records to be able to comment on their meeting

or not meeting the standard of care.
Q Well, assuming that you have received all of the records from Family Health Services of Erie County that exist, do you have an opinion as to whether or not those physicians provided care that met the standard of care when they prescribed narcotics for Mr. Dukeshire?
MR. ABRAMOWITZ: Objection. I'm not sure that's a fair assumption here. We just don't know that at this time, if we have all the records or not.
Q Do you have an opinion?
A No.
Q Is there anything that you saw in the Family Health Services record that caused you to think gee, I don't have all of the records from this office?
MR. ABRAMOWITZ: Objection.
A I'm sorry. Was there anything in those records that made we wonder whether I might not have all the records?
Q Correct.
A I can't answer that.
Q As you sit here today, you are not prepared to state that the doctors at Family Health

Services breached the standard of care; is that correct?
A That's correct.
Q Were you aware from the records that the family had reported to medical providers in 2010 that Mr. Dukeshire had a history of polysubstance abuse?
A Yes.
Q What was your understanding as to what was being abused?
A Cocaine and alcohol.
Q Not narcotics?
A I don't recall opioids being a piece of that.
Q So I assume you were aware that in 2011 and 2012 Mr. Dukeshire was being treated with narcotics for back pain, correct?
A Correct.
Q To your knowledge, were those physicians aware of Mr. Dukeshire's history of prior cocaine and alcohol abuse?
MR. ABRAMOWITZ: Objection. Calls for speculation.
MR. GROEDEL: No, it doesn't. It calls for him to give an answer based upon the records.

MR. ABRAMOWITZ: Of what they knew or did not know, it's more than what's in the records, so I think it is speculation. You didn't ask what's in those records, you asked what they knew. I think those are different. I think that's speculation.

Q Based upon the records that you reviewed, were the physicians who were treating Mr. Dukeshire in 2011 and 2012 aware of Mr. Dukeshire's history of cocaine and alcohol abuse?

MR. ABRAMOWITZ: Objection, but you can answer.

A I'm not sure.

Q Based upon the records that you have seen, was there any evidence that the physicians at Family Health Care followed the guidelines of the Ohio Administrative Code with respect to the use of narcotics?

A I'm not sure.

Q You couldn't tell from the records one way or the other?

A Correct.

Q What's your understanding as to what opioids Mr. Dukeshire received from the doctors at Family Health Care?

MR. ABRAMOWITZ: Objection, but you can answer.

A I do not recall.

Q From your review of those records, could you tell whether or not the narcotics that he received from that facility alleviated his pain?

MR. ABRAMOWITZ: Objection, but you can answer.

A I'm not sure.

Q Is there evidence in the records at Family Health Care that in 2012 Mr. Dukeshire was referred to a pain management specialist?

A I'm not sure.

Q If he had been referred to a pain management specialist at that point in time, and we're talking about May of 2012, would that have been an appropriate referral?

MR. ABRAMOWITZ: Objection, but you can answer.

A I can speak in the general sense that if someone's primary care group or primary care provider is hoping to get expert opinion, that referral to an expert is appropriate.

Q What do pain management physicians do?

A Well, in general help, use their expertise, diagnostic and treatment expertise to improve the patient's pain and functioning.
Q Do they utilize methadone or Suboxone?
A Well, so methadone, as you may be aware, can be used for the treatment of pain, as well as the treatment of opioid use disorder. So some pain specialists do use methadone for the treatment of pain. Increasingly, pain specialists are getting themselves trained in the use of Suboxone, but that's a more recent phenomenon I would say.
Q I would assume that pain management physicians would be particularly adept at recognizing when a patient may be addicted to narcotics?
A You said you can assume that, so are you asking me if I have that same assumption?
Q Yes.
A I don't have that same assumption.
Q You don't believe pain management physicians are capable of determining when a patient may have an addiction disorder?
A Some are capable. They are all capable. Some are adept, which is the word you used, and some are not.

Q You would agree that a pain management physician generally would be capable of recognizing when a patient should be referred to an addiction medicine specialist?
A Yes.
Q Do you know whether or not Mr. Dukeshire saw a pain management specialist in May of 2012 or thereabouts?
MR. ABRAMOWITZ: Objection, but you can answer.
A I'm not sure.
Q Were you aware that a tox screen from Bellevue Hospital in October of 2012 was positive for methadone and cocaine?
MR. ABRAMOWITZ: Objection, but you can answer.
A No, I was not.
Q Assuming that that tox screen was accurate, where would somebody like Mr. Dukeshire be able to access methadone?
MR. ABRAMOWITZ: Objection, but you can answer.
A He could have gotten it as a pain management prescription, he could have gotten it from the streets, or he could have gotten it from an

opioid treatment program.
Q Do you have any knowledge as to where he would have received methadone?
A No.
Q If a physician saw that tox screen result, in other words, the result that was positive for methadone or cocaine, should that physician have referred Mr. Dukeshire to an addiction medicine specialist?
A Well, you know, a little more context would be necessary to fully answer that, but illicit cocaine use would very often generate, me to generate a referral to addiction specialists.
Q What was your understanding from everything you know about this case as to when Mr. Dukeshire was using cocaine?
MR. ABRAMOWITZ: Objection, but you can answer.
A That it was prior to -- well, the only documentation of it was that it was prior to him joining Dr. Gallagher's practice.
Q Do you have any information to indicate that he was using cocaine at all after he was with Dr. Gallagher?
MR. ABRAMOWITZ: Objection, but you

can answer.
A I have no indication of that.
Q I mean do you have any reason to believe that he was utilizing cocaine from when he started treating with Dr. Gallagher?
A Well, there's a history of use of cocaine and we have no urine drug test during his time with Dr. Gallagher, so it's certainly possible but we have no way to know.
Q Based upon everything that you have seen in this case, is there any evidence that you saw that Mr. Dukeshire was suffering any adverse effects from the opioids that he was receiving in 2010, 2011, 2012, or 2013 before he began treating with Dr. Gallagher?
A I don't know.
Q What information would you need to have, if you think there is information out there, that might allow you to answer that question?
A I would need to re-review the records from that practice.
Q When was the last time you looked at the records in this case?
MR. ABRAMOWITZ: Objection, but you can answer.

A Those particular records or any records?
Q Any records?
A Yesterday.
Q What records did you review yesterday?
MR. ABRAMOWITZ: Objection, but you can answer.
A I focused on Dr. Gallagher's records.
Q Any other records?
A Hospitalization records.
Q While Mr. Dukeshire was under Dr. Gallagher's care?
A Yes.
Q When is the last time you looked at the records from Family Health Services of Erie County?
MR. ABRAMOWITZ: Objection, but you can answer.
A When they were first sent to me. I would have --
Q Which was when?
A I am not sure.
MR. ABRAMOWITZ: Objection. You can answer.
A I'm not sure off the top of my head.
Q Well, your report is dated November 27, 2020,

does that provide you with any guidance as to when you would have reviewed those records?

MR. ABRAMOWITZ: Objection, but you can answer.

A Before then.

Q Well, yeah. You didn't really help me much with that one, Doctor.

Can you be anymore definitive than that?

A I would say roughly approximately three to six months before then.

Q Do you have an understanding as to the length of time in which Mr. Dukeshire was using cocaine?

MR. ABRAMOWITZ: Objection, but you can answer.

A No, I don't.

Q So if somebody is using cocaine, does the length of time and the frequency with which they use it need to be considered before you determine whether or not they are actually addicted to it?

A Length of time and frequency are factors, but ultimately it is how much impact the use of the substance is having on their ability to

function in a normal life.
Q Do you have any knowledge as to whether or not Mr. Dukeshire's cocaine usage was having an adverse impact upon his ability to function?
MR. ABRAMOWITZ: Objection, but you can answer.
A I don't.
Q To your knowledge, did Mr. Dukeshire tell Dr. Gallagher about his history of prior cocaine use?
MR. ABRAMOWITZ: Objection, you can answer.
A I don't believe that he did.
Q Is it your understanding that Mr. Dukeshire had a history of alcohol addiction?
A Yes.
Q What's your understanding about that condition?
A That it had resolved prior to him joining Dr. Gallagher's practice.
Q Do you have an understanding as to how it resolved?
A I don't remember.
Q Do you have an understanding as to how long he had that addiction for?

A I don't remember.
Q Was it your understanding that Dr. Gallagher made an attempt to obtain Mr. Dukeshire's records from Family Health Care?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes.
Q Was it your understanding that those records were ever sent to Dr. Gallagher?
MR. ABRAMOWITZ: Objection, you can answer.
A I believe they were.
Q You believe they were?
A Yeah.
Q Upon what do you base that information?
I assume you are looking at something?
A Yeah. I thought I saw reference to it in his records, but now I don't believe I -- I think I am mistaken. I would need to go back and check.
Q It's quite possible that although he asked for them, he never received those records?
MR. ABRAMOWITZ: Objection, but you can answer.
A Okay. So what I'm -- I am not certain that he

asked for them, and I am not certain that he received them.

