16 (JAMES GAVIN, M.D., PLAINTIFF witness, having been duly sworn,

17 testified as follows:)

18 DIRECT EXAMINATION

19 BY MR. GRIFFIN:

20 Q. Good morning, Dr. Gavin. Would you please introduce

21 yourself to the jury?

22 A. I'm Dr. James R. Gavin, III, and I'm CEO and chief medical

23 officer for a disease management company called Healing Our

24 Village, and clinical professor of medicine at Emory and Indiana

25 University Schools of Medicine.

1 Q. Dr. Gavin, would you tell the jury a little bit about
2 yourself, where you were born and raised, and your educational
3 background?
4 A. I was born and raised in Mobile, Alabama. I left Mobile
5 when I was 16, going to college at Livingstone College in
6 Salisbury, North Carolina. I actually went to college to
7 initially be a Methodist preacher, but that's a longer story
8 than you have time for. And after college I went to graduate
9 school at Emory University in Atlanta, and finished a Ph.D. in
10 biochemistry.
11 And after a few years of fellowship at the NIH here in
12 Bethesda, I went back to medical school and received my medical
13 degree at Duke University, and then did my clinical training at
14 Washington University, Barnes Hospital in St. Louis.
15 Q. Do you have family, sir?
16 A. I do. I have a wife of some 38 years, and three adult sons,
17 and unfortunately only one granddaughter.
18 Q. All right. I would like, Dr. Gavin, if you would, to go
19 over --
20 MR. GRIFFIN: Well, let me offer at this point
21 Plaintiff's Exhibit 28, Dr. Gavin's CV, to which the government
22 said there's no objection.
23 THE COURT: 28 will be received.
24 (PLAINTIFF'S Exhibit Number 28 was moved into
25 evidence.)

1 BY MR. GRIFFIN:
2 Q. Dr. Gavin, let's go over first -- you just shared with the
3 jury your educational experience. Is that right?
4 A. Yes.
5 Q. Okay. I would like you to share with the jury the positions
6 and the work that you have had, say, the first, we don't need to
7 go over the whole thing, but maybe the first 10 or so, the most
8 recent, your positions of what you served.
9 First, I'll ask you, what is Healing Our Village, Inc.?
10 What is that?
11 A. We are a disease management company that works with health
12 plans and hospital practice groups, working with their highest
13 risk patients to really deal with those people who are having
14 the most difficult time getting to goals with diabetes,
15 primarily. And we also have some few patients with whom we work
16 who have asthma. So we work with health plans to deal with the
17 folks who are really in the deepest trouble with their diabetes
18 management.
19 Q. All right. Now, are you currently a clinical professor of
20 medicine at the Indiana University School of Medicine?
21 A. Yes, I am. I have a clinical faculty appointment there.
22 And I do teaching there, and I also run a fellowship program out
23 of Indiana University School of Medicine.
24 Q. What kind of fellowship?
25 A. This is a fellowship program that has been continuously

1 funded for the last 26 years by the Robert Wood Johnson
2 Foundation, originally for underrepresented minorities who were
3 interested in pursuing academic medical careers in a variety of
4 disciplines, which include endocrinology and diabetes.
5 Q. What have you done the first three days of this week, before
6 you came in late last night?
7 A. I was teaching a course for fellows in diabetes and
8 endocrinology in Indiana. So I came here from my Indiana
9 office.
10 Q. All right. And are you also a professor at Emory University
11 in Atlanta?
12 A. I have a faculty appointment, clinical faculty appointment
13 at Emory, which my base. Atlanta is my base, and I do teaching
14 of residents and some medical student teaching. And then I
15 serve as an advisor on health affairs to both the chancellor and
16 the president at Emory.
17 Q. Before you -- well, let me ask you this: Your resumé - what
18 I call a resumé, doctors call CVs - but the resumé reflects that
19 you were president for several years of the Morehouse School of
20 Medicine in Atlanta.
21 Please tell the jury, if you would, what Morehouse
22 School of Medicine is.
23 A. Morehouse School of Medicine is one of what were formally
24 four, now there are three, since the Charles Drew Medical School
25 essentially went out of operation for a while, but

1 underrepresented or historically black medical schools, along
2 with Howard and Maharry. And it trains mostly primary care
3 providers to serve the medically underserved.
4 And it's been around in Atlanta since 1971, one of the
5 few medical schools that actually had its origins in a college,
6 not a university.
7 Q. Dr. Gavin, I want to skip down to where it says, "Director,
8 HHMI/NIH research scholars program."
9 What's that about?
10 A. For 11 years I worked here at the headquarters of the
11 Howard Hughes Medical Institute, which is headquartered in Chevy
12 Chase, Maryland. Howard Hughes shares programs with the NIH,
13 which is basically right down the street. One of the programs
14 that they share has medical students who come for a year. They
15 live on the campus at the NIH for a year, working in various
16 research laboratories. That's a Howard Hughes-sponsored
17 program, jointly with the NIH, and I was the director of that
18 program.
19 Q. Now, I'm not going to ask you about any of these other
20 positions, but if the jury wants to look at them later.
21 Do all of those reflect your previous positions which
22 you have held in your long career in diabetes?
23 A. Yes, they do.
24 Q. All right.
25 MR. GRIFFIN: Let's go to the bottom, if we could,

1 Garin.

2 BY MR. GRIFFIN:

3 Q. And I'll ask you about your military service to your

4 country. Describe for us, if you will, about that.

5 A. Well, I was a lieutenant commander, served my active duty at

6 the NIH during the Vietnam era, and then became a commander.

7 And then I've been actually in the inactive reserve. They

8 called that at one time the ready reserve. So I think I'm now

9 too old for them to deploy, but I was always ready.

10 Q. Thank you for that. Now, I want to go to the issue of

11 licensure and ask if you are licensed to practice medicine?

12 A. I am licensed to practice medicine, yeah.

13 Q. And are you a diplomate of the National Board of Medical

14 Examiners?

15 A. I am, sir.

16 Q. What does that mean?

17 A. It simply means that you've passed a series of the

18 qualifying examinations which show evidence of your preparation

19 to enter the field of medicine.

20 Q. If we could turn to the next page, that contains the

21 licensure and awards and honors, and look at the first five or

22 ten awards and honors. And we're not going to talk about all

23 these because we're short of time, but I want to ask about a few

24 of those, if I might.

25 I would like for you to share with us, I noticed third

1 to the bottom there on the screen is the Banting Medal For
2 Distinguished Service, American Diabetes Association. First of
3 all, what is the American Diabetes Association?
4 A. Well, the American Diabetes Association is the largest
5 professional and voluntary health society for diabetes in this
6 country, probably in the world. And it works to really seek
7 better ways of treating, better ways of promoting public
8 awareness, and better ways of pursuing cures for diabetes.
9 And the Banting Medal is given to the outgoing
10 president of the American Diabetes Association, because
11 generally that person will have had a long history of
12 voluntarism which culminates in having spent a four-year stint
13 in the presidential track. There's vice president,
14 president-elect, president, and then past president.
15 Q. Is the president of the American Diabetes also always a
16 physician, at least the president for medicine?
17 A. President for medicine is always a physician. That has been
18 historically the way this has operated.
19 Q. Does the American Diabetes Association publish the most
20 scientifically prestigious journals in terms of the care of
21 diabetes and helping physicians?
22 A. There's what's called a rating index for the impact of
23 medical journals. That means these are the journals that
24 scientists and medical care professionals view as the most
25 credible. The American Diabetes Association publishes the

1 highest index of journals in the field of diabetes in the world.
2 Q. Are they peer-reviewed?
3 A. They're all peer-reviewed.
4 Q. And does the American Diabetes Association fund research for
5 diabetes?
6 A. The American Diabetes Association has a very active research
7 funding program. In fact, a number of years ago, it formed the
8 American Diabetes Association Research Foundation, which is
9 specifically geared to do nothing but raise funds for research.
10 Q. All right. And let me just go to the last one. You were
11 named internist of the year by the National Medical Association
12 in 1997. What is that?
13 A. Well, the National Medical Association is an organization of
14 minority physicians in this country. For many years, of course,
15 minority physicians could not be admitted into the American
16 Medical Association, so in 1895 the National Medical Association
17 was formed to provide a professional home, if you will, for
18 African-American physicians. It is still in existence, and
19 still operational.
20 Each year the NMA, as we call it, gives an award for a
21 person who is elected by his or her peers as being an exemplary
22 practitioner in their field. And I was honored to receive that
23 award in 1997 as the internist of the year, and I was quite
24 proud of that.
25 Q. Thank you. Dr. Gavin, if you don't mind moving -- if we

