

1 STATE of OHIO,  
2 COUNTY of CUYAHOGA.

SS:

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4 IN THE COURT OF COMMON PLEAS  
5 - - - - -

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

7 Plaintiffs,

8 vs.

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

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

10 Defendants.  
11 - - - - -

12 Zoom deposition of **WILLIAM C. BECKER, M.D.**,  
13 a witness herein, called by the Defendants James  
14 Gallagher, M.D. and Gallagher & Gallagher, M.D.S.,  
15 LLC, for the purpose of cross-examination, pursuant  
16 to the Ohio Rules of Civil Procedure, taken before  
17 Frank P. Versagi, RPR, Notary Public in and for the  
18 State of Ohio, taken at Versagi Court Reporters,  
19 Brendan Place, North Olmsted, OHIO, on **MONDAY,**  
20 **NOVEMBER 1, 2021**, commencing at 2:31 p.m., pursuant  
21 to Notice of Deposition.  
22 - - - - -

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25 *frank@versagicourtreporters.com*

1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 (via Zoom)

4 Mark M. Abramowitz, Esq.  
5 DiCello Levitt Gutzler  
6 7556 Mentor Avenue  
7 Mentor, Ohio 44060  
8 440-953-8888  
9 Mabramowitz@dicellolevitt.com

10 On behalf of the Defendants James Gallagher, M.D.,  
11 and Gallagher & Gallagher, M.D.S., LLC:

12 (via Zoom)

13 Marc W. Groedel, Esq.  
14 Reminger Co., L.P.A.  
15 1400 Midland Building  
16 Cleveland, Ohio 44115  
17 216-687-1311  
18 Mgroedel@reminger.com

19 On behalf of the Defendants Rite Aid of Ohio, Inc.,  
20 and Rite Aid Headquarters Corporation:

21 (via Zoom)

22 John M. McManus, Esq.  
23 The McManus Firm  
24 117 West Fourth Street  
25 Suite 201  
Royal Oak, Michigan 48067  
248-268-8989  
John@TheMcManuslawfirm.com

On behalf of Drs. Gallagher and Gallagher:

(via Zoom)

Stephen P. Griffin, Esq.  
Griffin Law, LLC  
4051 Whipple Avenue NW, Suite 201  
Canton, Ohio 44718  
234-360-8090  
Sgriffin@griff-law.com

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(NO DEPOSITION EXHIBITS MARKED)

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(for objection and word index, see appendix)

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1                    WILLIAM C. BECKER, M.D.  
2    of lawful age, being first duly sworn, as  
3    hereinafter certified, was examined and testified as  
4    follows:

5                    - - - - -

6                    CROSS-EXAMINATION

7    BY MR. GROEDEL:

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

10   A        William C. Becker.

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

15                    I assume you have been deposed before?

16   A        Yes.

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

1 A Okay.

2 Q You understand that my purpose here today is  
3 to explore and have you identify all of the  
4 standard of care criticisms you have of  
5 Dr. Gallagher; you understand that?

6 A Yes.

7 Q I assume you understand that you're under oath  
8 and you understand the implications of that  
9 oath, correct?

10 A Correct.

11 Q Where are you now?

12 A I am in New Haven, Connecticut.

13 Q Is anybody with you in the room?

14 MR. ABRAMOWITZ: I am.

15 Q Who is with you?

16 A Mark Abramowitz.

17 Q Is anybody else with you in the room?

18 A No.

19 Q If I ask a question that you don't understand,  
20 will you let me know?

21 A Yes.

22 Q If you answer a question, I'm going to assume  
23 you understood it and answered it truthfully;  
24 fair enough?

25 A Fair.

1 Q If you need to take a break for any reason,  
2 let me know, I'm sure we'll be able to  
3 accommodate you. The only thing that I would  
4 ask is if there is a question pending, you  
5 answer the question and you can then go ahead  
6 and take the break. You can take a break for  
7 any reason; understood?

8 A Understood.

9 Q All right. Very good. Doctor, I have a copy  
10 of the report that you wrote in this case  
11 that's dated November 27, 2020; is that the  
12 only report that you have written in this  
13 case?

14 A That's the final report.

15 Q Are there any other reports that you have  
16 written?

17 MR. ABRAMOWITZ: Objection.

18 Q You can answer.

19 A No.

20 MR. GROEDEL: Mark, are you the  
21 screen?

22 MR. ABRAMOWITZ: I'm on this screen  
23 here. Can you see me, as well?

24 MR. GROEDEL: I just wasn't sure if  
25 you were hooked in as well.

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

3 MR. GROEDEL: Very good.

4 BY MR. GROEDEL:

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

9 A No.

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

13 A No.

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

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

20 A Yes.

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

23 A No.

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

1 kind?

2 A No.

3 Q Doctor, your business address is what?

4 A It is there on the top of my report. It

5 should be 950 Campbell Avenue, West Haven,

6 Connecticut.

7 Q What sort of building, is that a hospital, is

8 that a free-standing office building, what is

9 that?

10 A That's a hospital.

11 Q Is that where your main office is located?

12 A Yes, that's correct.

13 Q Who is your employer?

14 A I have two employers. VA Connecticut Health

15 System and Yale School of Medicine.

16 Q So what are your responsibilities as an

17 employee of the VA Connecticut Health Care

18 System?

19 A I am the Medical Director of a clinic and I

20 run a number of research studies.

21 Q What are your responsibilities as an employee

22 of Yale?

23 A To run other research studies.

24 Q What you just told me, does that encompass all

25 of the professional work that you do?



1 A I do additionally teach medical students and  
2 residents as part of both of those roles.

3 Q Both as an employee of VA Connecticut Health  
4 and the Yale School?

5 A Correct.

6 Q We have been provided with a copy of your CV.  
7 Did you bring a copy of that with you?

8 A Yes.

9 Q The CV that I have is 24 pages and the last  
10 article or reference is number 126; is that an  
11 up-to-date CV?

12 A Yes.

13 Q Are there any changes, additions, corrections  
14 that you believe you need to make?

15 A I don't believe so.

16 Q So what I would like to do now is talk to you  
17 a little bit or have you tell me a little bit  
18 about your current practice, what it entails  
19 professionally.

20 A My clinical practice is running a multi-  
21 disciplinary pain clinic at the VA Hospital,  
22 where we help individuals, we treat  
23 individuals with chronic pain, which sometimes  
24 also have opiate addiction.

25 Q Well, is that the extent of your clinical

1 practice?

2 A I also serve as a teaching attending physician  
3 on the inpatient hospital wards for four weeks  
4 a year.

5 Q Where is that at?

6 A At West Haven VA.

7 Q So your clinical practice entails running the  
8 pain clinic, and then serving as an attending  
9 on the inpatient service several weeks out of  
10 the year?

11 A Yes.

12 Q So do you see patients in an outpatient basis,  
13 in an office basis?

14 A Yes.

15 Q Describe for me when you see patients on an  
16 outpatient basis.

17 A That's the multi-disciplinary pain clinic runs  
18 in an outpatient setting.

19 Q How many days a week do you work at that  
20 outpatient clinic?

21 A One.

22 Q What day of the week is that?

23 A Tuesday.

24 Q So on Tuesday what are you doing during that  
25 day?

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

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

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

8   A       Correct.

9   Q       So what do you do on Wednesday?

10  A       Research projects.

11  Q       Same thing that you were doing on Monday?

12  A       Correct.

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

15  A       Correct.

16  Q       What do you do on Thursday?

17  A       Research projects.

18  Q       Same thing as Wednesday?

19  A       Yes.

20  Q       What about Friday?

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

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

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

7 A Yes.

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

10 A Yes.

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

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

16 Q And the same would be true on Sunday?

17 A Correct.

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

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

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

1 A I'm not sure if you're trying to separate out  
2 the administrative responsibilities of those  
3 projects, or that was just meant to mean  
4 research in general; but my professional  
5 effort is split 20 percent clinical, 80  
6 percent research.

7 Q The 20 percent clinical, that would involve  
8 the Tuesday that you're seeing patients?

9 A Yes.

10 Q The 80 percent research is what you already  
11 told us about?

12 A Yes.

13 Q Are you saying then that you have some  
14 administrative responsibilities within that 80  
15 percent research?

16 A Yeah. I mean, I'm responsible for making sure  
17 that the reports get back to the NIH and  
18 things are being accounted for in the way they  
19 need to, to show productivity, so yes.

20 Q So limiting your answer to your research  
21 responsibilities, what percentage of your time  
22 would you say is devoted to administrative  
23 functions?

24 A 20 percent of the research effort.

25 Q I assume you know what Dr. Gallagher does for

1 a living?