Q Is it true that the narcotics that Mr. Dukeshire received prior to him starting with Dr. Gallagher was to help control his back pain?

MR. ABRAMOWITZ: Objection, but you can answer.

A I believe that's true.

Q Is back pain the most common reason why narcotic medications are prescribed in this country?

A I believe that's true.

Q What was your understanding as to how long Mr. Dukeshire had been suffering from back pain prior to his starting up with Dr. Gallagher?

MR. ABRAMOWITZ: Objection. You can answer.

A I'd say my understanding was in the order of years.

Q I saw some reference in the record to him having a history of 20 years worth of back pain, does that sound about right to you?

A Yes.

Q So if Mr. Dukeshire had been seen by a pain management specialist in 2012 or 2013 before he started with Dr. Gallagher, do you have an opinion as to what treatment he likely would have received at that point?

MR. ABRAMOWITZ: Objection, but you can answer.

A No.

Q Is there a possibility that if he had been seen by a pain management specialist in 2012 or early 2013, he would have been referred to an addiction medicine specialist?

MR. ABRAMOWITZ: Objection, but you can answer.

A Is there a possibility of that?

Q Yes.

A Yes.

Q Is there a probability of that?

A I don't know.

Q So I know that in your report you discuss the presence of red flags with respect to Mr. Dukeshire, and your opinion that Dr. Gallagher didn't appropriately respond to those red flags.

What I would like you to do now is to

identify for me each and every instance where you believe a red flag was present or occurring.

A Okay.

MR. ABRAMOWITZ: You want him to go through the records one-by-one, look at each visit, or the gestalt of it? How would you like to handle that, rather than just --

MR. GROEDEL: Well, I mean, I want him to identify each and every red flag. I mean, you can do it -- the doctor can do it any way he thinks would be the best way to communicate his opinions to me on that issue. I'll leave it to Dr. Becker.

A Okay. Well, some I can be a little more specific in terms of dates, but others will be more general in terms of concepts.

So one of the major red flag categories that pops up a number of times is running out early from -- his prescription running out and asking for early refills, which I believe started happening as early of April of 2014, and then again June 2014, then July 2015, August 2015, November 2015, April 2016, and then again October 2017, which is right before

he died.

Q Let me stop you for a moment there.

Do you have an understanding as to whether or not Mr. Dukeshire was having increased complaints of pain beyond his usual baseline on those occasions that caused him to run out of his narcotics early?

MR. ABRAMOWITZ: Objection, but you can answer.

A I know on several of those instances Mr. Dukeshire was complaining of increased pain.

Q Are there occasions when patients on narcotics take more than they should because they are having more pain than what they are usually dealing with?

A So the treatment agreement signed says that if you are having increased pain, call us and we can talk about what we can do. This issue of escalating one's dose on one's own is really concerning for loss of control; and I have no doubt that Mr. Dukeshire reported pain as a potential reason for doing this, but doesn't make it safe or consistent with the treatment agreement.

Q When you say treatment agreement, what agreement are you referring to?
A Well, he signed a treatment agreement in November of 2016.
Q Is it your belief that any one of these episodes where he ran out early required different action on the part of Dr. Gallagher than what was provided?
A That any one required a different action?
Q Yes.
A It's my belief that any one of them pass maybe the initial one, should have been reacted to differently.
Q For instance, when he ran out early, for instance, say in June of 2014, you believe that episode should have warranted some action on Dr. Gallagher's part?
A Correct. Correct.
Q What action do you believe was required?
A We really needed a urine drug test there to see if this patient is taking what I am prescribing and not taking things that I am not prescribing.
Q Anything else?
A Definitely a query of the prescription drug

monitoring program to see if there were other sources of medication.

Q I'm not sure I understood what you mean by that.

A Checking the prescription drug monitoring program.

Q You mean to see whether or not he was being prescribed other narcotics or other medications?

A Right.

Q Do you have an opinion based on reasonable medical probability as to what a urine drug screen would have shown if one had been obtained in June of 2014?

MR. ABRAMOWITZ: Objection, but you can answer.

A No, I don't.

Q Do you have an opinion as to what a urine drug screen would have shown beyond his narcotics that he was being given by Dr. Gallagher at any point in time prior to his death?

MR. ABRAMOWITZ: You asked -- I apologize, Marc. Can you ask it again?

Q The idea behind a urine drug screen, Dr. Becker, is to see whether or not the

patient is taking medications other than what is being prescribed, correct?

A Well, taking -- A, taking what is being prescribed; and B, making sure nothing that isn't being prescribed is being taken.

Q Are you able to tell us that a urine drug screen obtained at any time before Mr. Dukeshire's death would have shown that he was taking something beyond what Dr. Gallagher was prescribing?

MR. ABRAMOWITZ: Objection, but you can answer.

A I think it's possible, but I can't say with any certainty.

Q So just that we're clear here, you are unable to state to within a reasonable degree of medical probability that a urine drug screen taken at any point in time before Mr. Dukeshire's death, would have revealed anything other than what Dr. Gallagher was prescribing, correct?

MR. ABRAMOWITZ: Objection, but you can answer.

A With medical certainty?

Q Probability, yeah.

A So I would say that it wouldn't have surprised me to find something other than what was being prescribed.
Q It also wouldn't surprise you to see a urine drug test that showed only the use of narcotics being prescribed, correct?
MR. ABRAMOWITZ: Objection, but you can answer.
A If all had shown only what was being prescribed, that would have been surprising.
Q At what point do you believe a urine drug screen would have shown something other than narcotics being prescribed by Dr. Gallagher?
MR. ABRAMOWITZ: Objection, but you can answer.
A It's hard to say. It's too hard to speculate.
Q Because it would be speculation to say that a urine drug screen would have shown something other than narcotics at any point in time while Mr. Dukeshire was alive, correct?
MR. ABRAMOWITZ: Objection.
A No.
MR. ABRAMOWITZ: You can answer.
A He's fairly clearly demonstrating symptoms of the disease of opioid addiction. It's a

relapsing disease that causes periods of more intense use than others. We don't have any urine drug tests to look at so I could match his varying points of acting more erratically to say well, there could have been something in his urine if it had been looked for; but to say exactly when these times would be, I am not prepared to do that.

Q Because it would be speculation?

MR. ABRAMOWITZ: Objection, you can answer.

A I don't know how else to describe imagining what the results of the urine tox would be that was never drawn, but should have been.

Q Which is why you can't say a urine drug screen would have shown something other than narcotics, true?

MR. ABRAMOWITZ: Objection. You've asked and he answered already.

Q Are you thinking about it?

A No.

Q No what?

A No, I am not thinking about it.

Q Can you answer the question then?

A No.

MR. ABRAMOWITZ: I think he's saying that he already answered it.

Q Beyond these running out early instances, are there any other red flags that you believe were present in Mr. Dukeshire's case that warranted different action on the part of Dr. Gallagher?

A Yes. There were at least three episodes where it appeared Mr. Dukeshire had an episode of drug toxicity, which could have been due to an overdose of opioids, opioids plus benzodiazepines. One in February 2016, one June 2017, and then another in August 2017, where various points he was confused, slurring his speech, required admission to the hospital; and these episodes are compared to, as I mentioned, overdose, and if we're trying to be thoughtfully prescribing these medications, which we should be, a patient is experiencing these sorts of symptoms, they need to be really delved into, and it doesn't appear that they were.

Q So you believe the episodes of February 2016, June 2017, and August 2017 represented overdoses?

A Yeah.
Q Which you believe were red flags?
A Right. The harms of this treatment are outweighing any benefit, and it's really concerning for the diseased patients -- well, his prior ability to control his use of the medication.
Q Any other red flags that you believe are present in this case?
A Well, I think the fact that his family, various members of his family are coming to Dr. Dukeshire to explain their concern about the way Mr. Dukeshire is using his medication, the way he had been acting; that they had set up various ways to help him count his medication, keep track of his medication; and even with those pretty concerted efforts they weren't able to. That is a red flag for sure, red flags, plural.
Q In what respect was Dr. Dukeshire -- I'm sorry, Dr. Gallagher told that Mr. Dukeshire was using his medications inappropriately by family members?
A I believe the son had come to -- either come in person or made a phone call to

Dr. Gallagher to express concern. The wife phone called, and I think came in person; and then a daughter, as well, made a phone call.

Q Did any of Mr. Dukeshire's family members tell Dr. Gallagher that he was purchasing narcotics on the street?

A I am not sure.

Q Did any of Mr. Dukeshire's family members tell Dr. Gallagher that Mr. Dukeshire was purchasing narcotics on the street, crushing them, and snorting them?

MR. ABRAMOWITZ: Objection, but you can answer.

A Not that I am aware of.

Q Based on your review of the deposition testimony, would it be fair to -- well, would you agree that Mr. Dukeshire's family members were aware that Mr. Dukeshire was purchasing narcotics on the street?

MR. ABRAMOWITZ: Objection, but you can answer.