1 could move to the next page under "Editorial positions," if we
2 could, up near the top, I'll ask you, have you served on
3 boards -- or I should say, have you served in an editorial
4 capacity for journals in our country that have to do with
5 medicine and diabetes?
6 A. Yes, I have, a number of them. Some of them are shown right
7 here on this little screen.
8 Q. I want to go on the one you're on right now, the most recent
9 in 2005, to the present. And I'll ask you, when it says,
10 "Editorial board member for Insulin," what does that mean?
11 A. Well, Insulin actually is a specialty journal which actually
12 focuses on issues related to the care and cure of diabetes,
13 where insulin, the hormone, is the principal focus. So it
14 will -- that journal will cover articles that really go all the
15 way from research to patient care.
16 Q. Practical advice for physicians?
17 A. Absolutely.
18 Q. Okay. Let's move to the next section. I'm not going to ask
19 you any questions about it, but I'll ask if your CV contains the
20 many advisory boards and committees where you have served as a
21 physician?
22 A. Yes, it does contain that list. And looking at it makes me
23 tired.
24 MR. GRIFFIN: Go to the next page, will you, Garin?
25 BY MR. GRIFFIN:

1 Q. And the next page is more of those. Is that right?
2 A. Yes.
3 Q. All right. Moving to the next section in your CV, the
4 awards and honors that have been bestowed upon you, let's just
5 look at, say, for example -- let's just take a few of those,
6 look at the first few of them. There are so many. Let me just
7 see if I can cut this short, everything from distinguished
8 alumnus in Washington to distinguished alumnus from Emory, all
9 of these. Does this section, the other awards and honors --
10 MR. GRIFFIN: Garin, if you would put the whole thing,
11 at least, on that first page.
12 BY MR. GRIFFIN:
13 Q. Does this list that we see before us list awards and honors
14 that have been bestowed upon you by others?
15 A. That is correct. And mostly for the work that I've done in
16 the area of diabetes, I should add.
17 Q. Okay. All right.
18 THE COURT: That's enough, isn't it, Mr. Griffin?
19 MR. GRIFFIN: I think so. I was thinking the same
20 thing, Your Honor.
21 BY MR. GRIFFIN:
22 Q. Let's move, then, to the section of teaching.
23 THE COURT: No, I mean that's enough of the
24 qualifications, isn't it?
25 MR. GRIFFIN: Your Honor, I would move at this time

1 that Dr. Gavin be qualified as an expert.
2 THE COURT: In the field of?
3 MR. GRIFFIN: Diabetes.
4 MR. GARDNER: We continue our objection, Your Honor.
5 THE COURT: To his qualifications?
6 MR. GARDNER: Correct.
7 THE COURT: Do you want to voir dire him?
8 MR. GARDNER: No. I haven't heard anything about the
9 facts or data he relied upon; therefore, I haven't heard a basis
10 for the admissibility of his opinions.
11 THE COURT: The first step is to qualify him as an
12 expert in the field of diabetes, to render opinion testimony in
13 that area. And he is qualified to render opinion testimony, and
14 the objection is overruled.
15 MR. GRIFFIN: Thank you, Your Honor.
16 BY MR. GRIFFIN:
17 Q. Now, I want to ask you about the foundation of your opinions
18 in this case. I would like for you to share with the jury, if
19 you would, the types of patients you have assisted in the many
20 years that you have been a person with expertise in diabetes.
21 A. Over the years of my medical career I have assisted, and
22 that is to say, been responsible for the direct management of,
23 have been responsible as a consultant for, or had otherwise
24 interactions with a full spectrum of patients; patients with
25 Type I diabetes, patients with Type II diabetes, who have

1 actually spanned the age ranges, all the way from age 14 to 84.
2 People who have been involved in all walks of life, from
3 students to people who have been workers, construction workers
4 for skyscrapers, or people who have worked as cattlemen and
5 ranchers. And consulted with patients who have been mountain
6 climbers, or people who have done exotic kinds of things of that
7 nature; high-risk patients, patients who have really been really
8 challenged to achieve better control of their diabetes.
9 And so I've done that in a variety of settings and in a
10 variety of ways over the last 35 years.
11 Q. Have you assisted patients like that in the numbers of
12 hundreds and thousands over your career?
13 A. Certainly I would say in the thousands. By now that
14 certainly has crossed that threshold.
15 Q. Do you regularly discuss with those who you are assisting
16 their day-to-day activities and their job functions in
17 connection with their diabetes?
18 A. Well, certainly. And that has always been an element of
19 care. And even now, in the work that we do with Healing Our
20 Village, with our company, where the patients who are referred
21 to our company who are really having a difficult time getting to
22 their diabetes targets, which is why the health plans send them
23 to us in the first place. And in fact, we do work over at
24 Chartered Family Health Clinic here in Washington.
25 It's important to know, what are obstacles that might

1 interfere with those patients getting to those treatment goals,
2 and so we have to talk to them about what their day-to-day
3 issues are in their jobs, in their homes, and our wellness
4 coaches in fact are instructed to gather that information. And
5 much of that information is conveyed to me if it's thought to be
6 relevant to improving their health outcomes.
7 Q. Is it fair to say, Dr. Gavin, that your patients range in
8 terms of their jobs and daily activities, those who are
9 sedentary to those who have the most arduous and strenuous jobs?
10 MR. GARDNER: Objection. Leading.
11 THE COURT: It is leading.
12 MR. GRIFFIN: Let me rephrase the question.
13 BY MR. GRIFFIN:
14 Q. Give the jury a flavor of the types of patients you have
15 helped, in terms of the relative sedentariness or activeness of
16 their jobs.
17 A. Well, I would simply say that the range of physical activity
18 that -- job-related physical activity that patients that I have
19 been directly involved with or consulted upon, those levels of
20 activity have run the gamut. They've gone all the way from are
21 very sedentary, people who did very little on a day in/day out
22 basis --
23 THE COURT: Like judges?
24 THE WITNESS: I think judges have a very strenuous
25 level --

1 THE COURT: Maybe. But sedentary.
2 MR. GRIFFIN: At least this week.
3 A. To people who literally are working 14-hour days under
4 conditions where they're doing really heavy lifting, very
5 stressful kinds of activities; to people, as I mentioned, the
6 group that I consulted with in Portugal as part of our
7 international activities, that had climbed many of the highest
8 peaks in the world, including Mount Kilimanjaro. And that gets
9 to be pretty heavy duty.
10 Q. And were you able to assist them in determining whether
11 their diabetes would interfere with any of those arduous tasks?
12 A. Well, this has always been part of the topic of whatever the
13 discussions and interactions have been; that is, to basically
14 talk about what they needed to do, or what were they doing,
15 sometimes just to affirm that they were doing the right things,
16 to make sure that diabetes did not serve as an impediment to
17 doing what they were doing in a fashion that was going to be
18 safe and healthy for them.
19 Q. And were they able to attain those goals?
20 A. Well --
21 Q. As mountain climbers?
22 A. I would say, Mr. Griffin, that as a matter of, course in the
23 overwhelming majority of cases, okay, and this is across the
24 spectrum of all those kinds of patients that I've just been
25 alluding to, in those instances where they have been willing to