2 A Yes.

3 Q Have you ever worked as a primary care

4 physician like Dr. Gallagher?

5 A Not in a community setting, no.

6 Q Well, have you ever worked as a primary care

7 physician at all?

8 A Yes.

9 Q In what respect?

10 A I was a primary care physician at the

11 Philadelphia VA from 2007 to 2009.

12 Q Would that have been the extent of your

13 experience as a primary care physician?

14 A No. I was also a primary care physician when

15 I returned to Yale from 2007 to 2012.

16 Q Anything else?

17 A No, that's all.

18 Q So tell me what sort of work you did and where

19 you did it as a primary care physician when

20 you were in Philadelphia?

21 A I was managing a panel of approximately 800

22 patients with their adult medical problems

23 full time at the Philadelphia VA.

24 Q You were employed by the VA at that time?

25 A Correct.

1 Q So were you working like in a big office or  
2 out of a VA Medical Center? Explain that to  
3 me.

4 A Yeah. Multi physician practice, 15 to 20  
5 full-time internists out of the VA.

6 Q What about your work at Yale from 2009 to  
7 2012, explain that for me.

8 A There I was teaching faculty, so I had my own  
9 panel of patients; but I was also supervising  
10 residents with their panel of patients.

11 Q Did you actually provide hands-on care to  
12 patients while you were at Yale?

13 A Yes.

14 Q During that period of time?

15 A Yes.

16 Q How often were you doing that, roughly?

17 A Two and a half days a week.

18 Q About how often were you providing direct  
19 hands-on care to patients when you were  
20 working as a primary care physician in  
21 Philadelphia?

22 A Seven half days a week.

23 Q I'm sorry?

24 A Seven half days a week.

25 Q So just tell us a little bit about the pain



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

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

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

13 A Yes.

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

16 A We have a psychiatrist who works with me.

17 Q Anybody else?

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

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

1 clinic?

2 A Yes.

3 Q What's the role of the psychiatrist?

4 A Well, many of the patients we see have  
5 co-occurring psychiatric disorders that's  
6 complicating their chronic pain, and she helps  
7 weigh in on optimizing their care plans.

8 Q If you have a patient at your clinic that you  
9 think would benefit from medication assisted  
10 therapy, such as methadone or Suboxone, do you  
11 provide that sort of treatment at your clinic?

12 A We provide Suboxone. We can't -- well, we are  
13 not allowed to prescribe methadone for opiate  
14 use disorder, but we do refer patients to the  
15 opioid treatment program to do so, but we do  
16 provide Suboxone.

17 Q I assume you don't provide methadone because  
18 you got to have special license from the  
19 government to utilize that medicine?

20 A Correct.

21 Q The psychiatrist that works with you, is that  
22 psychiatrist capable of recognizing when a  
23 patient has an addiction disorder?

24 A Yes.

25 Q An opioid use disorder?

1 A Yes.

2 Q Is that a skill that most or if not all  
3 psychiatrists have or should have?

4 A So I heard two different questions. That they  
5 have or that they should have. I would say  
6 not all of them -- most don't have it, but  
7 most should have it.

8 Q Why do you say that?

9 A Well, the data shows that a majority of  
10 psychiatrists don't feel comfortable  
11 diagnosing addiction, but if they're taking  
12 care of patients who have mental health  
13 issues, addiction is very commonly  
14 co-occurring, so they probably should gain  
15 comfort with that.

16 Q Would you agree that most psychiatrists are  
17 sufficiently skilled to recognize when a  
18 patient might have an opioid use disorder or  
19 an addiction disorder?

20 MR. ABRAMOWITZ: Objection, but can  
21 answer.

22 A Most physicians skilled? Yes.

23 Q I know you have written a number of articles  
24 and have spoken on opioid use disorder. I'm  
25 just wondering whether there are any

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

4 MR. ABRAMOWITZ: Objection, but you  
5 can answer.

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

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

13 MR. ABRAMOWITZ: Objection, but you  
14 may answer.

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

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

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

5    A       Okay.

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

10   A       Approximately 12 to 15 hours.

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

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

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

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

20                   MR. GROEDEL:        Thank you.

21                   MR. ABRAMOWITZ:    No problem.

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

25                   Can you tell me approximately how many

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

3    A       Three prior times, so this is my fourth.

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

8    A       Twice with the plaintiff, once with the  
9           defendant.

10   Q       Were all three of these cases involving  
11           narcotic usage?

12   A       Yes.

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

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

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

19   A       Yes.

20   Q       How many times?

21   A       This will be my third time.

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

24   A       One plaintiff, one defendant.

25   Q       Have you testified in trial before?

1 A No.

2 Q What do you charge for trial testimony?

3 A Looking up my fee schedule here. \$5,000 per  
4 day, plus travel expenses.

5 Q You say you got a formal fee schedule?

6 A Yes.

7 Q Would you send a copy of that to  
8 Mr. Abramowitz so that he can send that along  
9 to us; do you have any problem with that?

10 MR. ABRAMOWITZ: We have no problem  
11 with that. We'll get that to you, Marc.

12 MR. GROEDEL: Thank you.

13 Q Are you scheduled to testify at the trial of  
14 this matter?

15 MR. ABRAMOWITZ: Objection, but you  
16 can answer.

17 A I have not been scheduled, but I'm willing to  
18 do so.

19 Q Besides this case, are there any other cases  
20 that you have reviewed either for the DiCello  
21 firm or for Mr. Stombaugh?

22 A No.

23 Q To your knowledge, are you on the roster of  
24 any company that advertises its ability to  
25 find expert witnesses?

1 A No.

2 Q I assume you don't advertise your services as  
3 an expert witness?

4 A Correct.

5 Q How did the DiCello firm find you to review  
6 this case?

7 MR. ABRAMOWITZ: Objection, but you  
8 can answer.

9 A I actually don't know. I don't know.

10 Q Do you recall how you were contacted, was it  
11 by telephone, email, letter, in person?

12 MR. ABRAMOWITZ: Objection, but you  
13 can answer.

14 A I don't recall.

15 Q When you were reviewing the records in this  
16 case, would I be correct in assuming that you  
17 were aware that Mr. Dukeshire had died?

18 A You would be correct.

19 Q Would I be correct in assuming that when you  
20 were reviewing these records, you knew that he  
21 had died from narcotics?

22 A Yes.

23 Q Or illicit drugs?

24 A Yes.

25 Q We know from the records we received in



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

5    A       Yes.

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

9    A       The names of those physicians you are asking?

10   Q       Yes.

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

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

17   A       Yes.

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

22                   MR. ABRAMOWITZ: Objection, but you  
23           can answer.

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

1 or not meeting the standard of care.

2 Q Well, assuming that you have received all of  
3 the records from Family Health Services of  
4 Erie County that exist, do you have an opinion  
5 as to whether or not those physicians provided  
6 care that met the standard of care when they  
7 prescribed narcotics for Mr. Dukeshire?

8 MR. ABRAMOWITZ: Objection. I'm not  
9 sure that's a fair assumption here. We just  
10 don't know that at this time, if we have all  
11 the records or not.

12 Q Do you have an opinion?

13 A No.

14 Q Is there anything that you saw in the Family  
15 Health Services record that caused you to  
16 think gee, I don't have all of the records  
17 from this office?

18 MR. ABRAMOWITZ: Objection.

19 A I'm sorry. Was there anything in those  
20 records that made we wonder whether I might  
21 not have all the records?

22 Q Correct.

23 A I can't answer that.

24 Q As you sit here today, you are not prepared to  
25 state that the doctors at Family Health

1 Services breached the standard of care; is  
2 that correct?

3 A That's correct.

4 Q Were you aware from the records that the  
5 family had reported to medical providers in  
6 2010 that Mr. Dukeshire had a history of  
7 polysubstance abuse?

8 A Yes.

9 Q What was your understanding as to what was  
10 being abused?

11 A Cocaine and alcohol.

12 Q Not narcotics?

13 A I don't recall opioids being a piece of that.

14 Q So I assume you were aware that in 2011 and  
15 2012 Mr. Dukeshire was being treated with  
16 narcotics for back pain, correct?

17 A Correct.

18 Q To your knowledge, were those physicians aware  
19 of Mr. Dukeshire's history of prior cocaine  
20 and alcohol abuse?

