UNINSURED MOTORIST CLAIM

IN RE:

Robert McPherson,

vs.

Westfield Insurance Company.

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Deposition of DENNIS B. BROOKS, M.D., a witness herein, called for cross-examination by Robert McPherson, taken before Michelle A. Bishilany, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Dennis B. Brooks, M.D., 26900 Cedar Road, Beachwood, Ohio, on Thursday, the 13th day of August, 1992, at 4:22 p.m.

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APPEARANCES:

Willis & Linnen, by
Mr. Jerome T. Linnen, Jr.,

On behalf of Robert McPherson;

Davis & Young, by
Ms. Jan L. Roller,

On behalf of Westfield Insurance Company.

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(Exhibit 1 was marked for identification purposes.)

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DENNIS B. BROOKS, M.D.,

of lawful age, a witness herein, called for cross-examination by Robert McPherson, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. LINNEN:

Q. Doctor, I'm Jay Linnen. I represent Bob McPherson in this action which we have against Westfield Insurance Company.

I'm sure you've been through this process many times. I'm going to ask you a few questions about your background very briefly and then I'm going to conduct a discovery deposition about your examination of Bob McPherson,

If I ask you a question and you don't understand, of course, let me know. Give a verbal response for the court reporter.

How long have you been an orthopedic surgeon?

A. Good afternoon.

How long have 1 been an orthopedic surgeon?

21 years -- well, actually that's not true. I

finished my residency in 1968. 24 years.
Q. 24 years you've been an orthopedic surgeon?
A. Yes.
Q. Have you been engaged in a specific specialty in t ose 24 years?
A. No. I practice general orthopedics.
Q. Do you do surgery currently?
A. Yes.
Q. What types of surgeries do you do?
A. General orthopedic surgery.
Q. So you're not limited to any specific areas of he body?
A. If I were I would have told you.
Q. Okay. Approximately how many medical examinations do you perform a week for attorneys?
A. I don't really keep track of it so I can't tell you how many I perform per week for attorneys.
Q. All right. I'm not asking for a specific number, but approximately how many times a week do you find yourself examining patients for insurance companies or attorneys?
A. Again, I don't keep track of it so I can't tell you.
The only thing I can tell you is that I limit myself to three examinations on behalf of

defendants.

I also examine on behalf of plaintiffs, and I don't know how many of those, I don't have any limit on the number of those.

Q. So that's three examinations a week?

A. On behalf of the defendant, yes.

Q. Have you ever performed an examination for Mr. Eklund or his firm prior to Mr. McPherson?

A. Yes.

Q. Do you have a file concerning Mr. McPherson?

A. Yes.

Q. May I take a look at it?

A. Sure.

Q. Thank you.

What do you generally charge for a so-called independent medical examination?

A. I don't have a general charge.

Q. Well what do you charge for that service; do you know? I assume that you're getting paid?

A. I certainly hope that I'm being compensated for my time.

When I do an independent medical I don't have a flat rate fee for an independent medical.

Q. Well then do you charge an hourly basis?

A. Yes.

Q. What would your hourly basis be then?
A. At the present time?
Q. Yes.
A. $325 an hour.
Q. And you indicated that on occasion you perform examinations for plaintiffs?
A. Yes.
Q. I assume that's some type of independent examination at the request of the plaintiff's attorney?
A. Yes.
Q. Do you also -- on some of these independent medical examinations for attorneys do you also sometimes provide treatment?
A. Yes.
Q. So you examined Bob McPherson on May 28th of '92?
A. Yes.
Q. Approximately how long did the examination take, are you aware?
A. I don't know.
Q. No idea? All right.

Why don't we go through, we've previously marked as exhibit 1 your report which I believe you generated dated May 29th, '92.

I assume you've got, there was a copy I guess in your file, why don't you pull that out? We're going to skip over the history itself and let's go right to the physical examination that you performed and what complaints Mr. McPherson had on that date.

A. Whatever you'd like.

Q. Okay. What physical examination did you perform at the time of the IME?

A. Examined the cervical spine, his shoulders, his thoracic spine and his lumbosacral spine.

Q. Did you find any abnormalities with any of those areas of his body?

A. No, I did not find any abnormal objective findings with respect to any of those areas.

Q. Was there any indication of abnormal subjective findings?

A. Yes.

Q. What abnormal subjective findings did you discover?

A. There was limitation of cervical motion. There were complaints of pain with external rotation of the right shoulder.

There was decreased perception of pinprick in the left upper extremity. There was decreased perception of pinprick which extended from the

midline of the chest into the left upper extremity.

Extension was performed by walking up his thighs.

There was limitation of supine straight leg raising.

There was decreased perception of pinprick in the left lower extremity.