1 make the kinds of sacrifices, to do the things that they were
2 taught and instructed and assisted in doing to achieve control
3 of their diabetes, when they've been willing to make that kind
4 of sacrifice and do that work, they have actually performed in
5 outstanding fashions, and to accomplish goals that they've set
6 for themselves, in addition to doing what they've been expected
7 to do on their jobs.
8 THE COURT: Mr. Griffin, would you proceed to the
9 opinion in this case, please?
10 BY MR. GRIFFIN:
11 Q. Dr. Gavin, will you share with the jury what you were asked
12 to do in this case?
13 A. Well, I was asked to come in the case of Jeff Kapche, to
14 comment on two things; one, did he have a disability under the
15 terms that had been set forth defining disability; and two, was
16 he qualified to do the job as an FBI agent.
17 Q. And were you -- did you have an opportunity to review a
18 large amount of paperwork from the FBI as to his rejection by
19 the FBI and the documentation of the FBI's witnesses and other
20 documents relating to the FBI's branding him as disqualified?
21 A. I reviewed a number of documents, which included documents
22 related to his examinations, documents related to depositions
23 that were taken from one or another person, and then memos
24 related to why he was felt to be not qualified.
25 Q. Did you rely on the FBI's own examining board-certified

1 internal medicine doctor, who declared him qualified for
2 worldwide duty?
3 MR. GARDNER: Objection. Leading.
4 THE COURT: Sustained.
5 BY MR. GRIFFIN:
6 Q. What did you rely on in terms of documentation that the FBI
7 had prepared in connection with its decision to reject him as an
8 agent?
9 A. Well, since I was asked to comment on the issue of whether
10 or not he was qualified to be an agent, and I assume that to be
11 medically qualified, I had to depend on the input from the
12 examining physician. And in this case I relied on the fairly
13 extensive physical examination and historical record that had
14 been obtained by the examining physician on behalf of the FBI.
15 Q. And are you able, because of your education and experience
16 and expertise, to assist the jury in sharing your opinion as to
17 whether or not Jeff was qualified for the job?
18 A. I think I'm comfortable in saying that I think I agree with
19 the FBI's examining physician in that regard, that he appears to
20 have been fully qualified to assume the responsibilities that
21 they were vetting him for.
22 Q. Do you have an opinion on whether he was trained by his
23 education and experience for the job?
24 THE COURT: I don't think he's got any expertise about
25 that.

1 BY MR. GRIFFIN:
2 Q. Let me just ask you this --
3 THE COURT: He's been medically qualified. I think
4 that's the limits of his expertise.
5 BY MR. GRIFFIN:
6 Q. But in any event, medically, you felt that he was qualified?
7 A. I had to agree with the examining physician in that case.
8 Q. Dr. Gavin, in terms of the expertise of people, the jury has
9 heard that Dr. Burpeau was a board-certified internal medicine
10 physician. Would you please share with the jury what a
11 board-certified internal medicine physician is?
12 THE COURT: Irrelevant. Move on. We've been over that
13 many times.
14 BY MR. GRIFFIN:
15 Q. Let's turn, then -- let me just ask you, if you would,
16 there's some terms that we have been talking about during the
17 trial, and I'm going to -- can you see those okay, Dr. Gavin?
18 A. Yes, I can see them fine.
19 Q. We've prepared an aid for the jury, a demonstrative aid.
20 And I would ask if we non-doctors have done a good job of
21 putting definitions for some of the many terms that have gone
22 around in this case.
23 A. This appears to have been put together quite nicely. There
24 are a couple of things that you would need to add. For example,
25 next to DKA, for diabetic ketoacidosis, where you have

1 "Treatment: Insulin," you really have to say "Treatment:
2 Insulin plus fluids." The dehydration that you get in diabetic
3 ketoacidosis is one of the most dangerous consequences of that
4 condition.
5 Q. Sure.
6 A. But other than what, the rest of this is pretty much okay.
7 MR. GRIFFIN: Your Honor, may we publish this to the
8 jury?
9 THE COURT: "Pretty much okay"?
10 THE WITNESS: It's accurate. I'm sorry.
11 THE COURT: Yes, you can publish it.
12 MR. GRIFFIN: Thank you.
13 BY MR. GRIFFIN:
14 Q. Now, without going through a whole lot of talk with you, let
15 me just ask you, is anything in the history that you had for
16 Jeff Kapche, that he ever has had any of the problems with the
17 bottom three issues that sometimes confront people with
18 diabetes?
19 A. In the records that I reviewed that were available to me, I
20 can't see any indication that Mr. Kapche had experienced issues
21 with these problems. He was actually under extraordinarily good
22 control.
23 Q. Okay. Then let's move on. Let's turn to the issue of
24 whether Jeff Kapche's diabetes is a substantial limitation in
25 the major life activities of eating and caring for oneself when

1 compared to average members of the population who don't have
2 diabetes. Is that okay?
3 A. Okay.
4 Q. All right. And let me just ask you this: Can you tell the
5 jury whether that's so, that he does have substantial
6 limitations in the way he eats and cares for himself when
7 compared to an average member of the population who doesn't have
8 diabetes?
9 MR. GARDNER: Objection. Calls for a legal conclusion.
10 THE COURT: Well, it remains to be seen whether that's
11 the right law, but he's entitled to ask the question in that
12 form, and the answer will be captured in that little legal
13 capsule. We'll see how it works out.
14 Go ahead.
15 A. So, I would answer that question in the following way: When
16 compared to a person who does not have diabetes, Mr. Kapche is
17 subject to a number of severe limitations in terms of his eating
18 and the way he cares for himself.
19 In the first place, he doesn't have the prerogative to
20 simply eat what he wants when he wants. Everything has to be
21 calculated and planned because everything has consequences. He
22 doesn't have the luxury of simply engaging in physical activity,
23 doing exercise, or participating in what might be strenuous
24 leisure time activity without considering what the consequences
25 could be.

1 He can't just be sick, get the flu or get a cold.
2 There are specific rules that now have to be applied in order to
3 keep him from progressing into a more severe stage of physical
4 illness.
5 BY MR. GRIFFIN:
6 Q. Let me stop you right there. You mentioned a couple of
7 things, and I want to break those down. Let's first talk about
8 exercise and strenuous activity.
9 When Jeff want does do that, what does he have to do
10 when he starts or before he starts?
11 A. Well, in the first place he has to know what his starting
12 blood sugar is, okay. And then he has to assess, how much
13 activity is he going to engage in? Is it going to be a walk, is
14 it going to be a run, is he going to cycle, is he going to swim,
15 is he going to dance, for how long and at what level?
16 So he basically has to have some means of assessing
17 what that impact is going to be on his blood sugar level,
18 because now he has to decide, how much is he going to preload in
19 terms of taking enough additional carbohydrates if that's
20 necessary in order to keep from going low as a result of that
21 exercise.
22 And the risk of going low, that is, developing
23 hypoglycemia, is not just immediate or during the exercise, but
24 that risk is one that can exist for several hours afterwards.
25 So a person like Mr. Kapche has to be aware and

1 vigilant about the effects of strenuous physical exercise before
2 the event, during the event, and hours after the event. And he
3 really has to be taught how to monitor himself to prevent
4 adverse consequences.
5 Q. Does it take -- how much discipline does it take to maintain
6 good blood sugars in order to do the kinds of things that he's
7 done over the past 10 years of his life as a law enforcement
8 officer?
9 MR. GARDNER: Objection. Lack of foundation. Calls
10 for speculation.
11 THE COURT: Overruled. Overruled.
12 A. Well, I think I can comment on the question of what kind of
13 discipline is required for a person to achieve the levels of
14 control that I've seen displayed in the records that I've
15 reviewed for Mr. Kapche, whether he's in law enforcement or any
16 other thing that requires constant vigilance, decision making.
17 What I would tell you is, this is a person who has had
18 to be extremely attentive to details. He's had to be constantly
19 vigilant, he's had to be fastidious and very conscientious in
20 the way he has made decisions and applied the things that he has
21 been taught. Because you just don't get these kinds of outcomes
22 casually.
23 And so this is a kind of person that I would say
24 deserve our highest commendations. I mean, these are the kind
25 of people that we as diabetes physicians really cherish, in the