21 MR. ABRAMOWITZ: Objection. Calls for  
22 speculation.

23 MR. GROEDEL: No, it doesn't. It  
24 calls for him to give an answer based upon the  
25 records.

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

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

11               MR. ABRAMOWITZ:    Objection, but you  
12                  can answer.

13   A           I'm not sure.

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

19   A           I'm not sure.

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

22   A           Correct.

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

1                   MR. ABRAMOWITZ:    Objection, but you  
2                   can answer.

3    A            I do not recall.

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

8                   MR. ABRAMOWITZ:    Objection, but you  
9                   can answer.

10   A            I'm not sure.

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

14   A            I'm not sure.

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

19                  MR. ABRAMOWITZ:    Objection, but you  
20                  can answer.

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

25   Q            What do pain management physicians do?

1 A Well, in general help, use their expertise,  
2 diagnostic and treatment expertise to improve  
3 the patient's pain and functioning.

4 Q Do they utilize methadone or Suboxone?

5 A Well, so methadone, as you may be aware, can  
6 be used for the treatment of pain, as well as  
7 the treatment of opioid use disorder. So some  
8 pain specialists do use methadone for the  
9 treatment of pain. Increasingly, pain  
10 specialists are getting themselves trained in  
11 the use of Suboxone, but that's a more recent  
12 phenomenon I would say.

13 Q I would assume that pain management physicians  
14 would be particularly adept at recognizing  
15 when a patient may be addicted to narcotics?

16 A You said you can assume that, so are you  
17 asking me if I have that same assumption?

18 Q Yes.

19 A I don't have that same assumption.

20 Q You don't believe pain management physicians  
21 are capable of determining when a patient may  
22 have an addiction disorder?

23 A Some are capable. They are all capable. Some  
24 are adept, which is the word you used, and  
25 some are not.

1 Q You would agree that a pain management  
2 physician generally would be capable of  
3 recognizing when a patient should be referred  
4 to an addiction medicine specialist?

5 A Yes.

6 Q Do you know whether or not Mr. Dukeshire saw a  
7 pain management specialist in May of 2012 or  
8 thereabouts?

9 MR. ABRAMOWITZ: Objection, but you  
10 can answer.

11 A I'm not sure.

12 Q Were you aware that a tox screen from Bellevue  
13 Hospital in October of 2012 was positive for  
14 methadone and cocaine?

15 MR. ABRAMOWITZ: Objection, but you  
16 can answer.

17 A No, I was not.

18 Q Assuming that that tox screen was accurate,  
19 where would somebody like Mr. Dukeshire be  
20 able to access methadone?

21 MR. ABRAMOWITZ: Objection, but you  
22 can answer.

23 A He could have gotten it as a pain management  
24 prescription, he could have gotten it from the  
25 streets, or he could have gotten it from an

1           opioid treatment program.

2       Q       Do you have any knowledge as to where he would  
3           have received methadone?

4       A       No.

5       Q       If a physician saw that tox screen result, in  
6           other words, the result that was positive for  
7           methadone or cocaine, should that physician  
8           have referred Mr. Dukeshire to an addiction  
9           medicine specialist?

10      A       Well, you know, a little more context would be  
11           necessary to fully answer that, but illicit  
12           cocaine use would very often generate, me to  
13           generate a referral to addiction specialists.

14      Q       What was your understanding from everything  
15           you know about this case as to when  
16           Mr. Dukeshire was using cocaine?

17                   MR. ABRAMOWITZ:    Objection, but you  
18           can answer.

19      A       That it was prior to -- well, the only  
20           documentation of it was that it was prior to  
21           him joining Dr. Gallagher's practice.

22      Q       Do you have any information to indicate that  
23           he was using cocaine at all after he was with  
24           Dr. Gallagher?

25                   MR. ABRAMOWITZ:    Objection, but you



1           can answer.

2     A       I have no indication of that.

3     Q       I mean do you have any reason to believe that  
4           he was utilizing cocaine from when he started  
5           treating with Dr. Gallagher?

6     A       Well, there's a history of use of cocaine and  
7           we have no urine drug test during his time  
8           with Dr. Gallagher, so it's certainly possible  
9           but we have no way to know.

10    Q       Based upon everything that you have seen in  
11           this case, is there any evidence that you saw  
12           that Mr. Dukeshire was suffering any adverse  
13           effects from the opioids that he was receiving  
14           in 2010, 2011, 2012, or 2013 before he began  
15           treating with Dr. Gallagher?

16    A       I don't know.

17    Q       What information would you need to have, if  
18           you think there is information out there, that  
19           might allow you to answer that question?

20    A       I would need to re-review the records from  
21           that practice.

22    Q       When was the last time you looked at the  
23           records in this case?

24                   MR. ABRAMOWITZ:    Objection, but you  
25           can answer.

1 A Those particular records or any records?

2 Q Any records?

3 A Yesterday.

4 Q What records did you review yesterday?

5 MR. ABRAMOWITZ: Objection, but you  
6 can answer.

7 A I focused on Dr. Gallagher's records.

8 Q Any other records?

9 A Hospitalization records.

10 Q While Mr. Dukeshire was under Dr. Gallagher's  
11 care?

12 A Yes.

13 Q When is the last time you looked at the  
14 records from Family Health Services of Erie  
15 County?

16 MR. ABRAMOWITZ: Objection, but you  
17 can answer.

18 A When they were first sent to me. I would  
19 have --

20 Q Which was when?

21 A I am not sure.

22 MR. ABRAMOWITZ: Objection. You can  
23 answer.

24 A I'm not sure off the top of my head.

25 Q Well, your report is dated November 27, 2020,

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

3                   MR. ABRAMOWITZ:    Objection, but you  
4           can answer.

5   A       Before then.

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

8                   Can you be anymore definitive than  
9           that?

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

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

15                   MR. ABRAMOWITZ:    Objection, but you  
16           can answer.

17  A       No, I don't.

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

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

1 function in a normal life.

2 Q Do you have any knowledge as to whether or not  
3 Mr. Dukeshire's cocaine usage was having an  
4 adverse impact upon his ability to function?

5 MR. ABRAMOWITZ: Objection, but you  
6 can answer.

7 A I don't.

8 Q To your knowledge, did Mr. Dukeshire tell  
9 Dr. Gallagher about his history of prior  
10 cocaine use?

11 MR. ABRAMOWITZ: Objection, you can  
12 answer.

13 A I don't believe that he did.

14 Q Is it your understanding that Mr. Dukeshire  
15 had a history of alcohol addiction?

16 A Yes.

17 Q What's your understanding about that  
18 condition?

19 A That it had resolved prior to him joining  
20 Dr. Gallagher's practice.

21 Q Do you have an understanding as to how it  
22 resolved?

23 A I don't remember.

24 Q Do you have an understanding as to how long he  
25 had that addiction for?

1 A I don't remember.

2 Q Was it your understanding that Dr. Gallagher  
3 made an attempt to obtain Mr. Dukeshire's  
4 records from Family Health Care?

5 MR. ABRAMOWITZ: Objection, but you  
6 can answer.

7 A Yes.

8 Q Was it your understanding that those records  
9 were ever sent to Dr. Gallagher?

10 MR. ABRAMOWITZ: Objection, you can  
11 answer.

12 A I believe they were.

13 Q You believe they were?

14 A Yeah.

15 Q Upon what do you base that information?

16 I assume you are looking at something?

17 A Yeah. I thought I saw reference to it in his  
18 records, but now I don't believe I -- I think  
19 I am mistaken. I would need to go back and  
20 check.

21 Q It's quite possible that although he asked for  
22 them, he never received those records?

23 MR. ABRAMOWITZ: Objection, but you  
24 can answer.

25 A Okay. So what I'm -- I am not certain that he

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

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

7                   MR. ABRAMOWITZ:    Objection, but you  
8           can answer.

9   A       I believe that's true.

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

13   A       I believe that's true.

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

18                   MR. ABRAMOWITZ:    Objection.   You can  
19           answer.

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

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

25   A       Yes.

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

6 MR. ABRAMOWITZ: Objection, but you  
7 can answer.

8 A No.

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

13 MR. ABRAMOWITZ: Objection, but you  
14 can answer.

15 A Is there a possibility of that?

16 Q Yes.

17 A Yes.

18 Q Is there a probability of that?

19 A I don't know.

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

25 What I would like you to do now is to

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

4 A Okay.

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

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

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

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



1           he died.

2       Q       Let me stop you for a moment there.

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

8                       MR. ABRAMOWITZ:    Objection, but you  
9       can answer.

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

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

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

1 Q When you say treatment agreement, what  
2 agreement are you referring to?

3 A Well, he signed a treatment agreement in  
4 November of 2016.

5 Q Is it your belief that any one of these  
6 episodes where he ran out early required  
7 different action on the part of Dr. Gallagher  
8 than what was provided?

9 A That any one required a different action?

10 Q Yes.

11 A It's my belief that any one of them pass maybe  
12 the initial one, should have been reacted to  
13 differently.

14 Q For instance, when he ran out early, for  
15 instance, say in June of 2014, you believe  
16 that episode should have warranted some action  
17 on Dr. Gallagher's part?