A I am not sure what they were aware of.

Q Didn't you read Mrs. Dukeshire's testimony where she said that she knew that her husband was purchasing narcotics from friends of his?

MR. ABRAMOWITZ: Objection, but you can answer.

A I did read that.

Q Are there any other red flags that you believe are present in this case?

A Let's see. The early refills, the overdoses, the family concern, family rationing his medication. Oh, another one. This is a general kind of category, it's hard to point to specific instances, per se; but the over time not pursuing other aspects of his medical care and kind of focusing all his energy on filling the medication often early, sort of letting everything else to do with his health and wellness just kind of go. That to me is a big red flag that this person has developed an addiction.

Q In other words, the patient's non compliance with respect to other aspects of his medical care to you is a red flag?

A Yeah. Or maybe as I put it or I will rephrase it, a singular focus on getting the medications at the exclusion of pursuing other necessary medical care.

Q Any other red flags?

A I think those are the main ones I can recall at this time.
Q In your report you make reference to the Ohio Administrative Code, and I'm wondering what specific code you are referring to?
MR. ABRAMOWITZ: Objection, but you can answer.
A I don't know that I have the actual title of the code, but the Federation of State Medical Boards developed a model policy for the use of controlled substances. And Ohio -- that came out in 2013 -- and Ohio adopted its own version, as many states did, that was modeled after the Federation's policy.
I was just going to say, it essentially outlines best practices and the stewardship and how to safely manage controlled substances to be patient centered and safe.
Q Do you know when Ohio essentially in its Administrative Code adopted the information in the Federation of State Medical Boards?
MR. ABRAMOWITZ: Objection, but you can answer.
A I do not know off the top of my head. I would have to do some digging.

Q Well, do you know whether or not the Ohio Administrative Code set out guidelines that were in effect when Mr. Dukeshire was under the care of Dr. Gallagher?
A I believe so, yes.
Q You're just not sure exactly when?
A Correct.
Q Do you believe that the information and the recommendations contained in the Administrative Code are standard of care requirements?
MR. ABRAMOWITZ: Objection, but you can answer.
A I guess I'm not sure standard of care requirements? Establishing a standard of care is how I would say.
Q Well, so for instance, if a physician didn't follow any portion of the Administrative Code guidelines, would you consider a lack of or the absence of following those guidelines to be a breach of the standard of care?
A Yes.
MR. ABRAMOWITZ: Marc, I don't want to rush you for a break, but we've been going for about an hour here. Is it a good time for

one?

MR. GROEDEL: We can take a break now if you would like. Ten minutes or so; is that okay with you, Doctor?

THE WITNESS: Yes.

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(Recess taken)

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MR. GROEDEL: Doctor, we're back on the record. Just a couple of minor cleanup points that I forgot to follow up on.

Q With respect to medical literature, I assume based on what you've told us previously, as you sit here today, you don't plan on citing to any medical literature beyond what you have written; is that correct?

MR. ABRAMOWITZ: Objection, you can answer.

A I would -- I have a number of thoughtful colleagues in the field who have written impactful things. I would like to reserve the right to also present or reference their material, but I haven't identified what those might be.

Q Without waiving my objection to the late

identification of that literature, I would ask that if you do identify any literature from other folks beyond yourself, you identify that literature for Mr. Abramowitz so he can let us know about it?

A Yes.

MR. MCMANUS: I will second that request also as it relates to my client Rite Aid. Thank you.

A Yes.

Q You made reference, Doctor, to the treatment agreement that Mr. Dukeshire signed during the course of his treatment with Dr. Gallagher, correct?

A Yes.

Q That's treatment agreements that are frequently entered into between patients and physicians when those patients are receiving narcotics on a regular basis?

A Yes.

Q Based upon everything you know about this case, would you agree that Mr. Dukeshire violated that agreement on a number of occasions?

MR. ABRAMOWITZ: Objection. You can

answer.
A He violated it and Dr. Gallagher did too.
Q In what respect did Mr. Dukeshire violate that agreement?
A I'm fairly certain the -- one of the lines is -- asks that the patient not increase the dose of the medication on their own, which the patient did.
Q Does the agreement also obligate the patient not to purchase narcotics outside of those that are being prescribed by Dr. Gallagher?
MR. ABRAMOWITZ: Objection, but you can answer.
A I'm not sure I would agree that it obligates the patient not to do that. My understanding of these documents is that it says if this -- we advise you not to do that, we think that would be unsafe, and if that is to happen, we'll have to reconsider the appropriateness of this treatment.
Q Wouldn't you agree that it would have been a breach of the treatment agreement if Mr. Dukeshire was purchasing narcotics from friends or other people besides Dr. Gallagher; that's a breach of the agreement, isn't it?

A That is a breach of the agreement. I'm trying to put a point on your phrasing that it obligates patients to do something. I don't think it obligates patients to do anything. It advises them.

Q It tells them things that they shouldn't be doing, correct?

MR. ABRAMOWITZ: Objection, but you can answer.

A Tells them things that if they do, the appropriateness of the treatment will be reassessed.

Q Do you have an opinion as to what Dr. Gallagher likely would have done had he been told that Mr. Dukeshire was purchasing narcotics on the street and then crushing them and snorting them?

MR. ABRAMOWITZ: Objection, but you can answer.

A What Dr. Gallagher would have done? No, I don't have an opinion. I -- no, I don't.

MR. ABRAMOWITZ: This is a speculation of what Dr. Gallagher himself would do, or what a prudent physician would do in that situation?

MR. GROEDEL: I'm going to ask the next question.

Q Do you have an opinion as to what Dr. Gallagher should have done if he had been told by anyone that Mr. Dukeshire was purchasing narcotics on the street, crushing them, and snorting them on a fairly regular basis?

A What he should have done is made the diagnosis of opioid use disorder with that information, and then provided addiction treatment himself to the patient, or provided a warm handoff to a treatment facility, so that that treatment facility could provide addiction treatment.

Q Are you able to state an opinion to within a reasonable degree of probability as to whether a referral to that sort of facility would have avoided Mr. Dukeshire's death?

MR. ABRAMOWITZ: Objection, you can answer.

A A referral with the appropriate, you know, what I am saying a warm handoff, meaning the provider that's on the other end of the referral knows of the patient, knows when to expect them. A meaningful way that the

patient can actually engage with the treatment, yes, that could have prevented Mr. Dukeshire's death.

Q So when you say could have prevented, are you able to say to within a reasonable degree of medical certainty that referral to an addiction center would have in all likelihood prevented Mr. Dukeshire's death?

A Well, referral to an addiction center, and initiation of appropriate medication, yes.

Q Are you able to state to within a reasonable degree of medical probability that Mr. Dukeshire would have been compliant with the treatment that would have been offered to him at an addiction center?

MR. ABRAMOWITZ: Objection. Speculation. You can answer, if you can.

A I'm not going to speculate on that.

Q Are you saying that because it requires speculation to give an answer?

A It is -- hum? I think it is within reasonable certainty that he would have been compliant with that treatment, yes.

Q Why do you believe he would have been compliant with that treatment?

A Because he would recognize that his source of opioids was going away and that he would need to pursue this treatment to forestall going into opiate withdrawal.
Q Did you see any evidence of Mr. Dukeshire exhibiting signs of opiate withdrawal while he was under Dr. Gallagher's care?
A I don't believe that I did.
Q I may have asked you this before, if so, I apologize: Are you going to have an opinion at trial as to whether or not Mr. Dukeshire utilized heroin at any point in time prior to his death?
MR. ABRAMOWITZ: Objection. Other than the fatal dose, I mean, we know that he did that.
MR. GROEDEL: Well, no, we don't.
Q But go ahead.
A So sorry? Am I going to -- could you please repeat the question?
Q Let me just start at this point: We know the autopsy showed there was evidence of morphine in the toxicology report, correct?
A Right.
Q Is it your opinion that that morphine was due

to the ingestion of heroin?

MR. ABRAMOWITZ: Objection, but you can answer.

A I mean, it could have been, but you clearly know that already.

Q So you are saying it's something that could have been part of what he ended up taking on the day that he died?

A Yes.

Q Forgetting about that day for a moment, the day that he died, is there any evidence that Mr. Dukeshire utilized heroin?

MR. ABRAMOWITZ: Objection, you can answer.

A Not that I am aware of, other than if a urine toxicology was done, we would have had more basis to comment.

Q We know from the records that Mr. Dukeshire had two back surgeries performed in December of '2014, correct?

A Correct.

Q I assume you saw from the records that he had documented significant degenerative changes in his lumbar spine, correct?

A Correct.

Q And he was having a lot of back pain as a result?
A Correct.
Q I assume you don't have any criticisms of the decision to go ahead and provide two operations in an attempt to alleviate his back pain, true?
A I'm not a surgeon. I am not going to comment on that.
Q Surgeries don't always alleviate back pain, true?
A That is true.
Q Why is that?
MR. ABRAMOWITZ: Objection. If you can answer.
A Well, the back is complicated physiologically, muscles, ligaments, bones. The target that is aimed at for surgical decompression can sometimes be the source of the pain, and sometimes not.
Q Was it appropriate for Mr. Dukeshire to receive narcotic medication following these two operations?
MR. ABRAMOWITZ: Objection, but you can answer.