1 sense that these are the people who demonstrate that it can be
2 done, that if you use the tools that have been developed, apply
3 them in a way that's vigilant and fastidious, make that
4 commitment, do those sacrifices. Yes, it puts severe
5 limitations on many of the things that you do. But if you do
6 that, if you're willing to make those sacrifices, it is possible
7 to have these outcomes.
8 Q. Is that part of that discipline; for example, before going
9 out and exercising, that Jeff stick his finger with a lancet and
10 let it register on a blood glucose meter so he'll know what his
11 blood sugar is?
12 MR. GARDNER: Objection. Leading.
13 THE COURT: Yeah, you're just leading and leading.
14 MR. GRIFFIN: Let me ask a different question.
15 BY MR. GRIFFIN:
16 Q. In terms of the manner in which Jeff exercises compared to
17 the manner in which people who don't have diabetes, how is he
18 limited when compared to them in what he has to do before he
19 exercises?
20 A. Well, what I tried to indicate before is that, for somebody
21 like Mr. Kapche, it's not just a matter of, I think I'll go for
22 a run. He really has to now do a lot more planning, he has to
23 be a lot more thoughtful. There are many more rules that he has
24 to be observant of. He has to know -- I don't have to know what
25 my blood sugar is before I start an exercise program, but

1 Mr. Kapche does. He has to know whether or not he's going to do
2 mild, moderate, or heavy exercise. Is he going to do it for
3 20 minutes, 30 minutes, or an hour? All of those things become
4 extremely important as part of the calculus of how he's going to
5 now have to make decisions.
6 Start with monitoring the blood sugar, and then he has
7 to not only do that but he's got to make decisions about what
8 else is he going to eat, drink, when, and when he's going to
9 monitor some more.
10 Q. And what about times when he doesn't know what he's going to
11 be doing for the next couple of hours? How does he deal with
12 that?
13 A. In situations like that, remember that Type I diabetes is
14 not a condition from which you ever have a vacation. I mean, it
15 doesn't take breaks in the sense that you can relax at some
16 point and not be aware of the fact.
17 So when you are not -- when you don't know what you're
18 going to do, then what is assumed is that your baseline
19 treatment plan is in order and is able to keep you in a stable
20 condition. It's when you make a decision to do something else
21 that you have to make the adjustments.
22 Q. No worries. Even in unplanned activities, share with the
23 jury whether patients can check their blood sugar on an ongoing
24 basis to either take carbohydrates, Lifesavers, or insulin, as

25 necessary.

1 MR. GARDNER: Objection. Leading.
2 MR. GRIFFIN: I'll rephrase the question.
3 BY MR. GRIFFIN:
4 Q. What do patients do on an hourly basis or regular basis even
5 when they're undergoing different kinds of activities during the
6 day?
7 A. Well, if I go back to what I just mentioned, patients with
8 diabetes are able to do any of a number of things. I mean, they
9 can do whatever it is that they decide to do, as long as they
10 are willing to accommodate those decisions by putting in place
11 the kinds of actions that they have been taught and instructed
12 to do with respect to checking their blood sugars, supplementing
13 their carbohydrate or other nutrient intake.
14 Or in some instances they have to wait. For example,
15 if you want to take a snack and it turns out that your blood
16 sugar is already very high, you have to wait. You have to have
17 the discipline to wait until your blood sugar has been brought
18 down by, in some instances, a supplemental injection of insulin
19 before you can take that snack. You can't simply decide to do
20 it because you feel like doing it, and that's part of the
21 limitations that we're talking about.
22 Q. So are there times when a person with diabetes can't eat
23 when other members of the population can --
24 MR. GARDNER: Objection.

25 BY MR. GRIFFIN:

1 Q. -- under the circumstances you just described?

2 MR. GARDNER: Objection. Leading.

3 THE COURT: It is leading, and you've already got an

4 answer to that question. So why don't you just move on.

5 MR. GRIFFIN: Let me just move on to the chart, if we

6 might. And Garin, if you don't mind showing it to Dr. Gavin so

7 that he can look at it. And if you can't see it and need to

8 zoom in a little bit, let me know.

9 THE WITNESS: Can I move this screen just a little bit?

10 MR. GRIFFIN: I think you can. Right, judge?

11 THE COURT: Can he what?

12 MR. GRIFFIN: Can he move it closer to him, he asked.

13 THE COURT: Oh, sure. As close as you can, as you need

14 to.

15 BY MR. GRIFFIN:

16 Q. Have you reviewed the chart that talks about the limitations

17 of major life activities that's before you?

18 MR. GARDNER: Objection -- I'm sorry, objection.

19 Beyond the scope of Dr. Gavin's expert report.

20 THE COURT: I'm going to allow it. But I have one

21 problem with it, counsel, and that is the title in the upper

22 left-hand corner, which I'm going to take a moment to instruct

23 the jury on the subject of what is a limitation on major life

24 activities. Okay?

25 This doctor is going to -- has put together a chart of

1 things that he, in his view, I believe he's going to say, are
2 limitations on major life activities. The question of what is a
3 major life activity is a very serious, difficult question, and
4 in part it's going to be one that you're going to be required to
5 decide.
6 So putting this title on here that says, "Limitation of
7 major life activities" does not necessarily mean that any of
8 these things are major life activities. That's a subject we're
9 going to discuss later on.
10 So ignore the title that is on this chart.
11 Proceed, Mr. Griffin.
12 MR. GRIFFIN: Thank you.
13 BY MR. GRIFFIN:
14 Q. Dr. Gavin, I would ask you, when we talk about this chart,
15 to confine your answers to the major life activities of eating
16 and caring for oneself, if that's all right.
17 A. That's fine.
18 Q. Now, Dr. Gavin --
19 MR. GRIFFIN: May we publish this to the jury, Your
20 Honor?
21 MR. GARDNER: Your Honor, he hasn't testified to
22 everything that's in this document.
23 THE COURT: Have you reviewed this chart, Doctor?
24 THE WITNESS: Yes.

25 THE COURT: And are you prepared to testify about it?

1 THE WITNESS: I am prepared, Your Honor.
2 THE COURT: And the annotations on this chart of "yes"
3 and "not limited" and so forth are annotations that you approve?
4 THE WITNESS: I have reviewed and I approve of the
5 annotations for these categories.
6 THE COURT: You may publish it to the jury.
7 MR. GRIFFIN: Thank you.
8 BY MR. GRIFFIN:
9 Q. Now, Dr. Gavin, without belaboring these points, are all of
10 the facets that are listed on the left-hand corner in terms of
11 eating and caring for oneself, are these all substantial
12 limitations in the major life activities of caring for oneself
13 and eating?
14 A. These are all --
15 THE COURT: Subject to what I told the jury about what
16 is a major life activity.
17 MR. GRIFFIN: Subject to Your Honor's determining later
18 what are major life activities, that's right.
19 THE COURT: Your Honor's or the jury's. I'm not sure
20 who is going to decide that yet. This is a big, open question.
21 MR. GRIFFIN: All right.
22 THE COURT: If possible, leave that major life activity
23 thing out of your question. It makes it easier.
24 MR. GRIFFIN: Okay.

25 BY MR. GRIFFIN:

1 Q. Then leaving it out of my question, are these limitations on
2 the left-hand side -- describe the severity or the seriousness
3 of those limitations.
4 A. Well, with respect to people with diabetes, issues related
5 to their eating and their day-to-day caring for themselves,
6 which includes things like physical activity, are major issues.
7 I can just speak to that as a person who has spent all of his
8 adult life in the area of diabetes.
9 Each of these really represents a major activity with
10 respect to what a person like Mr. Kapche has to deal with,
11 compared to, it says here, "average person in the general
12 population." But we're really talking about people who do not
13 have diabetes, or Type I diabetes.
14 It is absolutely essential that they exercise constant
15 vigilance on their blood sugar. You know, people without
16 diabetes don't have to worry about their blood sugar at all
17 because they have a functioning pancreas that actually checks
18 that on a minute-to-minute, second-to-second basis, and makes
19 adjustments for whether you eat a Twinkie or whether you eat a
20 mint or whether you take a bite out of somebody's sandwich. It
21 is done for you. People with Type I diabetes, like Mr. Kapche,
22 have to monitor that themselves because they don't have that
23 internal possibility.
24 Side effects of insulin. If you don't take insulin,