18 A Correct. Correct.

19 Q What action do you believe was required?

20 A We really needed a urine drug test there to  
21 see if this patient is taking what I am  
22 prescribing and not taking things that I am  
23 not prescribing.

24 Q Anything else?

25 A Definitely a query of the prescription drug

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

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

5 A Checking the prescription drug monitoring  
6 program.

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

10 A Right.

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

15 MR. ABRAMOWITZ: Objection, but you  
16 can answer.

17 A No, I don't.

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

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

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

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

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

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

11 MR. ABRAMOWITZ: Objection, but you  
12 can answer.

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

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

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A With medical certainty?

25 Q Probability, yeah.

1 A So I would say that it wouldn't have surprised  
2 me to find something other than what was being  
3 prescribed.

4 Q It also wouldn't surprise you to see a urine  
5 drug test that showed only the use of  
6 narcotics being prescribed, correct?

7 MR. ABRAMOWITZ: Objection, but you  
8 can answer.

9 A If all had shown only what was being  
10 prescribed, that would have been surprising.

11 Q At what point do you believe a urine drug  
12 screen would have shown something other than  
13 narcotics being prescribed by Dr. Gallagher?

14 MR. ABRAMOWITZ: Objection, but you  
15 can answer.

16 A It's hard to say. It's too hard to speculate.

17 Q Because it would be speculation to say that a  
18 urine drug screen would have shown something  
19 other than narcotics at any point in time  
20 while Mr. Dukeshire was alive, correct?

21 MR. ABRAMOWITZ: Objection.

22 A No.

23 MR. ABRAMOWITZ: You can answer.

24 A He's fairly clearly demonstrating symptoms of  
25 the disease of opioid addiction. It's a

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

9 Q Because it would be speculation?

10 MR. ABRAMOWITZ: Objection, you can  
11 answer.

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

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

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

20 Q Are you thinking about it?

21 A No.

22 Q No what?

23 A No, I am not thinking about it.

24 Q Can you answer the question then?

25 A No.

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

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

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

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

1 A Yeah.

2 Q Which you believe were red flags?

3 A Right. The harms of this treatment are  
4 outweighing any benefit, and it's really  
5 concerning for the diseased patients -- well,  
6 his prior ability to control his use of the  
7 medication.

8 Q Any other red flags that you believe are  
9 present in this case?

10 A Well, I think the fact that his family,  
11 various members of his family are coming to  
12 Dr. Dukeshire to explain their concern about  
13 the way Mr. Dukeshire is using his medication,  
14 the way he had been acting; that they had set  
15 up various ways to help him count his  
16 medication, keep track of his medication; and  
17 even with those pretty concerted efforts they  
18 weren't able to. That is a red flag for sure,  
19 red flags, plural.

20 Q In what respect was Dr. Dukeshire -- I'm  
21 sorry, Dr. Gallagher told that Mr. Dukeshire  
22 was using his medications inappropriately by  
23 family members?

24 A I believe the son had come to -- either come  
25 in person or made a phone call to



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

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

7 A I am not sure.

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

12 MR. ABRAMOWITZ: Objection, but you  
13 can answer.

14 A Not that I am aware of.

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

20 MR. ABRAMOWITZ: Objection, but you  
21 can answer.

22 A I am not sure what they were aware of.

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

1                   MR. ABRAMOWITZ:    Objection, but you  
2                   can answer.

3    A            I did read that.

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

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

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

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

25   Q            Any other red flags?

1 A I think those are the main ones I can recall  
2 at this time.

3 Q In your report you make reference to the Ohio  
4 Administrative Code, and I'm wondering what  
5 specific code you are referring to?

6 MR. ABRAMOWITZ: Objection, but you  
7 can answer.

8 A I don't know that I have the actual title of  
9 the code, but the Federation of State Medical  
10 Boards developed a model policy for the use of  
11 controlled substances. And Ohio -- that came  
12 out in 2013 -- and Ohio adopted its own  
13 version, as many states did, that was modeled  
14 after the Federation's policy.

15 I was just going to say, it essentially  
16 outlines best practices and the stewardship  
17 and how to safely manage controlled substances  
18 to be patient centered and safe.

19 Q Do you know when Ohio essentially in its  
20 Administrative Code adopted the information in  
21 the Federation of State Medical Boards?

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A I do not know off the top of my head. I would  
25 have to do some digging.

1 Q Well, do you know whether or not the Ohio  
2 Administrative Code set out guidelines that  
3 were in effect when Mr. Dukeshire was under  
4 the care of Dr. Gallagher?

5 A I believe so, yes.

6 Q You're just not sure exactly when?

7 A Correct.

8 Q Do you believe that the information and the  
9 recommendations contained in the  
10 Administrative Code are standard of care  
11 requirements?

12 MR. ABRAMOWITZ: Objection, but you  
13 can answer.

14 A I guess I'm not sure standard of care  
15 requirements? Establishing a standard of care  
16 is how I would say.

17 Q Well, so for instance, if a physician didn't  
18 follow any portion of the Administrative Code  
19 guidelines, would you consider a lack of or  
20 the absence of following those guidelines to  
21 be a breach of the standard of care?

22 A Yes.

23 MR. ABRAMOWITZ: Marc, I don't want to  
24 rush you for a break, but we've been going for  
25 about an hour here. Is it a good time for

1           one?

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

5                   THE WITNESS:           Yes.

6                           - - - - -

7                           (Recess taken)

8                           - - - - -

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

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

17                   MR. ABRAMOWITZ:    Objection, you can  
18           answer.

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

25    Q           Without waiving my objection to the late

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

6    A       Yes.

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

10   A       Yes.

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

15   A       Yes.

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

20   A       Yes.

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

25                       MR. ABRAMOWITZ:    Objection. You can

1 answer.

2 A He violated it and Dr. Gallagher did too.

3 Q In what respect did Mr. Dukeshire violate that  
4 agreement?

5 A I'm fairly certain the -- one of the lines  
6 is -- asks that the patient not increase the  
7 dose of the medication on their own, which the  
8 patient did.

9 Q Does the agreement also obligate the patient  
10 not to purchase narcotics outside of those  
11 that are being prescribed by Dr. Gallagher?

12 MR. ABRAMOWITZ: Objection, but you  
13 can answer.

14 A I'm not sure I would agree that it obligates  
15 the patient not to do that. My understanding  
16 of these documents is that it says if this --  
17 we advise you not to do that, we think that  
18 would be unsafe, and if that is to happen,  
19 we'll have to reconsider the appropriateness  
20 of this treatment.

21 Q Wouldn't you agree that it would have been a  
22 breach of the treatment agreement if  
23 Mr. Dukeshire was purchasing narcotics from  
24 friends or other people besides Dr. Gallagher;  
25 that's a breach of the agreement, isn't it?

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

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

8             MR. ABRAMOWITZ:    Objection, but you  
9             can answer.

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

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

18             MR. ABRAMOWITZ:    Objection, but you  
19             can answer.

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

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



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

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

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

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

19               MR. ABRAMOWITZ:    Objection, you can  
20               answer.

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

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

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

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

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

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

18 A I'm not going to speculate on that.

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

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

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

1 A Because he would recognize that his source of  
2 opioids was going away and that he would need  
3 to pursue this treatment to forestall going  
4 into opiate withdrawal.

5 Q Did you see any evidence of Mr. Dukeshire  
6 exhibiting signs of opiate withdrawal while he  
7 was under Dr. Gallagher's care?

8 A I don't believe that I did.

9 Q I may have asked you this before, if so, I  
10 apologize: Are you going to have an opinion at  
11 trial as to whether or not Mr. Dukeshire  
12 utilized heroin at any point in time prior to  
13 his death?

14 MR. ABRAMOWITZ: Objection. Other  
15 than the fatal dose, I mean, we know that he  
16 did that.

17 MR. GROEDEL: Well, no, we don't.

18 Q But go ahead.

19 A So sorry? Am I going to -- could you please  
20 repeat the question?

21 Q Let me just start at this point: We know the  
22 autopsy showed there was evidence of morphine  
23 in the toxicology report, correct?

24 A Right.

25 Q Is it your opinion that that morphine was due

1 to the ingestion of heroin?

2 MR. ABRAMOWITZ: Objection, but you  
3 can answer.

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

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

9 A Yes.

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

13 MR. ABRAMOWITZ: Objection, you can  
14 answer.

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

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

21 A Correct.

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

25 A Correct.

1 Q And he was having a lot of back pain as a  
2 result?

3 A Correct.

4 Q I assume you don't have any criticisms of the  
5 decision to go ahead and provide two  
6 operations in an attempt to alleviate his back  
7 pain, true?