A So limited two to three day supply for incisional pain is appropriate, but beyond that, typically not needed, so inappropriate.
Q We know from the records that Mr. Dukeshire's back pain returned in May of 2015 when he was complaining of severe radiating pain. Do you have an opinion as to whether or not it was appropriate to treat him with narcotics for those complaints of back pain?
A It would have been appropriate to take a very, very close look at whether the benefit of doing that would have outweighed the risk. And there is a number of things working against him on the risk side of things that would have ultimately led me to think it was probably too risky and the benefit would be fairly minimal.
Q Is it your opinion that it was beneath the standard of care to prescribe narcotics for Mr. Dukeshire when he had recurrent low back pain in May of 2015?
MR. ABRAMOWITZ: Objection, but you can answer.
A I am not going to say beneath the standard of care, no.

Q We know from the records that Mr. Dukeshire also had a history of right knee infection and abscesses; is that correct?
A Yes.
Q Is it your understanding that a draining abscess can be painful?
A Yes.
MR. ABRAMOWITZ: Objection. You can answer.
Q We know from the records that in early 2015 he needed to be hospitalized in Toledo for further care for that knee abscess, correct?
A Yes.
Q Are you critical of the decision to treat him with narcotics for the right knee pain he was suffering from at that point?
MR. ABRAMOWITZ: Objection, but you can answer.
A No, I am not critical.
Q We know that he was readmitted to the hospital in April of 2015 because his knee pain returned. Are you critical of the decision to treat him with narcotics once again during that admission?
MR. ABRAMOWITZ: Objection, but you

can answer.
A Not critical of the use during admission for the drainage procedure, which is painful, a couple days post procedure. Ongoing use would have required more consideration, and again, harms probably would have outweighed the benefits in my opinion.
Q I assume you are aware that Mr. Dukeshire required seven separate surgical procedures for his right knee over about a three year period of time; is that correct?
A That's correct.
Q And you would agree that those recurrent infections would be a source of pain?
A Yes.
Q And would require narcotics?
A Again, the sort of a blanket "requiring narcotics" is a tough -- it's hard to answer in a blanket way. A couple days surrounding the procedures makes a lot of sense, but having a year's worth, less sense, because of the, again, the declining benefit of taking them and the increasing risks.
Q Did you have an understanding as to whether the left knee infections in 2017 was keeping

Mr. Dukeshire from working at all?
A I do not recall if that was the reason for keeping him out of work.
Q You would agree, though, that his recurrent left knee infections were an ongoing source of pain for him over the last few years of his life?
MR. ABRAMOWITZ: Objection, you can answer.
A Yes.
Q Would that abscess that required seven surgical procedures over the course of a few years, would that have an impact upon his gait?
MR. ABRAMOWITZ: Objection, but you can answer.
A I'm not sure.
Q We also know from the records that Mr. Dukeshire developed ulcers on his buttocks while he was under Dr. Gallagher's care, correct?
A Yes.
Q What is your understanding as to how those ulcers developed, what caused them?
A Well, he did have an admission to the hospital

I believe in 2014, heavy man, I think he was in ICU, he was on mechanical ventilation. Sometimes these develop, start as pressure ulcers, I think that is how this one started, and then once they are established, then they are often hard to resolve because of the extra fat tissue. The antibodies don't penetrate very well, et cetera, et cetera. So yeah, I think it started with the hospitalization.

Q These ulcers, they can be painful?

A Yes.

Q And it would not be unreasonable to treat ulcers like that with narcotics?

MR. ABRAMOWITZ: Objection, but you can answer.

A It's fairly atypical to treat those with opioids. The main treatment is to drain them, dress them, try to debride the dead tissue. Not a lot of innervation back there on your posterior buttocks with a lot of adipose tissue there, while I did say it would be painful, I'm not sure painful enough to warrant extended courses of opioids.

Q Do you believe any of the physicians who prescribed opioids to treat those ulcers

breached the standard of care?

MR. ABRAMOWITZ: Objection, but you can answer.

A So anybody who used those in a long term fashion without doing appropriate monitoring of what was going on with those opioids was breaching the standard of care. I'm not going to say the decision to use them at all was below the standard of care, but the decision to not follow up appropriately and monitor was.

Q Were you aware that Mr. Dukeshire was seen by a pain management specialist in February of 2015?

A Yes.

MR. ABRAMOWITZ: Objection.

Q Based upon everything you know about this case, did that pain management specialist refer Mr. Dukeshire to an addiction specialist?

A I am not certain.

Q Well, do you believe that that pain management specialist should have referred Mr. Dukeshire to an addiction specialist?

MR. ABRAMOWITZ: Objection, but you

can answer.
A So the responsibility for how the opioids are being monitored and the harm that may be accruing from them is on the prescriber to manage. And so I don't -- the referring pain physician was not the prescriber, I don't think it was their duty to do so.
Q You don't have any criticisms of the pain management specialist if he didn't feel that addiction referral was required, correct?
A Correct.
Q We know from the records that Mr. Dukeshire was an inpatient at Elmwood Health Care Center in May and June of 2014 for his wounds, you're aware of that?
A Yes.
Q Would it have been appropriate to treat him with narcotics for those wounds?
A Again, I would have recommended short courses for a matter of several days while those wounds were being debrided, but in terms of ongoing long term treatment, not appropriate.
Q We know from the records that in July of 2015 Mr. Dukeshire was admitted to Firelands Hospital for a large painful buttocks ulcer,

was it appropriate for him to be treated with narcotics during that admission?

MR. ABRAMOWITZ: Objection, but you can answer.

A During the admission, yes.

Q We know that his buttocks ulcer flared up again in July of 2017 and he was treated for that problem at the Bethesda Care Center, was it appropriate for him to be treated with narcotics during that admission?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes, during the admission.

Q It looks like Mr. Dukeshire started having pain related to carpal tunnel syndrome sometime in 2015, did you notice that in the records?

A Yes.

Q That's a painful condition?

A Yes.

Q Would it be appropriate to treat somebody with narcotics for that condition?

MR. ABRAMOWITZ: Objection, but you can answer.

A No. Really the treatment of choice for carpal

tunnel syndrome is braces, non steriodal anti-inflammatory drugs, and exercises, physical therapy, and ultimately surgery.

Q What is your understanding as to whether Mr. Dukeshire had surgery for his carpal tunnel symptoms?

A I'm not sure.

Q Would an MRSA infection of the wrist be a painful condition?

A Possibly.

Q Could require narcotics, potentially?

A Could require narcotics, potentially? Potentially, yes.

Q I also saw some reference to Mr. Dukeshire having a left biceps tear; were you aware of that?

A Yes.

Q What's your understanding as to how that injury occurred?

A I believe this was during a period of time he was repossessing cars. He might have gotten in a scuffle.

Q Would that sort of injury be painful?

A Yes.

Q Might require narcotics?

A It might, but it might not.
Q I want to switch gears a little bit and ask you some questions about Mr. Dukeshire's medical conditions.
We know from the records that he had a history of severe obstructive sleep apnea, correct?
A Correct.
Q CPAP is the appropriate treatment for that?
A Yes.
Q Mr. Dukeshire had the CPAP device?
A I believe he did. He did possess one.
Q Is it your understanding that he was non compliant with respect to the CPAP?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes, it is my understanding.
Q I mean, it's not all that unusual for patients with obstructive sleep apnea to not use the CPAP device because they find it very uncomfortable, correct?
A Correct.
Q So from your understanding, Mr. Dukeshire's sleep apnea was essentially untreated because he wasn't using his CPAP device?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes.

Q What sort of symptoms can a patient exhibit if they have sleep apnea that's not being sufficiently treated with a CPAP device?

MR. ABRAMOWITZ: Objection, but you can answer.

A Daytime somnolence is the most -- you know, daytime sleepiness is the most common symptom.

Q They can become drowsy while driving?

A Yes.

Q It can affect their memory and concentration?

A Yes.

Q The records indicate that Dr. Gallagher referred Mr. Dukeshire for a sleep clinic evaluation on two occasions, I assume you're aware of that?

A Yes.

Q Is it your understanding that Mr. Dukeshire failed to keep those appointments?

A Yes.

Q Does the record indicate that Dr. Gallagher on a number of occasions spoke to Mr. Dukeshire about the importance of using his CPAP device?