25 you don't have to worry about its side effects. And its

1 principal side effects, the one that we worry most about, is
2 going hypo, having low blood sugar.
3 Q. Slow down for a minute there. Does he have to be vigilant
4 24 hours a day to avoid what you just said?
5 MR. GARDNER: Objection. Leading.
6 THE COURT: Sustained.
7 BY MR. GRIFFIN:
8 Q. What does Jeff Kapche have to do to avoid what you just
9 talked about with the jury?
10 A. When I say constant vigilance, I said earlier that this is
11 not a disease from which you get a vacation. There are no
12 breaks. It doesn't take breaks. So the reason why we ask
13 people with Type I diabetes to monitor themselves on a very
14 regular basis, and people who are intensively controlled who are
15 taking multiple insulin injections, and people who achieve the
16 kind of results that I've seen with Mr. Kapche, are people who
17 are going to be checking themselves very frequently. They're
18 going to be checking themselves anywhere from five to sometimes
19 10 times a day.
20 Yes, that kind of daily vigilance is required.
21 Q. Well, in order to save time, since this is a demonstrative
22 aid, I'm going to ask you to consider the side effects from
23 insulin, the multiple blood tests each day, the limits on
24 quantities and quality of food, adjusting food for insulin

25 exercise, adjusting exercise for insulin diet, adjusting insulin

1 for exercise and diet, monthly/quarterly doctor visits, adjust
2 math conversions insulin during illness and exercise, and
3 carbohydrate counting and insulin calculation.
4 Do you see all of those?
5 A. Yes.
6 Q. Tell the jury whether or not those limitations with respect
7 to Jeff Kapche are substantially limiting.
8 MR. GARDNER: Objection. Calls for a legal conclusion,
9 Your Honor.
10 THE COURT: Counsel, I think the question is: Does
11 Jeff Kapche have to do these things that other members of the
12 population don't have to do? That takes it out of the legal
13 question, puts it in a factual question, and permits this
14 witness to answer with his full expertise.
15 MR. GRIFFIN: Do you mind asking that one more time?
16 THE COURT: I'll ask it myself.
17 Doctor, you see this list of things on the left-hand
18 side of this?
19 THE WITNESS: Yes, sir, I do.
20 THE COURT: Are these things that Jeff Kapche has to do
21 because he's a Type I diabetic that average people in the
22 general population do not have to do?
23 THE WITNESS: He absolutely has to do those, Your
24 Honor.

25 THE COURT: Thank you, sir.

1 BY MR. GRIFFIN:
2 Q. Now, with respect to people with diabetes, tell the jury
3 whether all patients are as disciplined and have limited
4 themselves in the way that he has?
5 MR. GARDNER: Objection. Lack of foundation. Calls
6 for speculation, Your Honor.
7 MR. GRIFFIN: He's had a lifetime of experience
8 treating patients, Your Honor. Let me rephrase. Would that
9 help, Your Honor?
10 THE COURT: That would help me a lot, because I'm about
11 to sustain the objection to that. So why don't you go ahead and
12 rephrase the question.
13 MR. GRIFFIN: Good. I did good.
14 BY MR. GRIFFIN:
15 Q. In your last answer, were you considering Jeff Kapche as an
16 individual in the way he takes care of his diabetes?
17 A. Yes.
18 Q. Now I want to show you, finishing up, Dr. Gavin, I want to
19 show you Exhibit Number 7.
20 MR. GRIFFIN: If we could have that on the board. It
21 has previously been admitted. Am I right? Plaintiff's Exhibit
22 Number 7, which I believe has been previously admitted.
23 May I approach the witness?
24 THE COURT: Yes, sir.

25 BY MR. GRIFFIN:

1 Q. Dr. Gavin, have you reviewed Dr. Yoder's January the 11th
2 letter rejecting Jeff Kapche as a special agent?
3 A. Yes, I have seen this and reviewed it.
4 Q. All right. I would like you to go down to the paragraph at
5 the bottom. And I would like for you to share --
6 First of all, if you don't mind, read what Dr. Yoder
7 has said about requirements for unstable and irregular working
8 hours.
9 A. It says here, "Requirements for unstable and irregular
10 working hours with prolonged or nontraditional shifts with
11 unpredictable access to food, water, or medical assistance
12 significantly interferes with the tight control needed to
13 prevent disease progression."
14 "Attempting to maintain tight control when food
15 portions and timing cannot be judged accurately increases the
16 risks of hypoglycemic episodes. Such individuals are normally
17 restricted from those situations which would place them or
18 others at increased risk."
19 Q. I would like for you to share with the jury whether the
20 statements made by Dr. Yoder about nontraditional shifts and
21 unpredictable access to food, whether those statements are
22 accurate.
23 A. Well, what I would say --

24 MR. GARDNER: Objection. Lack of foundation.

25 THE COURT: Are you talking about accurate or whether

1 he agrees with them?

2 BY MR. GRIFFIN:

3 Q. Do you agree with it? I would like to ask that question:

4 Do you agree with his statement, that they have to have

5 predictable -- what does it say?

6 A. I read this statement, Mr. Griffin. And what I would say is

7 that I don't agree with this because I think this reflects the

8 kind of thinking that was in place before people with Type I

9 diabetes had the kinds of tools and the kinds of instructions

10 that they have now, such that they can make adjustments to

11 different and difficult circumstances.

12 So the kinds of insulins that are available, the kinds

13 of monitoring that's available actually presents opportunities

14 to people with Type I diabetes to adjust to any of a number of

15 very different and difficult circumstances.

16 I talked about those mountain climbers. I spent time

17 with Will Cross, who climbed Mount Everest, and this is one of

18 the most arduous tasks. He did it twice. Okay? And he has had

19 Type I diabetes since he was nine years old.

20 So this kind of thinking, I think, is a bit outdated

21 with respect to what people with Type I diabetes are capable of

22 doing, and what I think Mr. Kapche has demonstrated his ability

23 to do by virtue of the record that he's written.

24 And so when it's concluded down here that "It's
25 incompatible with safe and efficient job performance," I cannot

1 agree with that, based on what I know about what's possible and
2 what I've seen in people that I've directly interacted with.
3 Q. Now let me ask you this: With the type of regimen that Jeff
4 has with his Lantus, does he need to have regularly timed meals?
5 A. No. When you have basal insulin, and this is the real
6 advantage that we have now with basal insulins, basal insulins
7 actually provide a background of insulin that keeps you from
8 slipping --
9 Q. Sure.
10 A. -- into ketoacidosis if you -- you know, at any time.
11 Because your body always needs some insulin.
12 But basal insulins are not really designed to cover
13 meals. That's why we have the rapid-acting insulins, or what we
14 call the prandial ones, the ones that you take when you know
15 you're going to eat something. And that's the advantage we have
16 now. You don't have to take those insulins until you know that
17 you're getting ready to have some food.
18 Q. Now, in the letter, the memo that Dr. Yoder wrote, read to
19 the jury what he wrote about how people with insulin-treated
20 diabetes, how restricted they are.
21 A. You're talking about in this next-to-last paragraph?
22 Q. Yeah, "Restricted from" --
23 A. "Such individuals are normally restricted from those

24 situations which would place them or others at increased risk."
25 Is that the sentence?

1 Q. Yes. Now, is that conclusion warranted, based upon what
2 Dr. Yoder says about regular meal times and that sort of thing?
3 MR. GARDNER: Objection.
4 BY MR. GRIFFIN:
5 Q. Do you agree with that?
6 MR. GRIFFIN: Objection, Your Honor. Cumulative.
7 THE COURT: I'll allow it. I'll allow the question,
8 whether he agrees with it.
9 BY MR. GRIFFIN:
10 Q. And I think the jury can -- let's see. Yeah, the last
11 sentence: "Such individuals are normally restricted from those
12 situations which would place themselves or others at risk."
13 A. In reading this sentence, I'm interpreting this as "those
14 situations," referring to the previous part of the paragraph,
15 where there might be some unpredictability of access to food.
16 And I think this is unwarranted as a concern in people who have
17 been taught how to make appropriate adjustments for periods of
18 less food access or more food access.
19 Q. And Dr. Gavin, were you able to see any evidence in the
20 record whatsoever that Jeff Kapche has some sort of a disability
21 in working?
22 MR. GARDNER: Objection, Your Honor. Calls for a legal
23 conclusion.