8 A I'm not a surgeon. I am not going to comment  
9 on that.

10 Q Surgeries don't always alleviate back pain,  
11 true?

12 A That is true.

13 Q Why is that?

14 MR. ABRAMOWITZ: Objection. If you  
15 can answer.

16 A Well, the back is complicated physiologically,  
17 muscles, ligaments, bones. The target that is  
18 aimed at for surgical decompression can  
19 sometimes be the source of the pain, and  
20 sometimes not.

21 Q Was it appropriate for Mr. Dukeshire to  
22 receive narcotic medication following these  
23 two operations?

24 MR. ABRAMOWITZ: Objection, but you  
25 can answer.

1 A So limited two to three day supply for  
2 incisional pain is appropriate, but beyond  
3 that, typically not needed, so inappropriate.

4 Q We know from the records that Mr. Dukeshire's  
5 back pain returned in May of 2015 when he was  
6 complaining of severe radiating pain. Do you  
7 have an opinion as to whether or not it was  
8 appropriate to treat him with narcotics for  
9 those complaints of back pain?

10 A It would have been appropriate to take a very,  
11 very close look at whether the benefit of  
12 doing that would have outweighed the risk.  
13 And there is a number of things working  
14 against him on the risk side of things that  
15 would have ultimately led me to think it was  
16 probably too risky and the benefit would be  
17 fairly minimal.

18 Q Is it your opinion that it was beneath the  
19 standard of care to prescribe narcotics for  
20 Mr. Dukeshire when he had recurrent low back  
21 pain in May of 2015?

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A I am not going to say beneath the standard of  
25 care, no.

1 Q We know from the records that Mr. Dukeshire  
2 also had a history of right knee infection and  
3 abscesses; is that correct?

4 A Yes.

5 Q Is it your understanding that a draining  
6 abscess can be painful?

7 A Yes.

8 MR. ABRAMOWITZ: Objection. You can  
9 answer.

10 Q We know from the records that in early 2015 he  
11 needed to be hospitalized in Toledo for  
12 further care for that knee abscess, correct?

13 A Yes.

14 Q Are you critical of the decision to treat him  
15 with narcotics for the right knee pain he was  
16 suffering from at that point?

17 MR. ABRAMOWITZ: Objection, but you  
18 can answer.

19 A No, I am not critical.

20 Q We know that he was readmitted to the hospital  
21 in April of 2015 because his knee pain  
22 returned. Are you critical of the decision to  
23 treat him with narcotics once again during  
24 that admission?

25 MR. ABRAMOWITZ: Objection, but you

1           can answer.

2   A       Not critical of the use during admission for  
3           the drainage procedure, which is painful, a  
4           couple days post procedure. Ongoing use would  
5           have required more consideration, and again,  
6           harms probably would have outweighed the  
7           benefits in my opinion.

8   Q       I assume you are aware that Mr. Dukeshire  
9           required seven separate surgical procedures  
10          for his right knee over about a three year  
11          period of time; is that correct?

12   A       That's correct.

13   Q       And you would agree that those recurrent  
14          infections would be a source of pain?

15   A       Yes.

16   Q       And would require narcotics?

17   A       Again, the sort of a blanket "requiring  
18          narcotics" is a tough -- it's hard to answer  
19          in a blanket way. A couple days surrounding  
20          the procedures makes a lot of sense, but  
21          having a year's worth, less sense, because of  
22          the, again, the declining benefit of taking  
23          them and the increasing risks.

24   Q       Did you have an understanding as to whether  
25          the left knee infections in 2017 was keeping



1 Mr. Dukeshire from working at all?

2 A I do not recall if that was the reason for  
3 keeping him out of work.

4 Q You would agree, though, that his recurrent  
5 left knee infections were an ongoing source of  
6 pain for him over the last few years of his  
7 life?

8 MR. ABRAMOWITZ: Objection, you can  
9 answer.

10 A Yes.

11 Q Would that abscess that required seven  
12 surgical procedures over the course of a few  
13 years, would that have an impact upon his  
14 gait?

15 MR. ABRAMOWITZ: Objection, but you  
16 can answer.

17 A I'm not sure.

18 Q We also know from the records that  
19 Mr. Dukeshire developed ulcers on his buttocks  
20 while he was under Dr. Gallagher's care,  
21 correct?

22 A Yes.

23 Q What is your understanding as to how those  
24 ulcers developed, what caused them?

25 A Well, he did have an admission to the hospital

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

10 Q These ulcers, they can be painful?

11 A Yes.

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

14 MR. ABRAMOWITZ: Objection, but you  
15 can answer.

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

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

1           breached the standard of care?

2                   MR. ABRAMOWITZ:    Objection, but you  
3           can answer.

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

12   Q       Were you aware that Mr. Dukeshire was seen by  
13           a pain management specialist in February of  
14           2015?

15   A       Yes.

16                   MR. ABRAMOWITZ:    Objection.

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

21   A       I am not certain.

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

25                   MR. ABRAMOWITZ:    Objection, but you

1           can answer.

2       A       So the responsibility for how the opioids are  
3           being monitored and the harm that may be  
4           accruing from them is on the prescriber to  
5           manage. And so I don't -- the referring pain  
6           physician was not the prescriber, I don't  
7           think it was their duty to do so.

8       Q       You don't have any criticisms of the pain  
9           management specialist if he didn't feel that  
10          addiction referral was required, correct?

11      A       Correct.

12      Q       We know from the records that Mr. Dukeshire  
13           was an inpatient at Elmwood Health Care Center  
14           in May and June of 2014 for his wounds, you're  
15           aware of that?

16      A       Yes.

17      Q       Would it have been appropriate to treat him  
18           with narcotics for those wounds?

19      A       Again, I would have recommended short courses  
20           for a matter of several days while those  
21           wounds were being debrided, but in terms of  
22           ongoing long term treatment, not appropriate.

23      Q       We know from the records that in July of 2015  
24           Mr. Dukeshire was admitted to Firelands  
25           Hospital for a large painful buttocks ulcer,

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

3                   MR. ABRAMOWITZ:    Objection, but you  
4           can answer.

5   A       During the admission, yes.

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

11                  MR. ABRAMOWITZ:    Objection, but you  
12          can answer.

13   A       Yes, during the admission.

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

18   A       Yes.

19   Q       That's a painful condition?

20   A       Yes.

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

23                  MR. ABRAMOWITZ:    Objection, but you  
24          can answer.

25   A       No.   Really the treatment of choice for carpal

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

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

7    A       I'm not sure.

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

10   A       Possibly.

11   Q       Could require narcotics, potentially?

12   A       Could require narcotics, potentially?

13           Potentially, yes.

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

17   A       Yes.

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

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

23   Q       Would that sort of injury be painful?

24   A       Yes.

25   Q       Might require narcotics?

1 A It might, but it might not.

2 Q I want to switch gears a little bit and ask  
3 you some questions about Mr. Dukeshire's  
4 medical conditions.

5 We know from the records that he had a  
6 history of severe obstructive sleep apnea,  
7 correct?

8 A Correct.

9 Q CPAP is the appropriate treatment for that?

10 A Yes.

11 Q Mr. Dukeshire had the CPAP device?

12 A I believe he did. He did possess one.

13 Q Is it your understanding that he was non  
14 compliant with respect to the CPAP?

15 MR. ABRAMOWITZ: Objection, but you  
16 can answer.

17 A Yes, it is my understanding.

18 Q I mean, it's not all that unusual for patients  
19 with obstructive sleep apnea to not use the  
20 CPAP device because they find it very  
21 uncomfortable, correct?

22 A Correct.

23 Q So from your understanding, Mr. Dukeshire's  
24 sleep apnea was essentially untreated because  
25 he wasn't using his CPAP device?

1                   MR. ABRAMOWITZ:    Objection, but you  
2                   can answer.

3    A            Yes.

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

7                   MR. ABRAMOWITZ:    Objection, but you  
8                   can answer.

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

11   Q            They can become drowsy while driving?

12   A            Yes.

13   Q            It can affect their memory and concentration?

14   A            Yes.

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

19   A            Yes.

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

22   A            Yes.

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



1 A Yes.

2 Q Do you have an opinion in this case as to what  
3 likely would have happened had Mr. Dukeshire  
4 seen a sleep clinic physician as Dr. Gallagher  
5 had recommended?

6 MR. ABRAMOWITZ: Objection, but you  
7 can answer.

8 A Not going to comment outside my area of  
9 specialty.

10 Q Do you have an opinion as to whether an  
11 evaluation by a sleep medicine specialist  
12 would have led to a change in his narcotic  
13 dosage?