A Yes.
Q Do you have an opinion in this case as to what likely would have happened had Mr. Dukeshire seen a sleep clinic physician as Dr. Gallagher had recommended?
MR. ABRAMOWITZ: Objection, but you can answer.
A Not going to comment outside my area of specialty.
Q Do you have an opinion as to whether an evaluation by a sleep medicine specialist would have led to a change in his narcotic dosage?
MR. ABRAMOWITZ: Objection, but you can answer.
A Hum? I don't know.
Q Possible?
A Possible.
Q Do you know what would be involved with a sleep clinic evaluation for somebody with obstructive sleep apnea?
A Yeah. Typically do an overnight polysomnogram and assess how many apneic episodes the patient is experiencing.
Q Regardless of the result, is the essential

treatment for this condition using the CPAP device?

A Well, there are -- I mean, first of all, there's a variety of masks that they can try. There are others. CPAP is one version of ventilation. There are a couple others that are sometimes better tolerated by patients, but positive airway pressure is the main modality, that is true.

Q It looks like Mr. Dukeshire was actually scheduled for a sleep study in March of 2017 and was a no show for that; you're aware of that?

A Yes.

Q If Mr. Dukeshire was able to regularly use his CPAP device, what impact would that have had on his overall health?

MR. ABRAMOWITZ: Objection, but you can answer.

A Typically leads to better quality sleep, overall improved sense of restfulness, which does tend to help improve mood and even pain.

Q Lessens the amount of pain one would have?

A It can, yeah.

Q We of course know that Mr. Dukeshire was

morbidly obese, correct?
A Yes.
Q Does the record indicate that Dr. Gallagher on multiple occasions talked to Mr. Dukeshire about the importance of losing weight?
A Yes.
Q To your knowledge, did Mr. Dukeshire follow up on any of these recommendations?
A Not to my knowledge.
Q Would a bariatric evaluation have been helpful to Mr. Dukeshire?
A Yes, probably.
Q Were you aware that he failed to appear for a bariatric evaluation that had been scheduled for him?
A Yes.
Q So based upon the records that you have seen and the deposition testimony that you have seen, would you agree that while he was under Dr. Gallagher's care, Mr. Dukeshire had a number of different stressors in his life?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes, I would agree.
Q What was your understanding as to what

different stressors were going on in Mr. Dukeshire's life while he was under Dr. Gallagher's care?

A I think he was experiencing a failing business and having financial stress due to that. He was also experiencing family stress, some of which was due to his irritable and labile mood, which was probably related to opiate addiction.

Q Any other stressors?

A I think there was some junior colleague at work who was problematic in some way, form, or another. I can't remember exactly what.

Q Mr. Dukeshire also had erectile dysfunction that Viagra was not helping?

A Hum?

Q Were you aware of that?

A I may have forgotten, but I did see erectile dysfunction as a diagnostic code in one of the visits.

Q That would be a stressor in his life?

MR. ABRAMOWITZ: Objection, but you can answer.

A Probably, sure.

Q I saw from the records that Dr. Gallagher

started Mr. Dukeshire on Zoloft for depression and anxiety in 2014, was that appropriate for him to do?

A Yes.

Q What is your understanding as to why Mr. Dukeshire was having issues with depression and anxiety?

MR. ABRAMOWITZ: Objection, but you can answer.

A Probably a multitude of factors, not limited to, but including, genetics, psychosocial stressors, and substance use.

Q When you say genetics, what are you referring to there?

A Genetic predisposition to have a mood disorder.

Q Is it your understanding that Dr. Gallagher had recommended to Mr. Dukeshire that he follow up with a psychiatrist?

A Yes.

Q Doesn't look like he actually followed up with a psychiatrist until just a couple weeks or so before he died, right?

MR. ABRAMOWITZ: Objection, but you can answer.

A That's correct.
Q It looks like the psychiatrist that he saw was a Dr. Travis, correct?
A Yes.
Q And based upon Dr. Travis' records, it looks like he was aware of the fact that Mr. Dukeshire was taking narcotics and was, in fact, on a benzodiazepine as well, correct?
A Yes.
Q It doesn't look like Dr. Travis recommended that he either stop the narcotics or wean off of them, correct?
MR. ABRAMOWITZ: Objection, but you can answer.
A That's correct.
Q It looks like from the records that Dr. Travis did, however, discuss the black box warning on the use of narcotics and benzodiazepines, correct?
A Correct.
Q What is your understanding as to the purpose behind that black box warning?
MR. ABRAMOWITZ: Objection, but you can answer.
A Data showing that co-occurring use or

concurrent use of benzodiazepines and opioids increases the risk of opioid overdose by double.

Q Is that because of the synergistic effect of using the two medicines at the same time?

A Yes.

Q According to the records it appears as though Mr. Dukeshire denied the use of illicit drugs, correct?

MR. ABRAMOWITZ: Objection, but you can answer.

A It does appear so, yes.

Q That would be an untruthful statement, correct?

A Well, we're lacking some key pieces of data to know whether he was using illicit drugs and when.

Q Well, you would agree that purchasing narcotics off the street, crushing them, and snorting them, that would constitute using illicit drugs, true?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes, that would constitute use of illicit drugs.

Q Did Mr. Dukeshire give an untruthful response when he was asked whether he was taking pain pills that were not prescribed for him?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes.

Q So if he had given a truthful answer to that question, do you believe that it would have had an impact upon Dr. Travis' treatment recommendations?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes.

Q In what way?

A It would have increased Dr. Travis' concern for substance use disorder.

Q And likely would have caused him to recommend referral to an addiction specialist?

MR. ABRAMOWITZ: Objection, but you can answer.

A Likely would have, yes.

Q Dr. Travis' diagnosis was major depressive disorder. First of all, do you have any reason to doubt that diagnosis?

MR. ABRAMOWITZ: Objection, but you

can answer.
A No.
Q Do you have an opinion as to the cause of that disorder?
MR. ABRAMOWITZ: Objection, but you can answer.
A Well, cause of major depressive disorder? Hum? So again, usually a genetic predisposition, and then psychodynamic factors going on in one's life; but I will say in the setting of an active substance use disorder, which he was potentially experiencing, likely experiencing, it's difficult to make a mood disorder diagnosis.
Q So I am not sure I follow you there. What are you trying to tell me?
A I guess my sense is if Dr. Travis had been addiction trained, I don't know that he was, I think he would have considered addiction a little more thoroughly on a differential diagnosis, would have probably also ordered a urine drug test himself; but he was concerned about mood disorder and I have already stated I don't have any reason to doubt that that was present.

Q But from what we can see from the records, Dr. Travis didn't raise substance use disorder as a potential diagnosis, correct?
A Correct.
Q It looks like he increased the patient's anti-depressants, the Lexapro, the Abilify; was that an acceptable thing to do?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes.
Q Did you see any indication that Dr. Travis said to Mr. Dukeshire stop taking the Valium?
A Gosh? I would have to review. I believe he warned him about the black box interaction, but I have to review for certainty; but I don't believe he said frankly stop taking it.
Q Was either Dr. Travis or the therapist, Mr. Seymour, who was seeing Mr. Dukeshire, aware of the fact that Dr. Gallagher had reduced Mr. Dukeshire's narcotic dosage at around that time?
MR. ABRAMOWITZ: Objection, but you can answer.
A I'm not sure.
Q If they were aware of that, would that have

raised any red flags on their part with respect to Mr. Dukeshire's potential need to see an addiction medicine specialist?

A Oh, I'm not sure.

Q You would agree that Dr, maybe I asked you this, but I apologize, Dr. Travis did not diagnose opioid use disorder, correct?

MR. ABRAMOWITZ: Objection, but you can answer.

A I did not see that in the consultation note.

Q Do you believe it was within the standard of care for Dr. Gallagher to be prescribing Valium?

A No.

Q Are you aware of any physician who said that narcotics and benzodiazepines should not be prescribed concurrently?

A Am I aware of any physician who said that?

Q Yeah.

A I'm aware of physicians who say that should be avoided whenever possible.

Q So you believe it was a breach of the standard of care for Dr. Gallagher to prescribe a benzodiazepine for Mr. Dukeshire?

A In this particular case, he was prescribing

opioids in an unmonitored way, he was not recognizing the signs and symptoms of opioid use disorder, so one should not be prescribing opioids in that situation, much less prescribing benzodiazepines and opioids. So it's sort of a cascade of things one should not be doing.

Q At what point do you believe the diagnosis of opioid use disorder should have been made according to the standard of care?

MR. ABRAMOWITZ: Objection, but you can answer.

A Once there was a clear pattern of loss of control of the use of the medication, which I would say was about a year into their treatment relationship.

Q And you believe at that point that's when there should have been a referral to an addiction medicine specialist?

A Correct.

Q To your knowledge, did you see anyone document Mr. Dukeshire suffering ill effects from the concurrent use of narcotics and benzodiazepines?

MR. ABRAMOWITZ: Objection, but you

can answer.
A Documenting ill effects? Well, there were documentation -- there is documentation of delirium and other effects that very likely could have been due to that combination. People weren't necessarily recognizing those as such, but they were documenting the presence of those symptoms.
Q Did any doctor document those symptoms as being potentially due to a combination of narcotics and benzos?
A Not that I saw.
Q I assume you saw testimony from family members about the family intervention that took place when the family expressed their concern to Mr. Dukeshire about his narcotic usage?
A Yes.
Q What is your understanding as to the outcome of that?
A I don't believe it was effective.
Q In what respect was it not effective?
A He didn't -- it didn't result in him seeking treatment.
Q Do you have an opinion as to why Mr. Dukeshire chose not to follow up on the family's desires

that he seek treatment?