24 THE COURT: Sustained.

25 BY MR. GRIFFIN:

1 Q. Dr. Gavin, did you see anything in the evidence that
2 suggested that his diabetes would interfere in any way with his
3 working?
4 A. No, I didn't see any evidence of that. In fact, with
5 respect to the FBI's own conclusion, he was offered a job. And
6 this is a guy who's been involved in law enforcement for more
7 than a decade, so it would seem to me that he had demonstrated
8 quite adequately that he was quite capable of doing this kind of
9 work.
10 Q. Now, Dr. Gavin, let me ask you this: A person who is
11 restricted from high-risk or increased-risk situations, how
12 limited would they be in working law enforcement if they were
13 restricted from high-risk situations?
14 MR. GARDNER: Objection. Lack of foundation. Calls
15 for speculation.
16 THE COURT: I'm going to sustain the objection to that.
17 I think the testimony was supposed to be whether he was
18 medically qualified for the job and whether he was limited in
19 eating and caring for himself. I think this is outside the
20 boundaries of the --
21 MR. GRIFFIN: Your Honor, we have the burden of showing
22 that he is regarded as having a disability or had an actual
23 disability, and I want to finish up with the "regarded as" prong

24 of the statute.

25 THE COURT: The question isn't what he regards. The

1 "regarded as" thing has nothing to do with his view; it has to

2 do with the FBI's view.

3 MR. GRIFFIN: Fair enough. Let me then conclude with a

4 couple of questions.

5 BY MR. GRIFFIN:

6 Q. Among your years of experience in assisting patients with

7 the kind of discipline that Mr. Kapche has, how have they done

8 in their life's work?

9 MR. GARDNER: Objection. Relevance.

10 THE COURT: I'll allow it. But a short answer to a

11 short question. I think he's wrapping up here.

12 MR. GRIFFIN: I am.

13 A. Yeah. With respect to people who have had the discipline to

14 achieve the kinds of control that Mr. Kapche has achieved, they

15 have been outstanding performers in the work that they've done.

16 BY MR. GRIFFIN:

17 Q. And Dr. Gavin, are you being paid anything by anyone to be

18 here to lend your assistance to the jury?

19 A. No, I'm not being paid, and I did not expect to be paid,

20 because this is really something that's an important issue for

21 me. I come out of a background where I was always taught, if

22 you -- you've got to be twice as good to get the opportunities,

23 you've got to work twice as hard. And if you do make those

24 sacrifices and you put that kind of work in, you can get the
25 type of opportunities to do what your heart's desire is.

1 And for me, for people like Jeff Kapche, this is
2 precisely that kind of situation.
3 Q. Dr. Gavin, thank you very much.
4 THE COURT: Cross-examine?
5 CROSS-EXAMINATION
6 BY MR. GARDNER:
7 Q. Good morning, Dr. Gavin.
8 A. Good morning.
9 Q. It's nice to see you again.
10 Dr. Gavin, you don't do research on insulin pumps.
11 Correct?
12 A. No, I do not do insulin pump research.
13 Q. You haven't done any research comparing, say, the relative
14 efficacy of pump therapy versus multiple daily injection
15 therapy. Correct?
16 MR. GRIFFIN: That's beyond the scope of his direct.
17 THE COURT: He's trying to find out the boundaries of
18 his expertise. That's allowable. It's cross-examination.
19 A. Would you repeat that question, please?
20 BY MR. GARDNER:
21 Q. Of course. You haven't done any research comparing the
22 relative efficacy of pump therapy versus multiple daily
23 injection therapy?

24 A. No, that has not been research that I have been directly
25 involved in.

1 Q. You don't consider yourself to be an expert on insulin
2 pumps. Correct?
3 A. No, I would not call myself an expert in that area.
4 Q. And you've never treated any FBI special agents before. Is
5 that right?
6 A. Not to my knowledge. If they were, they didn't confide that
7 to me.
8 Q. They were incognito?
9 A. Yes.
10 Q. And you've never treated anyone in federal law enforcement.
11 Correct?
12 A. Again, not that I am aware of.
13 Q. Now, Dr. Gavin, on direct examination you offered certain
14 opinions about the burdens that Jeff Kapche faces as a diabetic.
15 Correct?
16 A. Yes, I did.
17 Q. And I think there was a handy-dandy demonstrative.
18 Now, Dr. Gavin, if I were to change where it says,
19 "Jeff Kapche," and I were to substitute the word "Type I
20 diabetic," would any of the answers on this middle column
21 change?
22 A. Well, let me just make sure I'm clear on what the intent
23 would be. If the intent would be to ask whether or not,

24 compared to a person without Type I diabetes, would all of these
25 factors that are listed over here still constitute serious or

1 severe limitations in terms of how they have to eat and care for
2 themselves?
3 Q. Correct.
4 A. That would be true.
5 Q. Okay. So in other words, your opinion in this case,
6 Dr. Gavin, about the burdens and limitations relate to those
7 that insulin-dependent diabetics in general face. Correct?
8 A. Well, let me qualify this. It's one thing to talk about
9 burdens. Burdens actually play out when people do them. Okay?
10 Expectations are what we have in terms of what we hope people
11 will do.
12 In Mr. Kapche's case, these are the kinds of things
13 that, in order to achieve the results that he has achieved, that
14 he has done, that he has engaged. And in that sense, it's a
15 burden because those have been the realities of his life.
16 Quite frankly, if all Type I patients did like
17 Mr. Kapche, I think everybody in diabetes would be one happy set
18 of campers.
19 Q. Let's explore that a little bit. You've never met
20 Jeff Kapche before. Correct?
21 A. No, I've only reviewed his records and had discussions about
22 Mr. Kapche.
23 Q. You've never conducted a clinical exam of Jeff Kapche.

24 Correct?

25 A. That is correct. I've only reviewed the examinations that

1 are entered by the FBI's examining physician.

2 Q. Okay. You also reviewed, I think, some glucose logs that

3 the plaintiff's attorney, Mr. Griffin, provided to you.

4 Correct?

5 A. Yes, I did review glucose logs. And I don't know whether

6 those were provided by Mr. Griffin or part of the records that

7 I...

8 Q. Someone --

9 A. Somebody provided them, yes.

10 Q. -- provided those to you?

11 And those glucose logs that you looked at, that was for

12 a three-month period. Correct?

13 A. I can't tell you for exactly how long, but it was for a

14 substantial period of time.

15 Q. In fact, it was actually for a three-month period of time.

16 Correct, Dr. Gavin?

17 A. I would have to look at the records, to tell you the truth.

18 Q. Let me see if I can refresh your recollection.

19 Dr. Gavin, do you recognize those as the glucose logs

20 that the plaintiff provided to you?

21 A. I do recognize these glucose logs.

22 Q. And am I correct that these glucose logs are for a

23 three-month period between April 1st, 2006, and June 30th, 2006?

24 A. That is what these records reflect.

25 Q. And those were the glucose logs that you had at the time you

1 offered your opinions. Correct?

2 A. These certainly were among them. Whether there were more,

3 again, I would have to have --

4 Q. Sitting here today, you have no recollection of other

5 glucose logs that you were provided?

6 A. I couldn't -- I didn't really recall -- other than seeing a

7 flow of numbers that reflected this kind of control, I can't

8 tell you how many others I might have seen.