14 MR. ABRAMOWITZ: Objection, but you  
15 can answer.

16 A Hum? I don't know.

17 Q Possible?

18 A Possible.

19 Q Do you know what would be involved with a  
20 sleep clinic evaluation for somebody with  
21 obstructive sleep apnea?

22 A Yeah. Typically do an overnight polysomnogram  
23 and assess how many apneic episodes the  
24 patient is experiencing.

25 Q Regardless of the result, is the essential

1 treatment for this condition using the CPAP  
2 device?

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

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

14 A Yes.

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

18 MR. ABRAMOWITZ: Objection, but you  
19 can answer.

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

23 Q Lessens the amount of pain one would have?

24 A It can, yeah.

25 Q We of course know that Mr. Dukeshire was

1 morbidly obese, correct?

2 A Yes.

3 Q Does the record indicate that Dr. Gallagher on  
4 multiple occasions talked to Mr. Dukeshire  
5 about the importance of losing weight?

6 A Yes.

7 Q To your knowledge, did Mr. Dukeshire follow up  
8 on any of these recommendations?

9 A Not to my knowledge.

10 Q Would a bariatric evaluation have been helpful  
11 to Mr. Dukeshire?

12 A Yes, probably.

13 Q Were you aware that he failed to appear for a  
14 bariatric evaluation that had been scheduled  
15 for him?

16 A Yes.

17 Q So based upon the records that you have seen  
18 and the deposition testimony that you have  
19 seen, would you agree that while he was under  
20 Dr. Gallagher's care, Mr. Dukeshire had a  
21 number of different stressors in his life?

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A Yes, I would agree.

25 Q What was your understanding as to what

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

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

10 Q Any other stressors?

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

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

16 A Hum?

17 Q Were you aware of that?

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

21 Q That would be a stressor in his life?

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A Probably, sure.

25 Q I saw from the records that Dr. Gallagher

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

4     A       Yes.

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

8                   MR. ABRAMOWITZ:    Objection, but you  
9           can answer.

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

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

15    A       Genetic predisposition to have a mood  
16           disorder.

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

20    A       Yes.

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

24                   MR. ABRAMOWITZ:    Objection, but you  
25           can answer.

1 A That's correct.

2 Q It looks like the psychiatrist that he saw was  
3 a Dr. Travis, correct?

4 A Yes.

5 Q And based upon Dr. Travis' records, it looks  
6 like he was aware of the fact that  
7 Mr. Dukeshire was taking narcotics and was, in  
8 fact, on a benzodiazepine as well, correct?

9 A Yes.

10 Q It doesn't look like Dr. Travis recommended  
11 that he either stop the narcotics or wean off  
12 of them, correct?

13 MR. ABRAMOWITZ: Objection, but you  
14 can answer.

15 A That's correct.

16 Q It looks like from the records that Dr. Travis  
17 did, however, discuss the black box warning on  
18 the use of narcotics and benzodiazepines,  
19 correct?

20 A Correct.

21 Q What is your understanding as to the purpose  
22 behind that black box warning?

23 MR. ABRAMOWITZ: Objection, but you  
24 can answer.

25 A Data showing that co-occurring use or

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

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

6 A Yes.

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

10 MR. ABRAMOWITZ: Objection, but you  
11 can answer.

12 A It does appear so, yes.

13 Q That would be an untruthful statement,  
14 correct?

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

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

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A Yes, that would constitute use of illicit  
25 drugs.

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

4 MR. ABRAMOWITZ: Objection, but you  
5 can answer.

6 A Yes.

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

11 MR. ABRAMOWITZ: Objection, but you  
12 can answer.

13 A Yes.

14 Q In what way?

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

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

19 MR. ABRAMOWITZ: Objection, but you  
20 can answer.

21 A Likely would have, yes.

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

25 MR. ABRAMOWITZ: Objection, but you



1           can answer.

2   A       No.

3   Q       Do you have an opinion as to the cause of that  
4           disorder?

5                   MR. ABRAMOWITZ:    Objection, but you  
6           can answer.

7   A       Well, cause of major depressive disorder?  
8           Hum?  So again, usually a genetic  
9           predisposition, and then psychodynamic factors  
10          going on in one's life; but I will say in the  
11          setting of an active substance use disorder,  
12          which he was potentially experiencing, likely  
13          experiencing, it's difficult to make a mood  
14          disorder diagnosis.

15   Q       So I am not sure I follow you there.  What are  
16           you trying to tell me?

17   A       I guess my sense is if Dr. Travis had been  
18          addiction trained, I don't know that he was, I  
19          think he would have considered addiction a  
20          little more thoroughly on a differential  
21          diagnosis, would have probably also ordered a  
22          urine drug test himself; but he was concerned  
23          about mood disorder and I have already stated  
24          I don't have any reason to doubt that that was  
25          present.

1 Q But from what we can see from the records,  
2 Dr. Travis didn't raise substance use disorder  
3 as a potential diagnosis, correct?

4 A Correct.

5 Q It looks like he increased the patient's anti-  
6 depressants, the Lexapro, the Abilify; was  
7 that an acceptable thing to do?

8 MR. ABRAMOWITZ: Objection, but you  
9 can answer.

10 A Yes.

11 Q Did you see any indication that Dr. Travis  
12 said to Mr. Dukeshire stop taking the Valium?

13 A Gosh? I would have to review. I believe he  
14 warned him about the black box interaction,  
15 but I have to review for certainty; but I  
16 don't believe he said frankly stop taking it.

17 Q Was either Dr. Travis or the therapist,  
18 Mr. Seymour, who was seeing Mr. Dukeshire,  
19 aware of the fact that Dr. Gallagher had  
20 reduced Mr. Dukeshire's narcotic dosage at  
21 around that time?

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A I'm not sure.

25 Q If they were aware of that, would that have

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

4     A       Oh, I'm not sure.

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

8                   MR. ABRAMOWITZ:    Objection, but you  
9           can answer.

10    A       I did not see that in the consultation note.

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

14    A       No.

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

18    A       Am I aware of any physician who said that?

19    Q       Yeah.

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

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

25    A       In this particular case, he was prescribing

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

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

11               MR. ABRAMOWITZ:    Objection, but you  
12          can answer.

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

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

20       A       Correct.

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

25               MR. ABRAMOWITZ:    Objection, but you

1           can answer.

2       A       Documenting ill effects? Well, there were  
3           documentation -- there is documentation of  
4           delirium and other effects that very likely  
5           could have been due to that combination.  
6           People weren't necessarily recognizing those  
7           as such, but they were documenting the  
8           presence of those symptoms.

9       Q       Did any doctor document those symptoms as  
10           being potentially due to a combination of  
11           narcotics and benzos?

12      A       Not that I saw.

13      Q       I assume you saw testimony from family members  
14           about the family intervention that took place  
15           when the family expressed their concern to  
16           Mr. Dukeshire about his narcotic usage?

17      A       Yes.

18      Q       What is your understanding as to the outcome  
19           of that?

20      A       I don't believe it was effective.

21      Q       In what respect was it not effective?

22      A       He didn't -- it didn't result in him seeking  
23           treatment.

24      Q       Do you have an opinion as to why Mr. Dukeshire  
25           chose not to follow up on the family's desires

1           that he seek treatment?

2                   MR. ABRAMOWITZ:    Objection, but you  
3           can answer.

4    A       He was likely in denial.

5    Q       Denial that he had a problem?

6    A       Yes.

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

9                   MR. ABRAMOWITZ:    Objection, but you  
10          can answer.

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

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

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

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

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

25   Q       What about Suboxone treatment, is the success

1 rate any different?

2 A It's about the same. Maybe a hair lower, but  
3 still in the, you know, highly effective zone.

4 Q So those patients that receive initial success  
5 from medication assisted treatment, is there a  
6 significant percentage of those patients that  
7 suffer relapses?

8 MR. ABRAMOWITZ: Objection, but you  
9 can answer.

10 A Significant? Sort of a tough word to try to  
11 define for you. Some do, yes.

12 Q I have seen literature which indicates that 40  
13 to 60 percent of recovering addicts will  
14 suffer a relapse; does that sound accurate to  
15 you?