MR. ABRAMOWITZ: Objection, but you can answer.

A He was likely in denial.

Q Denial that he had a problem?

A Yes.

Q What is your understanding of the overall success rate of methadone treatment?

MR. ABRAMOWITZ: Objection, but you can answer.

A Compared to no treatment, it reduces cravings and return to drug use in about 75 percent of individuals.

MR. ABRAMOWITZ: Marc, just one second. Somebody walking by that works here.

MR. GROEDEL: It is fuzzy, but it's okay.

Q What is your understanding then as to why there is a 25 percent rate where methadone treatment is not successful?

A Patients -- well, few treatments are perfect, and patients don't always respond; but compared to many other medical interventions, it's considered high rates of success.

Q What about Suboxone treatment, is the success

rate any different?
A It's about the same. Maybe a hair lower, but still in the, you know, highly effective zone.
Q So those patients that receive initial success from medication assisted treatment, is there a significant percentage of those patients that suffer relapses?
MR. ABRAMOWITZ: Objection, but you can answer.
A Significant? Sort of a tough word to try to define for you. Some do, yes.
Q I have seen literature which indicates that 40 to 60 percent of recovering addicts will suffer a relapse; does that sound accurate to you?
MR. ABRAMOWITZ: Objection, but you can answer.
A I would put it lower than that.
Q How much lower?
A More like 15 to 30.
Q Is the relapse rate higher for those patients who have used heroin in the past?
MR. ABRAMOWITZ: Objection, but you can answer.
A I don't know.

Q Is the success rate lower for those patients who have a history of cocaine and alcohol abuse?

MR. ABRAMOWITZ: Objection, but you can answer.

A I would say it is who had active, not necessarily history of.

Q Did you have an understanding that towards the last few months of Mr. Dukeshire's care, Dr. Gallagher was tapering Mr. Dukeshire's narcotic dosage downward?

A Yes, attempting to.

Q Well, he was prescribing a lower dose of narcotic for him during the last few months of his life, correct?

A Yes, although there were a couple instances, I believe, where that was the intention and that was what the prescription said, but then the patient would use it faster and was given a bridge prescription. So how much it was actually lowered is less than what was intended.

Q What is your understanding as to when a bridge prescription was given?

A I would have to look back at the exact date.

Q How many times was it done?
A Over the whole treatment course?
Q Let's just say over the period of time when the dosage was being tapered downward?
A In those last three months, I would say at least once, and I think possibly twice.
Q If Dr. Gallagher didn't refer Mr. Dukeshire to an addiction specialist in the Summer of 2017, would it have been appropriate for him to taper the narcotic dose, as he was doing?
MR. ABRAMOWITZ: Objection, but you can answer.
A The evidence based treatment for opiate addiction, and by that I mean what we know from the scientific literature works, is getting the patient on medication. The new term is medications for opioid use disorder, it is not tapering, so you know, just tapering is below the standard of care.
Q What else then was required?
A Getting an earnest actionable referral to an addiction treatment center that could provide medication for opioid use disorder. I should remind us, prescribing it himself, which primary care docs can do so with Suboxone.

Q Do you know whether or not Dr. Gallagher was capable of managing somebody either on Suboxone or methadone?
A Considering the fact that he wasn't capable of diagnosing opioid use disorder, I would say almost certainly not.
Q If a patient is going to receive methadone treatment to treat an opioid use disorder, does that treatment also involve therapy sessions?
A It does. Most opiate treatment programs require counseling, along with medication administration.
Q How often are those counseling sessions required?
A Varies from state to state, but usually in the order of once or twice per month.
Q In this case if Mr. Dukeshire was receiving methadone, are you able to state to within a reasonable degree of probability that he would have attended counseling sessions as required?
A I have no reason to believe that he would not have.
Q And you say that, even though you would agree that there were many aspects of

Mr. Dukeshire's care where he was non compliant as a patient, correct?
A That's correct.
Q In fact, he missed a number of appointments with Dr. Gallagher, correct?
MR. ABRAMOWITZ: Objection, but you can answer.
A He did.
Q Would you agree that he was also dismissed from the Coumadin clinic because he failed to show up for a number of scheduled appointments?
A He was.
Q In your review of the records, did you see that he missed numerous wound care clinic appointments as well, correct?
A That is correct.
Q And of course, we've already talked about how he failed to keep two appointments for sleep study evaluations, true?
A That's true.
Q It looks like from the records that he had an appointment for a colonoscopy and he failed to keep that appointment also, correct?
A That's correct.

Q Does the record indicate that he also missed a number of appointments with his cardiologist?
A It does show that, yes.
Q Does the record also tell us that on several occasions he refused to accept pain management referrals that had been offered to him?
MR. ABRAMOWITZ: Objection, but you can answer.
A I believe that is the case.
Q Wouldn't it be fair to state that even if he had seen a pain management specialist at any point in time, there's a very good possibility that this outcome would have been averted?
MR. ABRAMOWITZ: Objection, but you can answer.
A No. Pain specialists really have historically not engaged in diagnosing and management of addiction, so I would not think that this would have been averted had he been referred to -- or had he attended a pain management appointment.
Q But pain management specialists certainly can suspect when somebody is suffering from an opioid use disorder, correct?
A They can, yes.

Q I mean, you believe that this internist should have had that suspicion, right?
A I believe that the person prescribing the opioids has a duty to be ever watchful for this problem.
Q What was your understanding as to how Mr. Dukeshire received the narcotics, drugs, whatever you want to call them, that ended up leading to his death?
MR. ABRAMOWITZ: Objection, but you can answer.
A I am not sure.
Q Well, I assume you know that the drugs that he ingested just prior to his death were received from one of his friends or associates, a Mr. Jurovcik, you're aware of that, aren't you?
A I believe that's what his wife speculates in the -- in her testimony. Is that correct?
Q Well, she didn't speculate. She actually saw it happen; you're aware of that, aren't you?
MR. ABRAMOWITZ: Objection, but you can answer.
A I'm aware that she states she saw it happen, yes.

Q Assuming that the drugs that immediately led to Mr. Dukeshire's death were provided by Mr. Jurovcik, you would agree that his criminal conduct contributed to Mr. Dukeshire's death, true?

MR. ABRAMOWITZ: Objection, but you can answer.

A His criminal conduct contributed to? Yes, it did contribute.

Q Do you believe that Mrs. Dukeshire should have told Dr. Gallagher about the fact that her husband was purchasing narcotics on an illicit basis over the last two years of his life?

MR. ABRAMOWITZ: Objection, but you can answer.

A Well, I believe it was reasonable for her to express concern, which she did.

Q But she never told Dr. Gallagher that her husband was buying narcotics off the street, crushing them, and snorting them, correct?

MR. ABRAMOWITZ: Objection, but you can answer.

A I am not sure what she did or did not tell him, but what I saw was that she says I came to him, I called him, I said I am worried

about him being addicted to these medications and I'm worried what is going to happen to him; which I am not -- I guess it sounds like mention of the word heroin would have really sealed it off, but it sounds like she did exactly what she was supposed to do, or what I would have advised her to do, which is express concern.

Q Well, if she knew that her husband was buying drugs on the street, crushing them, and snorting them, that's specific information she should have given Dr. Gallagher, true?

MR. ABRAMOWITZ: Objection, but you can answer.

A I'm not -- yeah, I'm not going to put that on her. That would have --

Q That would have helped, right?

A I am not going to comment on that. What I will again comment on is any number of urine drug screens would have shown that in black and white and it wouldn't have mattered what she was reporting or not reporting. So I am not going to put that on her.

Q Well, you can't say that a urine drug screen would have shown anything other than the

narcotics he was receiving, can you?

MR. ABRAMOWITZ: Objection, but you can answer.

A If you are asserting that you are certain that he was snorting heroin, it would have shown up in a urine drug screen.

Q I am not saying he was snorting heroin. I'm saying he was crushing up his ox -- his narcotic and snorting that.

A Only his?

Q What do you mean only his?

A The ones prescribed to him?

Q No. And medications that he was getting off the street.

A But only oxycodone?

Q Right.

MR. ABRAMOWITZ: Objection, but you can answer.

Q If that's the case, a urine drug screen isn't going to tell us anything other than that a narcotic that's being prescribed for him is in his system, true?

A I don't believe that if he was snorting opioids, it was only ever oxycodone.

Q What's the basis for that testimony?