9 Q. Now, Dr. Gavin, when you talk about the control and

10 discipline that Jeff Kapche has exhibited, what document, since

11 you've never met Mr. Kapche or conducted a medical exam of

12 Mr. Kapche, what are you relying on for that conclusion?

13 A. There are three elements that we would use to make that kind

14 of judgment about a person with Type I diabetes like Mr. Kapche:

15 One is the numbers that we just went through, what the flow of

16 those numbers look like, which reflect the number of times that

17 he was monitoring and faithfully capturing that information;

18 two, whether or not there was, by history now - we're talking

19 about over a longer period of time - whether there was an

20 absence of recorded events that would reflect the absence of

21 that kind of discipline. Namely, did he have episodes of

22 diabetic ketoacidosis? Did he have episodes of known

23 hypoglycemia? Were there times when his hemoglobin A1c levels,

24 which would capture now longer periods of time of average blood
25 sugar control, were there times when those numbers were clearly

1 out of target?
2 All of those are elements that we would look at.
3 Q. If I understand you, the basis for your conclusion that
4 Jeff Kapche is particularly disciplined, and therefore
5 particularly burdened, is the three months of glucose logs, the
6 absence of any records, and his A1c levels. Is that correct?
7 A. His A1c levels, the absence of any history of events that
8 signify erratic or poor control. Those would be the bases, yes.
9 Q. So those three things.
10 Now, just so I understand this, when you say on
11 direct -- and I want to make sure I'm not mischaracterizing
12 this. Did you testify on direct that it's your opinion that
13 Jeff Kapche particularly or specifically has the burden of
14 dealing with all of the things identified in this plaintiff's
15 demonstrative, which is number 11?
16 A. Let me see if I can repeat what I said, to make clear what I
17 was trying to convey. You asked if you substituted
18 Jeff Kapche's name for anybody with Type I diabetes.
19 Q. Correct.
20 A. I said, with the proviso that you're talking about whether
21 or not these issues really represent a substantial or severe or
22 burden set limitations. It becomes a burden when you do them.

23 It's an expectation that we would levy on anyone with Type I
24 diabetes.
25 So the fact that he is a person who has given evidence

1 of having done them, then that would allow me to say that he has
2 the burden of having these things.
3 Q. Let me see if I can tighten it up little bit. I apologize.
4 You say multiple blood tests each day. Do you know how
5 many times Jeff Kapche tests his blood every day?
6 A. Do I know how many times a day?
7 Q. Correct.
8 A. I don't know how many times he does each day, but on the
9 glucose logs he was doing at least four.
10 Q. Actually, sometimes three, according to those glucose logs.
11 Correct?
12 A. Sometimes three.
13 Q. Okay. And in your experience, Dr. Gavin, it takes just
14 about under a minute to test your blood glucose. Correct?
15 A. It may take a minute. Sometimes it may be more.
16 Q. Are you aware that Jeff Kapche, it takes him approximately a
17 minute each time to test his blood glucose?
18 A. I was not specifically aware of that, but I would presume
19 that if he's using the usual approaches, that that would be what
20 he would encounter.
21 Q. So the burden to Jeff Kapche, if we're right that three to
22 five times a day is somehow indicative, that burden then is

23 three to five minutes a day for that particular subset. Right?
24 A. If you think about this, Mr. Gardner, as a burden only in
25 the sense that, oh, it's just an activity that takes a minute.

1 But looking at this through the eyes of a person who has worked
2 with and interacted with people with diabetes, it's not just a
3 test. It really is an assessment of where you stand with
4 respect to your basic, you know, metabolic condition right
5 there.
6 Because it's not just the generation of a number, it's
7 a number upon which you may need to take some action. So...
8 Q. And that assessment, that testing and then the assessment,
9 that's something that all Type I diabetics are burdened with.
10 Correct?
11 A. That's something that all Type I diabetics are expected to
12 do. Not all of them do it.
13 Q. Sure. Of course not. But for those that comply, get in
14 line, that's the burden that all Type I diabetics face.
15 Correct?
16 A. That is correct.
17 Q. Now, do you know whether Jeff Kapche actually goes monthly
18 or quarterly to the doctor?
19 A. I don't know what the frequency of his visits...
20 Q. So with respect to the burdens for Jeff Kapche personally,
21 this would be an example of one where you're just talking about
22 the general burden of a compliant Type I diabetic. Correct?

23 A. I'm talking about a person, that is correct, who has had
24 regular assessments by their physician which include the
25 determination of, for example, their A1c, which would be done in

1 the context of a physician visit.
2 Q. Sure. Now, the carbohydrate counting and insulin
3 calculation, is it fair to say that if you generally eat the
4 same foods routinely, the carb counting is much more easy or
5 routine than if you're constantly eating new foods?
6 A. That is correct. If you have a routine, yes.
7 Q. Do you know if Jeff Kapche has a routine?
8 A. I don't know whether he has a routine.
9 Q. Now, you would agree, Dr. Gavin, that if a diabetic is
10 vigilant about counting their carbohydrates and taking their
11 insulin, that individual has some flexibility as to what they
12 can eat?
13 A. Yes, that's a correct statement.
14 Q. I mean, assuming one has an unlimited amount of insulin and
15 is testing their blood glucose and has properly counted their
16 carbohydrates, there's nothing that is per se off limits to a
17 diabetic. Correct?
18 A. Nothing that would be off limits, as long as they're willing
19 to do the appropriate calculation, make the appropriate
20 adjustment, and know what those numbers really mean.
21 Q. Sure. And of course, that process is easier if you're
22 eating the same types of foods day in and day out. Right?

23 A. That would be.

24 Q. And, for example, I mean, foods that are good for everyone

25 are also good for diabetics. Right?

1 A. That's what we teach, yes.

2 Q. And like the general population, Type I diabetics should eat

3 a well-balanced, low-fat diet, in the optimal world. Right?

4 A. Well balanced, limited in fat. But in people with Type I

5 diabetes, there are other considerations about their diet. It

6 depends on what their level of activity is overall, what their

7 stage of life is, even.

8 Q. Now, you offered an opinion, Dr. Gavin, that Mr. Kapche is

9 qualified to perform the duties of an FBI special agent.

10 Correct?

11 A. I'm not sure that was a question that I was directly asked.

12 Q. Well, you said that he was qualified for the position.

13 Correct?

14 A. Well, I simply agreed that he was qualified based on the

15 record that I saw, the FBI's examining physician. I didn't

16 examine Mr. Kapche. The FBI's examining physician came to that

17 conclusion.

18 Q. So is your opinion in this case just, I agree with

19 Dr. Burpeau?

20 A. I agree based on the record that Dr. Burpeau generated, and

21 on the basis of the other materials that accompanied

22 Mr. Kapche's files.

23 Q. I see. Now, you mentioned that, with respect to your

24 patients, the importance of knowing the day-to-day job

25 requirements that your patients have to face, because that's

1 going to implicate their treatment management. Correct?

2 A. It would implicate the kinds of instructions that those

3 people get about the adjustments that they need to be sensitive

4 to.

5 Q. And so that you can properly provide counsel or advice to

6 your patients, you talk to the patients to understand what those

7 day-to-day activities might be. Right?

8 A. That is correct. When you're trying to set up a treatment

9 plan, or when you're trying to determine whether or not the

10 person knows enough to make the kinds of adjustments that might

11 be required because of their job.

12 Q. And you would agree with me, Dr. Gavin, that without knowing

13 the particulars of a given job, you couldn't say whether, say,

14 the use of an insulin pump makes more sense than injections for

15 a particular job.

16 MR. GRIFFIN: Objection. Beyond the scope, Your Honor.

17 The objection is, he has not been offered to offer opinions on

18 the pump versus injections, long-term outcomes, and that is what

19 that question is directed to.