16 MR. ABRAMOWITZ: Objection, but you  
17 can answer.

18 A I would put it lower than that.

19 Q How much lower?

20 A More like 15 to 30.

21 Q Is the relapse rate higher for those patients  
22 who have used heroin in the past?

23 MR. ABRAMOWITZ: Objection, but you  
24 can answer.

25 A I don't know.

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

4 MR. ABRAMOWITZ: Objection, but you  
5 can answer.

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

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

12 A Yes, attempting to.

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

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

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

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



1 Q How many times was it done?

2 A Over the whole treatment course?

3 Q Let's just say over the period of time when  
4 the dosage was being tapered downward?

5 A In those last three months, I would say at  
6 least once, and I think possibly twice.

7 Q If Dr. Gallagher didn't refer Mr. Dukeshire to  
8 an addiction specialist in the Summer of 2017,  
9 would it have been appropriate for him to  
10 taper the narcotic dose, as he was doing?

11 MR. ABRAMOWITZ: Objection, but you  
12 can answer.

13 A The evidence based treatment for opiate  
14 addiction, and by that I mean what we know  
15 from the scientific literature works, is  
16 getting the patient on medication. The new  
17 term is medications for opioid use disorder,  
18 it is not tapering, so you know, just tapering  
19 is below the standard of care.

20 Q What else then was required?

21 A Getting an earnest actionable referral to an  
22 addiction treatment center that could provide  
23 medication for opioid use disorder. I should  
24 remind us, prescribing it himself, which  
25 primary care docs can do so with Suboxone.

1 Q Do you know whether or not Dr. Gallagher was  
2 capable of managing somebody either on  
3 Suboxone or methadone?

4 A Considering the fact that he wasn't capable of  
5 diagnosing opioid use disorder, I would say  
6 almost certainly not.

7 Q If a patient is going to receive methadone  
8 treatment to treat an opioid use disorder,  
9 does that treatment also involve therapy  
10 sessions?

11 A It does. Most opiate treatment programs  
12 require counseling, along with medication  
13 administration.

14 Q How often are those counseling sessions  
15 required?

16 A Varies from state to state, but usually in the  
17 order of once or twice per month.

18 Q In this case if Mr. Dukeshire was receiving  
19 methadone, are you able to state to within a  
20 reasonable degree of probability that he would  
21 have attended counseling sessions as required?

22 A I have no reason to believe that he would not  
23 have.

24 Q And you say that, even though you would agree  
25 that there were many aspects of

1           Mr. Dukeshire's care where he was non  
2           compliant as a patient, correct?

3    A       That's correct.

4    Q       In fact, he missed a number of appointments  
5           with Dr. Gallagher, correct?

6                   MR. ABRAMOWITZ:    Objection, but you  
7           can answer.

8    A       He did.

9    Q       Would you agree that he was also dismissed  
10           from the Coumadin clinic because he failed to  
11           show up for a number of scheduled  
12           appointments?

13   A       He was.

14   Q       In your review of the records, did you see  
15           that he missed numerous wound care clinic  
16           appointments as well, correct?

17   A       That is correct.

18   Q       And of course, we've already talked about how  
19           he failed to keep two appointments for sleep  
20           study evaluations, true?

21   A       That's true.

22   Q       It looks like from the records that he had an  
23           appointment for a colonoscopy and he failed to  
24           keep that appointment also, correct?

25   A       That's correct.

1 Q Does the record indicate that he also missed a  
2 number of appointments with his cardiologist?

3 A It does show that, yes.

4 Q Does the record also tell us that on several  
5 occasions he refused to accept pain management  
6 referrals that had been offered to him?

7 MR. ABRAMOWITZ: Objection, but you  
8 can answer.

9 A I believe that is the case.

10 Q Wouldn't it be fair to state that even if he  
11 had seen a pain management specialist at any  
12 point in time, there's a very good possibility  
13 that this outcome would have been averted?

14 MR. ABRAMOWITZ: Objection, but you  
15 can answer.

16 A No. Pain specialists really have historically  
17 not engaged in diagnosing and management of  
18 addiction, so I would not think that this  
19 would have been averted had he been referred  
20 to -- or had he attended a pain management  
21 appointment.

22 Q But pain management specialists certainly can  
23 suspect when somebody is suffering from an  
24 opioid use disorder, correct?

25 A They can, yes.

1 Q I mean, you believe that this internist should  
2 have had that suspicion, right?

3 A I believe that the person prescribing the  
4 opioids has a duty to be ever watchful for  
5 this problem.

6 Q What was your understanding as to how  
7 Mr. Dukeshire received the narcotics, drugs,  
8 whatever you want to call them, that ended up  
9 leading to his death?

10 MR. ABRAMOWITZ: Objection, but you  
11 can answer.

12 A I am not sure.

13 Q Well, I assume you know that the drugs that he  
14 ingested just prior to his death were received  
15 from one of his friends or associates, a  
16 Mr. Jurovcik, you're aware of that, aren't  
17 you?

18 A I believe that's what his wife speculates in  
19 the -- in her testimony. Is that correct?

20 Q Well, she didn't speculate. She actually saw  
21 it happen; you're aware of that, aren't you?

22 MR. ABRAMOWITZ: Objection, but you  
23 can answer.

24 A I'm aware that she states she saw it happen,  
25 yes.

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

6 MR. ABRAMOWITZ: Objection, but you  
7 can answer.

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

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

14 MR. ABRAMOWITZ: Objection, but you  
15 can answer.

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

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

21 MR. ABRAMOWITZ: Objection, but you  
22 can answer.

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

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

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

13                   MR. ABRAMOWITZ:    Objection, but you  
14           can answer.

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

17   Q       That would have helped, right?

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

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

1           narcotics he was receiving, can you?

2                   MR. ABRAMOWITZ:    Objection, but you  
3           can answer.

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

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

10  A        Only his?

11  Q        What do you mean only his?

12  A        The ones prescribed to him?

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

15  A        But only oxycodone?

16  Q        Right.

17                   MR. ABRAMOWITZ:    Objection, but you  
18           can answer.

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

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

25  Q        What's the basis for that testimony?



1 A My belief.

2 Q Well, what do you mean your belief? I don't  
3 follow that.

4 A Well, there is a wide array of opioids  
5 available on the street, and if he was, as you  
6 say, using illicit opioids from the streets,  
7 it seems highly unlikely that it would always  
8 only be oxycodone.

9 Q But as you sit here today, you see no  
10 testimony from anybody which indicated that  
11 Mr. Dukeshire was snorting heroin, correct?

12 MR. ABRAMOWITZ: Objection, but you  
13 can answer.

14 A Correct.

15 Q You mentioned at the beginning of your  
16 deposition that in February of 2016 there was  
17 an episode of what you considered drug  
18 toxicity that could have been secondary to a  
19 narcotic overdose; do you recall that?

20 A Yes.

21 Q And the records from that February 2016  
22 admission, you have seen those records,  
23 correct?

24 A Yes.

25 Q Did any of the physicians who were involved in

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

3 MR. ABRAMOWITZ: Objection, but you  
4 can answer.

5 A They did not.

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

8 A They were.

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

13 A Correct.

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

16 MR. ABRAMOWITZ: Objection, but you  
17 can answer.

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

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

24 A I believe so, yes.

25 Q And he didn't do that, correct?

1 A Correct.

2 Q And I think you also made reference to an  
3 emergency room visit in August of 2017 as a  
4 potential episode of narcotic overdose; would  
5 you agree that no one during that ER visit  
6 found any evidence of an addiction issue,  
7 correct?

8 A That's correct.

9 Q Would you agree that at various points in time  
10 during Mr. Dukeshire's care with  
11 Dr. Gallagher, he was admitted to hospitals  
12 and placed on some pretty high doses of  
13 narcotics during those admissions, correct?

14 A Yes.

15 Q For instance, I saw from the record in  
16 December of 2014 when he was treated at the  
17 Cleveland Clinic for back issues, he was on a  
18 narcotic dose that was the equivalent of 225  
19 mme, you saw that, correct?

20 A Yes.

21 Q That was appropriate?

22 A It's difficult to say without direct knowledge  
23 of other factors going on in the care at that  
24 time.

25 Q But as you sit here today, you are not

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

4 MR. ABRAMOWITZ: Objection, but you  
5 can answer.

6 A I'm not saying that.

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

11 MR. ABRAMOWITZ: Objection, but you  
12 can answer.

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

15 Q In January of 2017 he was at Freemont Hospital  
16 again for his right knee issues and he was on  
17 200 mme of narcotics, that was within the  
18 standard of care?