A My belief.
Q Well, what do you mean your belief? I don't follow that.
A Well, there is a wide array of opioids available on the street, and if he was, as you say, using illicit opioids from the streets, it seems highly unlikely that it would always only be oxycodone.
Q But as you sit here today, you see no testimony from anybody which indicated that Mr. Dukeshire was snorting heroin, correct?
MR. ABRAMOWITZ: Objection, but you can answer.
A Correct.
Q You mentioned at the beginning of your deposition that in February of 2016 there was an episode of what you considered drug toxicity that could have been secondary to a narcotic overdose; do you recall that?
A Yes.
Q And the records from that February 2016 admission, you have seen those records, correct?
A Yes.
Q Did any of the physicians who were involved in

Mr. Dukeshire's care during that hospital admission diagnose an overdose?

MR. ABRAMOWITZ: Objection, but you can answer.

A They did not.

Q And they were aware of the fact that he was on narcotics, correct?

A They were.

Q And I think the diagnosis from the physicians during that admission was that he had suffered a conversion reaction secondary to anxiety and depression, correct?

A Correct.

Q Are you critical of the physicians who were involved in that aspect of his care?

MR. ABRAMOWITZ: Objection, but you can answer.

A I'm critical of them leaving off the possibility that this was a -- the possibility that this could have been a drug toxicity reaction.

Q They did tell him that he should follow up with a psychiatrist, though, correct?

A I believe so, yes.

Q And he didn't do that, correct?

A Correct.
Q And I think you also made reference to an emergency room visit in August of 2017 as a potential episode of narcotic overdose; would you agree that no one during that ER visit found any evidence of an addiction issue, correct?
A That's correct.
Q Would you agree that at various points in time during Mr. Dukeshire's care with Dr. Gallagher, he was admitted to hospitals and placed on some pretty high doses of narcotics during those admissions, correct?
A Yes.
Q For instance, I saw from the record in December of 2014 when he was treated at the Cleveland Clinic for back issues, he was on a narcotic dose that was the equivalent of 225 mme, you saw that, correct?
A Yes.
Q That was appropriate?
A It's difficult to say without direct knowledge of other factors going on in the care at that time.
Q But as you sit here today, you are not

prepared to say that the doctors taking care of those issues at that point in time breached the standard of care, are you?

MR. ABRAMOWITZ: Objection, but you can answer.

A I'm not saying that.

Q And the records show that in December of 2015 when Mr. Dukeshire was at Saint Luke's Hospital for his knee abscess, he was on 220 mme, was that within the standard of care?

MR. ABRAMOWITZ: Objection, but you can answer.

A Nothing during the hospitalization that I saw suggested below the standard of care.

Q In January of 2017 he was at Freemont Hospital again for his right knee issues and he was on 200 mme of narcotics, that was within the standard of care?

MR. ABRAMOWITZ: Objection, but you can answer.

A I am not willing to suggest it was below.

Q Then in May of 2017 he was at the Toledo Hospital for his buttocks ulcer and he was on a dose of 220 mme for narcotics, that wasn't below the standard of care, was it?

MR. ABRAMOWITZ: Objection, but you can answer.

A I saw nothing to suggest it was below the standard of care.

Q Then in June of 2017 he was back at Freemont Hospital for right knee and buttocks issues, and it looks like he was actually on 500 mme for a period of time, are you critical of that usage?

MR. ABRAMOWITZ: Objection, but you can answer.

A When we start to talk about, you know, three, four times what his outpatient dose was, it does start to call into question what's the explanation for the need for that high of a dose.

Q So that's a little high?

A That's a little high.

Q And then it looks like in July of 2017 he was at the Bethesda Care Center for his buttocks and right knee issues and they had him on 300 mme, was that within the accepted standard of care?

MR. ABRAMOWITZ: Objection, but you can answer.

A Nothing to state that it was below the standard of care, but I will note in all these instances you're talking about a controlled setting, where monitoring can easily take place. In an outpatient setting where the prescriber really needs to be relying on, and I'll say it again, not to be a broken record, but urine drug screens to know exactly what the patient is taking.

Q What's your understanding as to what Mr. Dukeshire was doing from a working standpoint during the years 2014 through 2017?

MR. ABRAMOWITZ: Objection, but you can answer.

A I don't have a precise timeline. I believe some period of that time he was repossessing cars.

Q So it appears as though he was able to do some sort of physical activity?

A Yes.

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes.

MR. ABRAMOWITZ: Marc, are you done or should we take a break now?

MR. GROEDEL: I would say I got another maybe 15, 20 minutes, or so. You can take a break. If you would like to take a break, I'm perfectly fine; or we can continue to just plow ahead. Either way.

MR. ABRAMOWITZ: Let's take a break then.

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(Recess taken)

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MR. GROEDEL: Doctor, we're back on the record.

Q Is it your understanding that the narcotics that or the drugs that Mr. Dukeshire received on the day he died, that he also received narcotics from that person previously?

MR. ABRAMOWITZ: Objection, but you can answer.

A I don't know.

Q You don't recall seeing that in Mrs. Dukeshire's deposition?

MR. ABRAMOWITZ: Objection, but you can answer.

A Correct, I don't recall.

Q If the family knew that Mr. Dukeshire was

using heroin, is that something they should have brought to Dr. Gallagher's attention?

MR. ABRAMOWITZ: Objection, but you can answer.

A Not necessarily.

Q Would you agree that the carfentanil that was found on toxicology was of a sufficient dose in and of itself to cause Mr. Dukeshire's death by respiratory depression?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes.

Q Would you agree that the oxycodone that they found in his system, while it was above the therapeutic level, was not at a toxic level?

MR. ABRAMOWITZ: Objection.

A There is a very weak correlation between serum and other fluid levels postmortem, and what one would call quote/unquote toxic levels. It's something some pathologists like to opine on, but there is really no data to support this. What we can say for sure is that the combination of benzodiazepine, oxycodone, and carfentanil was enough to kill him, because that's what killed him.

Q But you would agree, though, that the level of oxycodone in his system, particularly for somebody who was tolerant like Mr. Dukeshire was, wasn't at a toxic level?

MR. ABRAMOWITZ: Objection, asked and answered, but you can answer.

A We don't know the level that he -- that is in his system when he dies, could have been at any stage of metabolism. We don't know what it was at its peak. We just know what it was when the blood is drawn, so it's sort of a meaningless bit of data.

Q So based upon that answer, you really can't say whether or not the oxycodone was a significant contributing factor to his death, correct?

MR. ABRAMOWITZ: Objection, but you can answer.

MR. MCMANUS: I'm sorry. I didn't hear that question.

Q You would agree that based upon what you just told me, that you really can't say that the oxycodone was a significant contributing factor to the patient's death, can you?

MR. MCMANUS: Thank you.

MR. ABRAMOWITZ: Objection.
A I can't. I can say that it was likely a significant contributor to his death.
Q Would you agree that he would have died if he had just received the carfentanil?
MR. ABRAMOWITZ: Objection, but you can answer.
A It is possible that just receiving the carfentanil could have been fatal.
Q Do you know what carfentanil looks like?
A Yes.
Q What's it looked like?
MR. ABRAMOWITZ: Objection, but you can answer.
A I can -- I don't care to answer.
Q Why not?
A Is it relevant?
Q Well, here's the point I'm trying to figure out: Does crushed carfentanil look different than crushed oxycodone?
MR. ABRAMOWITZ: Objection, but you can answer.
A Does it look different? Yes.
Q In what way?
MR. ABRAMOWITZ: Objection, but you

can answer.
A Well, I guess depending on the degree of crushing that goes on, it may look -- it may not look different. I'm going to revise my statement that it looks different.
Q Is the color different?
MR. ABRAMOWITZ: Objection, but you can answer.
A Not necessarily.
Q Have you seen carfentanil?
MR. ABRAMOWITZ: Objection, but you can answer.
A I have seen a picture.
Q What color was it in the picture?
MR. ABRAMOWITZ: Objection, but you can answer.
A It was white.
Q This was a narcotic overdose death, is that your opinion?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes.
Q How does a narcotic overdose death manifest itself from a clinical standpoint, what do we see?

MR. ABRAMOWITZ: Objection, but you can answer.

A The respiratory depression and depression of consciousness. In the fatal version we see complete cessation of respiration and then cardiopulmonary collapse.

Q Is it a gradual process?

A No.

Q How long does it usually take?

MR. ABRAMOWITZ: Objection, but you can answer.

A A matter of seconds to minutes.

Q So with a narcotic overdose death, is there usually a period of an increasing sedation?

MR. ABRAMOWITZ: Objection, but you can answer.

A I mean, there could be, yes.

Q Then there is a slowing of respiration?

A Yes.

Q Followed by a cessation of respiration?

A Correct.

Q To your knowledge, did Mr. Dukeshire's final moments, according to Mrs. Dukeshire, follow that course?