20 THE COURT: That's right.

21 MR. GARDNER: Your Honor, may we approach the bench?

22 THE COURT: No. I think that's right. Sustained.
23 BY MR. GARDNER:
24 Q. You agree that knowledge of the essential functions of an
25 FBI special agent would be important to you in giving you an

1 understanding of what the demands would be on a person like
2 Jeff Kapche with respect to his particular insulin therapy?
3 A. Knowledge of the job requirement for a person like
4 Mr. Kapche would be important for our discussion about the kinds
5 of adjustments that he would need to be prepared to make.
6 Q. Yeah. And let me be really clear about this. When you say
7 that you agree that Jeff Kapche was qualified, you are saying
8 that he is qualified, as a diabetic who uses injection therapy,
9 to perform a job as an FBI special agent. Correct?
10 A. I am agreeing with, one, the assessment that was made, which
11 I have no basis for disagreement with, that this was a man who
12 had been examined, his records had been examined, he had been
13 examined, and by somebody who was doing this on a fairly regular
14 basis, I assume, he was found to be qualified.
15 I had no basis upon which to disagree with that
16 assessment. And here was a man who had been involved in the
17 direct conduct of law enforcement activity for over a decade
18 already. So...
19 Q. Let me see -- and if my question wasn't clear, let me try it
20 again.
21 It's your opinion, as I understand it, that Jeff Kapche

22 is qualified to perform the functions of an FBI special agent on
23 his insulin injection therapy. Correct?
24 A. It is my opinion that, on the treatment program that
25 Mr. Kapche is on, given the results that Mr. Kapche has

1 achieved, that he is -- I agree with the assessment that he is
2 qualified that was made by the physicians who had examined him.
3 Q. And by qualified, you mean medically qualified?
4 A. Medically qualified.
5 Q. Okay. Perfect. Perfect.
6 Now, you say you had no basis to disagree with
7 Dr. Burpeau. Correct?
8 A. About his medical qualification.
9 Q. Do you know what Dr. Burpeau's background is?
10 A. He is -- from the record is what I know, and from his
11 deposition, he's a board-certified internist.
12 Q. He's not an occupational medicine physician. Correct?
13 A. There was no indication of that.
14 Q. And you don't have any personal understanding, Dr. Gavin, as
15 to Dr. Burpeau's understanding of the essential functions of an
16 FBI special agent. Correct?
17 A. Well, I can only answer that, Mr. Gardner, in the following
18 way: As I read the record that was generated by Dr. Burpeau, he
19 was, as I understand it, contracted by the FBI to examine people
20 for the express purpose of determining whether or not they were
21 qualified for duty as an FBI agent, whether it's a special agent

22 or some kind of other agent.

23 So the presumption that I think was not unreasonable on

24 my part was that, given that expectation of him, given the fact

25 that he had been doing that for some time, that he would be in a

1 position to know what the qualifications were to declare

2 somebody medically qualified for that role.

3 Q. Is it your understanding, Dr. Gavin, that Dr. Burpeau's

4 determination is a preliminary determination that ultimately has

5 to be reviewed at FBI headquarters?

6 A. Logistically, I can't tell you that I knew anything about

7 what the logistical --

8 Q. So you don't know whether Dr. Burpeau's conclusion is a

9 tentative conclusion, a final conclusion, or any other type of

10 conclusion?

11 A. I only knew that Dr. Burpeau's conclusion was a medical

12 conclusion about qualification.

13 Q. And to be clear, Dr. Gavin, you don't have an understanding

14 of what the essential functions of an FBI special agent are.

15 Correct?

16 A. That is correct.

17 Q. You've never studied the specific job functions that an FBI

18 special agent is required to perform?

19 A. No, I have not.

20 Q. Okay. And you haven't really thought, Dr. Gavin, one way or

21 the other about the different job functions that would weigh in

22 favor of one therapy, meaning pumps or injections, over the
23 other therapy?
24 MR. GRIFFIN: Objection, Your Honor. That's again
25 comparing different kind of therapies.

1 THE COURT: Same ruling.
2 BY MR. GARDNER:
3 Q. And you agree, Dr. Gavin, that in order to quantify the
4 magnitude of the risks associated with a particular job, you
5 need to know the functions of that particular job?
6 MR. GRIFFIN: Your Honor, he's not been offered on
7 direct threat either. We object.
8 MR. GARDNER: Your Honor, can we side-bar?
9 THE COURT: No. Sustain the objection. I think you've
10 gotten that answer two or three different ways, counsel.
11 Sustained. Move on.
12 BY MR. GARDNER:
13 Q. Now, you agree, Dr. Gavin, it's more challenging for a
14 Type I diabetic to manage his or her diabetes when that
15 individual has demanding and unpredictable job responsibilities?
16 A. It is more demanding for a person with Type I diabetes when
17 there is unpredictability with respect to eating and physical
18 activity, which is why they really have to understand the
19 principles of diabetes management, the balance between insulin
20 intake, food intake, and physical activity.
21 Q. And because of that, it may in fact require changing the

22 amount of foods that an individual eats. Correct?

23 A. People with Type I diabetes are in fact instructed

24 concerning those kinds of adjustments.

25 Q. Or changing the amount of insulin that individual takes?

1 A. Same principle.

2 Q. Or even changing the frequency or the timing of the

3 monitoring that a diabetic does. Correct?

4 A. That's exactly the kind of thing that they are taught to do,

5 and that, if they're vigilant, they will follow.

6 Q. Now, by the way, I neglected to ask you this, Dr. Gavin. Do

7 you know how many shots, injections, Mr. Kapche takes a day?

8 A. I am not familiar with what his routine is. I know he is on

9 basal bolus, and by that I would expect that he's taking at

10 least one shot of basal insulin, and that his bolus insulins,

11 that is, the ones that are used to cover his meals, would really

12 depend on how many times he's eating and making the decision

13 that he needs to take the --

14 Q. But the bottom line is, you don't have any sort of general

15 sense. Correct?

16 A. No.

17 Q. Now, you mentioned in your direct testimony these

18 long-acting insulins, and I think you mentioned Lantus insulin?

19 A. I didn't mention Lantus, I mentioned basal insulin.

20 Q. Basal insulin, thank you. And can you describe for me the

21 types or the brand names of these basal insulins?

22 A. Yes. There are two insulins that are considered classical,
23 if you will, basal insulins. And by that we're talking about an
24 insulin that you can give one time and it doesn't have a peak,
25 okay, it has basically what we call a square wave: It gets up

1 to a certain level, and that level is maintained for a period of
2 up to 24 hours, and that's in order to do what your own pancreas
3 does for you.
4 Your own pancreas is always secreting insulin, even
5 when you're not eating. That's called basal or background
6 insulin. And that's what the basal insulins do, and those are
7 Lantus insulin, or insulin glargine, is the generic name; Or
8 Levemir insulin, which is detemir, which is the generic name.
9 Now, those are the two that have that square wave kind
10 of issue. People have used -- clinicians have used MPH insulin
11 as a basal insulin, but that was before these others were
12 available. MPH was never designed to be a basal insulin. It
13 has a peak. It is long-acting, but it has a peak, and that peak
14 can occur any time, which was one of the problems with it.
15 So we've really made significant advances in protecting
16 people from the unpredictability of MPH as a basal insulin when
17 we were able to get to Lantus and detemir.
18 Q. Thank you, that was very helpful. I want to follow up on
19 with that. You said the unpredictabilities of MPH. What do you
20 mean, the unpredictability of MPH?
21 A. There is a measurement that you can make regarding insulin's

22 action in an individual, and it is the variability of when that
23 insulin is going to have its peak glucose-lowering effects.
24 Okay? And that peak occurs with MPH -- when given to the same
25 patient on different days at the same dose, that peak can occur

1 anywhere from two hours to eight hours to 12 hours. That's why
2 MPH was always such a problem as a basal insulin. You don't see
3 that kind of variability with Lantus or with Levemir.
4 Q. Now, in the 2004 time frame, Dr. Gavin, most of the studies
5 that analyzed injection therapy versus pump therapy compared it
6 with MPH insulin. Correct?
7 A. Many of them did. We were starting to see comparisons made
8 at that time with Lantus. Levemir wasn't around, but Lantus had
9 been studied for -- by 2004, Lantus had been studied for some
10 years.
11 Q. And to be clear, Lantus entered the American market in 2002.
12 Correct?
13 A. It entered the American marketplace in 2002. Studies on it
14 had appeared certainly well before that.
15 Q. And the detemir insulin, the other type of long-acting
16 insulin you referred to, that made its way into the American
17 marketplace in 2006. Correct?
18 A. That is correct.
19 Q. And as I understand it, Dr. Gavin, the studies in the 2004
20 time frame that were comparing this MPH injectable insulin to
21 pumps concluded that the pump was a superior method. Correct?

22 MR. GRIFFIN: Same objection, Your Honor.

23 THE COURT: That's three times, counsel.

24 MR. GARDNER: All right, Your Honor.

25 No further questions.

1 THE COURT: All right. Any redirect?

2 MR. GRIFFIN: No redirect, Your Honor.

3 THE COURT: Dr. Gavin, thank you, sir. That completes

4 your testimony. You're excused.

5 THE WITNESS: Thank you.