19 MR. ABRAMOWITZ: Objection, but you  
20 can answer.

21 A I am not willing to suggest it was below.

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

1 MR. ABRAMOWITZ: Objection, but you  
2 can answer.

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

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

10 MR. ABRAMOWITZ: Objection, but you  
11 can answer.

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

17 Q So that's a little high?

18 A That's a little high.

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

24 MR. ABRAMOWITZ: Objection, but you  
25 can answer.

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

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

13 MR. ABRAMOWITZ: Objection, but you  
14 can answer.

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

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

20 A Yes.

21 MR. ABRAMOWITZ: Objection, but you  
22 can answer.

23 A Yes.

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

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

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

8                                 - - - - -  
9                                 (Recess taken)

10                                - - - - -

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

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

17                   MR. ABRAMOWITZ:    Objection, but you  
18                   can answer.

19    A           I don't know.

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

22                   MR. ABRAMOWITZ:    Objection, but you  
23                   can answer.

24    A           Correct, I don't recall.

25    Q           If the family knew that Mr. Dukeshire was

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

3                   MR. ABRAMOWITZ:    Objection, but you  
4           can answer.

5   A       Not necessarily.

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

10                   MR. ABRAMOWITZ:    Objection, but you  
11          can answer.

12   A       Yes.

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

16                   MR. ABRAMOWITZ:    Objection.

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



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

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

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

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

17 MR. ABRAMOWITZ: Objection, but you  
18 can answer.

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

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

25 MR. MCMANUS: Thank you.

1 MR. ABRAMOWITZ: Objection.

2 A I can't. I can say that it was likely a  
3 significant contributor to his death.

4 Q Would you agree that he would have died if he  
5 had just received the carfentanil?

6 MR. ABRAMOWITZ: Objection, but you  
7 can answer.

8 A It is possible that just receiving the  
9 carfentanil could have been fatal.

10 Q Do you know what carfentanil looks like?

11 A Yes.

12 Q What's it looked like?

13 MR. ABRAMOWITZ: Objection, but you  
14 can answer.

15 A I can -- I don't care to answer.

16 Q Why not?

17 A Is it relevant?

18 Q Well, here's the point I'm trying to figure  
19 out: Does crushed carfentanil look different  
20 than crushed oxycodone?

21 MR. ABRAMOWITZ: Objection, but you  
22 can answer.

23 A Does it look different? Yes.

24 Q In what way?

25 MR. ABRAMOWITZ: Objection, but you

1           can answer.

2   A       Well, I guess depending on the degree of  
3           crushing that goes on, it may look -- it may  
4           not look different. I'm going to revise my  
5           statement that it looks different.

6   Q       Is the color different?

7           MR. ABRAMOWITZ:   Objection, but you  
8           can answer.

9   A       Not necessarily.

10   Q      Have you seen carfentanil?

11           MR. ABRAMOWITZ:   Objection, but you  
12           can answer.

13   A       I have seen a picture.

14   Q       What color was it in the picture?

15           MR. ABRAMOWITZ:   Objection, but you  
16           can answer.

17   A       It was white.

18   Q       This was a narcotic overdose death, is that  
19           your opinion?

20           MR. ABRAMOWITZ:   Objection, but you  
21           can answer.

22   A       Yes.

23   Q       How does a narcotic overdose death manifest  
24           itself from a clinical standpoint, what do we  
25           see?

1                   MR. ABRAMOWITZ:    Objection, but you  
2                   can answer.

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

7    Q            Is it a gradual process?

8    A            No.

9    Q            How long does it usually take?

10                  MR. ABRAMOWITZ:    Objection, but you  
11                  can answer.

12   A            A matter of seconds to minutes.

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

15                  MR. ABRAMOWITZ:    Objection, but you  
16                  can answer.

17   A            I mean, there could be, yes.

18   Q            Then there is a slowing of respiration?

19   A            Yes.

20   Q            Followed by a cessation of respiration?

21   A            Correct.

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

25                  MR. ABRAMOWITZ:    Objection, but you

1           can answer.

2     A       I'm not sure.

3     Q       Why aren't you sure?

4     A       I don't recall how she described the event.

5     Q       Did Mr. Dukeshire's cardiac condition place  
6           him at high risk for a sudden cardiac death?

7               MR. ABRAMOWITZ:    Objection, but you  
8           can answer.

9     A       Yes.

10    Q       What cardiac conditions did he have that would  
11           have placed him at a higher risk for a sudden  
12           cardiac death?

13    A       I want to be clear that I am convinced that he  
14           died of opioid overdose, but in terms of his  
15           risk for sudden cardiac death, which I don't  
16           believe is at play here, he had a history of  
17           atrial fibrillation.

18    Q       In your opinion did Mr. Dukeshire have any  
19           chronic conditions that would have had an  
20           adverse impact upon his life expectancy,  
21           assuming he didn't die on the day that he did?

22               MR. ABRAMOWITZ:    Objection, but you  
23           can answer.

24    A       Yes, he did.

25    Q       So what conditions did he have that would have

1           had an adverse impact upon his life  
2           expectancy?

3                   MR. ABRAMOWITZ:    Objection, but you  
4           can answer.

5   A       Morbid obesity and sleep apnea.

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

8                   MR. ABRAMOWITZ:    Objection, but you  
9           can answer.

10   A       Yes, that's true.

11   Q       What was the cause of that severe  
12           cardiomegaly?

13                   MR. ABRAMOWITZ:    Objection, but you  
14           can answer.

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

20   Q       How would you characterize the degree of  
21           cardiomegaly?

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

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

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

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

8 MR. ABRAMOWITZ: Objection, but you  
9 can answer.

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

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

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

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

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

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

3                   MR. ABRAMOWITZ:    Objection, but you  
4           can answer.

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

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

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

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

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

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

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



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

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

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

8 Q Is it also consistent with hypertensive heart  
9 disease?

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

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

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

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

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

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

5   Q       No evidence of what?

6   A       Thinning of the left ventricle.

7   Q       His lung was noted to weigh 760 grams, his  
8           right lung. His left lung was noted to weigh  
9           640 grams. Would you consider those weights  
10          to be abnormal?

11               MR. ABRAMOWITZ:    Objection, but you  
12          can answer.

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

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

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

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

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

1           that he did?

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

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

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

11               MR. ABRAMOWITZ:    Objection.  Calls for  
12          speculation.

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

15   Q       As a result of his pre-existing conditions?

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

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

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

25               MR. GROEDEL:        That's what I thought

1           he said.

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

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

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

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

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

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

1 under the scope of a research protocol.

2 Q So the patients that are involved in these  
3 research protocols, are the patients that you  
4 see on Tuesday?

5 A No. By and large they are other patients from  
6 around the -- from the VA population.

7 Q So they are not your patients then, are they?

8 A Well, they're patients who have enrolled in  
9 our studies, so I -- when you say they are not  
10 my patients, you mean am I their primary care  
11 doctor or?

12 Q Right. Are you the doctor of any of the  
13 patients that are enrolled in these research  
14 projects?

15 MR. ABRAMOWITZ: Objection, that's  
16 asked and answered. He said he was. But you  
17 can answer again.

18 A I'm treating them under a study protocol, so  
19 that would be they are my patients.

20 Q So are these the patients then that you see on  
21 Tuesday?

22 A Those patients are typically not enrolled in a  
23 study protocol, so they are typically a  
24 different set of patients.

25 Q I got the impression from your earlier

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

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

8    Q       Where do you see them?

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

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

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

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

21   A       A good two-thirds of that time.

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

25   A       Yes.

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

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

7                                       - - - - -

8                                       CROSS-EXAMINATION

9                   BY MR. MCMANUS:

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

12          A       That's correct.

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

17          A       That's correct.

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

22                   MR. ABRAMOWITZ:    Objection, but you  
23                   can answer.

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

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

11 A Correct.

12 MR. ABRAMOWITZ: Yes.

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

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

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

19

20 - - - - -

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

23 - - - - -

24

25



1	<u>ERRATA PAGE</u>	
2	PAGE/LINE	NOTATION
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20		_____
21		WILLIAM C. BECKER, M.D.
22	Subscribed and sworn to before me this	_____
23	day of _____,	2021.
24		_____
25	Commission expiration:	Notary Public _____.

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

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

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

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

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

*Frank P. Versagi*

24 Frank P. Versagi, RPR  
 25 Notary Public in and for the State of Ohio.  
 Commission expiration: 8-2-23.

\$400

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**you're****zoom**

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 (97:2) (97:15) (102:10) (103:13)  
 (107:19) (108:22) (109:18) (111:11)  
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 (117:7) (117:25) (119:3) (119:13)  
 (119:18) (120:2)  
**you're** (5:7) (14:1) (14:8) (20:8)  
 (20:19) (20:20) (52:6) (68:14)  
 (72:17) (74:12) (93:16) (93:21)  
 (102:3)

**yours** (118:4)**yourself** (54:3) (118:14)**you've** (7:17) (46:18) (53:13)**Z****zoloft** (77:1)**zone** (87:3)**zoom** (1:12) (2:3) (2:9) (2:15)  
 (2:21) (4:17) (122:10)