MR. ABRAMOWITZ: Objection, but you

can answer.
A I'm not sure.
Q Why aren't you sure?
A I don't recall how she described the event.
Q Did Mr. Dukeshire's cardiac condition place him at high risk for a sudden cardiac death?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes.
Q What cardiac conditions did he have that would have placed him at a higher risk for a sudden cardiac death?
A I want to be clear that I am convinced that he died of opioid overdose, but in terms of his risk for sudden cardiac death, which I don't believe is at play here, he had a history of atrial fibrillation.
Q In your opinion did Mr. Dukeshire have any chronic conditions that would have had an adverse impact upon his life expectancy, assuming he didn't die on the day that he did?
MR. ABRAMOWITZ: Objection, but you can answer.
A Yes, he did.
Q So what conditions did he have that would have

had an adverse impact upon his life expectancy?

MR. ABRAMOWITZ: Objection, but you can answer.

A Morbid obesity and sleep apnea.

Q According to the autopsy he also had severe cardiomegaly, true?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yes, that's true.

Q What was the cause of that severe cardiomegaly?

MR. ABRAMOWITZ: Objection, but you can answer.

A So he had an echocardiogram in I believe 2016 that shows pretty well preserved ejection fraction. So the cardiomegaly was likely due to enlarged right-sided heart from obstructive sleep apnea.

Q How would you characterize the degree of cardiomegaly?

MR. ABRAMOWITZ: Objection, but you can answer, if you can answer.

A I would need to look at the pathology report again.

Q So his heart, according to the pathology report, weighed 680 grams. It's my understanding that an adult normal heart weighs anywhere from 280 to 312 grams.

So assuming my figures aren't that far off, his heart was about double the size of a normal human heart, correct, for an adult?

MR. ABRAMOWITZ: Objection, but you can answer.

A I am not aware of any of those measurements, but your math is correct.

Q Would the presence of that degree of cardiomegaly also have had an adverse impact upon Mr. Dukeshire's life expectancy had he not died on the die he did?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A As a physician who deals with living people, we think about symptoms and disease states that are manifest by symptoms, and when I hear cardiomegaly, I hear congestive heart failure, which based on his relatively preserved ejection fraction of 55 to 60 percent, didn't appear that he had.

Q So you don't believe he ever had evidence of

congestive heart failure during the course of time he was treated by Dr. Gallagher?

MR. ABRAMOWITZ: Objection, but you can answer.

A I can only tell you that the echocardiogram report showing a relatively preserved ejection fraction of 55 to 60 percent.

Q Well, that was more than a year before he died, right?

A Yeah. It's a chronic condition, can worsen gradually over time, true.

Q Would you agree that his autopsy showed evidence of significant cardiomyopathy?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A Yeah, I would need to go back and look. You were talking about according to the weight of the heart, which isn't really -- I'm not familiar with.

Q Here, I'll tell you. The right ventricle thickness was measured at 1 centimeter, and according to what I have seen, the normal thickness of a right ventricle is 3 to 5 millimeters. So Mr. Dukeshire's right ventricle thickness was almost three times

normal. If my numbers are correct, would you agree with that?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A Yes, I agree with that, and that right-sided hypertrophy is consistent with his history of obstructive sleep apnea.

Q Is it also consistent with hypertensive heart disease?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A As we typically see in hypertensive heart disease, it presents on the left side of the heart, left ventricular contractility, that's where we see the reduced ejection fraction; and as I mentioned, last known EF was close to normal.

Q So if his left ventricle was thicker than normal, would that be consistent with hypertensive heart disease?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A It would be, but the thicker than normal is actually just the first stage. Then over time, decades, the heart starts to thin out

and become floppy, and that's when your ejection fraction starts to come down. So I'm actually impressed by the fact that there was no evidence of that.

Q No evidence of what?

A Thinning of the left ventricle.

Q His lung was noted to weigh 760 grams, his right lung. His left lung was noted to weigh 640 grams. Would you consider those weights to be abnormal?

MR. ABRAMOWITZ: Objection, but you can answer.

A Yeah, as a non pathologist, I don't know.

Q He also had an enlarged liver. It looks like his liver weighed about twice the normal weight of a liver, do you have an opinion as to the cause of that?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A Very well could be fatty liver, which wouldn't surprise me in a man of his weight.

Q Would you agree that based upon what we know about Mr. Dukeshire's medical history and what was found on the autopsy, he had a reduced life expectancy had he not died on the day

that he did?

MR. ABRAMOWITZ: Objection, but you can answer, if you can.

A Reduced? I would say yeah, you know, by a matter of a couple of years.

Q So it's your testimony that Mr. Dukeshire's life expectancy, had he not died when he did, would only be a couple years less than what the normal life expectancy would be for a 55 year old gentleman?

MR. ABRAMOWITZ: Objection. Calls for speculation.

A His life was cut short by well more than a decade, in my view.

Q As a result of his pre-existing conditions?

A No. As a result of overdose death, as a result of unmonitored, untreated opioid addiction.

Q So is it your belief then that his life expectancy would have been an additional ten years had he not died from opioid use disorder?

MR. ABRAMOWITZ: Objection. That's not what he said.

MR. GROEDEL: That's what I thought

he said.

MR. ABRAMOWITZ: Over ten years. You limited his testimony, limited it and changed the way he referenced it.

Q What is your testimony then as to what Mr. Dukeshire's probable life expectancy would have been had he not died from opioid overdose?

A I would say he had at least ten more years to live.

Q Just one quick question about the research that you told us about oh, a long time ago, it seems.

The research that you are doing, can you just explain for me a little bit about what's involved with that research?

A Yeah. I'm glad I'm having a chance to clarify this. So the research is very much what we call patient oriented research. We are enrolling patients into clinical studies where we deliver actual clinical care. So even though it's done under research protocols, we are treating patients, I am treating patients with usual clinical intervention. It's very much hands-on patient care, it's just done

under the scope of a research protocol.
Q So the patients that are involved in these research protocols, are the patients that you see on Tuesday?
A No. By and large they are other patients from around the -- from the VA population.
Q So they are not your patients then, are they?
A Well, they're patients who have enrolled in our studies, so I -- when you say they are not my patients, you mean am I their primary care doctor or?
Q Right. Are you the doctor of any of the patients that are enrolled in these research projects?
MR. ABRAMOWITZ: Objection, that's asked and answered. He said he was. But you can answer again.
A I'm treating them under a study protocol, so that would be they are my patients.
Q So are these the patients then that you see on Tuesday?
A Those patients are typically not enrolled in a study protocol, so they are typically a different set of patients.
Q I got the impression from your earlier

testimony that the only day you actually see patients is on Tuesday. So when is it that you see these other patients that you say are yours that are enrolled in these research projects?

A Right. Any of the other days of the week, Monday, Wednesday, Thursday, Friday.

Q Where do you see them?

A In the outpatient setting. We have separate facilities for people involved in clinical trials.

Q So these patients then that are involved in these research projects, are you actually, are you yourself the physician actually providing hands-on care, or do you supervise the care that's provided by others?

A A mixture of both. I do some hands-on and some supervision.

Q And to what extent do you provide hands-on care to these patients?

A A good two-thirds of that time.

Q Doctor, have we covered all of the standard of care criticisms that you plan on offering at trial?

A Yes.

MR. GROEDEL: Doctor, I don't have any further questions for you. Thank you for your time.

MR. MCMANUS: Doctor, my name's John McManus. I represent Rite Aid in this case.

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CROSS-EXAMINATION

BY MR. MCMANUS:

Q Fair to say that you are not a pharmacist, correct.

A That's correct.

Q Reviewing your November 2020 report it is clear that there aren't any criticisms or standard of care opinions advanced against Rite Aid, correct?

A That's correct.

Q Is it your expectation to rely upon any literature or articles that address in any measure the standard of care of a pharmacy in the State of Ohio?

MR. ABRAMOWITZ: Objection, but you can answer.

A It's not my at this time as I speak to you now, a plan to do that.

Q As we have requested previously with regard to your opinions as to the standard of care of a primary care physician, specifically those set forth against Dr. Gallagher in this case, if you are going to be presenting any of the evidence that you just discussed, articles, or any other item critical of a pharmacy, we would reserve our right to object to that and/or to examine you at a later date; do you understand that?

A Correct.

MR. ABRAMOWITZ: Yes.

MR. MCMANUS: Subject to that, I have nothing further. Thank you.

MR. ABRAMOWITZ: Frank, we'll read, please.

MR. GROEDEL: Hey, Frank, you can go ahead and type that up.

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(Deposition concluded 5:52 p.m.;
signature not waived.)

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ERRATA PAGE

PAGE/LINE NOTATION

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WILLIAM C. BECKER, M.D.

Subscribed and sworn to before me this _____ day of _____, 2021.

_____

Notary Public

Commission expiration: _____.

State of Ohio,)
) SS: CERTIFICATE
County of Cuyahoga,)

I, Frank P. Versagi, RPR, Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness **WILLIAM C. BECKER, M.D.** by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy/computer realtime in the Zoom presence of said witness, afterward transcribed, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify I have no contractual obligations to any counsel or their client, that I am not a relative, counsel, or attorney of either party, or otherwise interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, November 4, 2021.

frank p. versagi
_____
Frank P. Versagi, RPR
Notary Public in and for the State of Ohio.
Commission expiration: 8-2-23.

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