Q. Based on those subjective abnormalities did you draw any conclusions with respect to Mr. McPherson's condition? And from those findings did you make any conclusions that he had any abnormal condition?

A. I would never make any kind of conclusions based only on a physical examination.

Q. Okay. What other records did you take a look at?

A. I reviewed the emergency room record from Women's and Children's Hospital from March 24th, 1989; the radiographs that were obtained on March 24th, 1989; Chiropractor Shimmel's letter of March 3rd, 1990; Dr. Sveda's records, the period between May 18th, 1989 and May 25th, 1989; Dr. Lefkovitz's letter of August 14th, 1989; Dr. Lefkovitz's letter of June 13th, 1989; Chiropractor Fakhoury's, F-a-k-h-o-u-r-y, handwritten records; Dr. Smith's

letter of August 30th, 1990; Dr. Burke's letter of August 31st, 1990; Dr. Mann's letter of March 16th, 1992; and radiographs of the cervical spine obtained on January 8th, 1992.

Q. All right. Referring you to page four of your report. On the first paragraph you make an indication: Neurologic examination of the upper extremities reveal symmetrically depressed deep tendon reflexes. Can you explain that in laymen terms?

A. It meant that his reflexes were not active but they were depressed or not as active as the "average" is, but that decreased activity was present in each arm so that it was symmetrical.

Q. All right. If it's symmetrical does it cause any, does it raise any concern neurologically?

A. No. If it's symmetrical it does not raise any neurologic concern.

Q. Under any circumstances would that raise neurologic concern?

A. That's like asking me to define the universe and give examples.

Q. Then it ought to be easy.

A. It ought to be easy. I can't define the universe and give examples,

Are there any conditions where somebody could have symmetrically depressed deep tendon reflexes and that would be of concern neurologically?

I can't think of any.

Q. All right. How do you actually go about doing that; can you show me?

A. You want to come into the examining room? I mean, I can't believe you're asking these questions.

Take a little red rubber hammer and I put my finger over the biceps tendon and I palpate that. I also palpate the triceps tendon where it inserts into the ulna. And I also tap over the brachial radialis and the forearm.

Q. And from that you determined he had depressed tendon reflexes?

A. Yes.

Q. You also indicate that the left upper extremity had decreased perception to pinprick. And I think you're indicating because he's the one that tells you how it feels that that would be subjective?

A. That's correct.

Q. As a doctor does a doctor from time to time use subjective tests to make a diagnosis; yes or no?

A. No.

Q. Does he use that as one of the things in making a diagnosis?
A. Yes.
Q. And you also found symmetrically decreased deep tendon reflexes with the lower extremities and you didn't find that to be of any consequence; is that correct?
A. I can't answer that yes or no.
Q. And on your fourth page of your report the third paragraph down you could explain to me, you indicate that there was decreased perception of pinprick in the left lower extremity in a nonanatomic pattern. What do you mean by that?
A. May I answer it other than yes or no?
Q. Yes.
A. Thank you.

Each nerve root that leaves the area of the spine, and here we're talking about the lower part of the spine, the lumbosacral plexus, supplies a particular area of the body, and that's referred to as a dermatome or a myotome.

When an individual has a true problem or a true pathology with a particular nerve root as, for example, compression from a herniated disk or a tumor, and because of that compression there is lack

of conductivity down that nerve root, an examiner will pick up loss or decrease in perception of pinprick in a specific area.

Contrast that with Mr. McPherson's examination where he had a generalized decrease in perception of pinprick in his left lower extremity which was in a nonanatomic pattern. It didn't follow any nerve root distribution.

Q. Okay. There are more definitive neurological tests performed, I assume, such as the NCT and an EMG; would that be a correct statement?

THE WITNESS: Would you read back the question, please?

(Record read.)

A. There are additional neurologic tests other than those performed during a physical examination. I don't know whether they're necessarily more definitive or not.

Q. Would an NCT be more objective than your pinprick examination in your test of strength and so forth?

A. An NCT, a nerve conduction test, is more objective in that it measures certain parameters. But it is not the same test as my pinprick test which is the same as all doctors use, or my muscle

strength test.
Q. If a person complained of cervical pain in the cervical region and he was negative on an NCT and negative on EMG, is it still possible that he could have a disk problem of some kind?
A. I can't answer your question.
Q. What are the ways to make a diagnosis of a disk problem?
A. Where?
Q. In the neck.
A. Okay. Taking the patient's history, performing the physical examination. And then we've got to define what is a disk problem, I mean, I don't know what that means.
Q. How about if you have a patient that comes in and says he has a pain in the neck, how would you go about making that diagnosis as to what might cause that problem?
A. Okay. Somebody came in to see me and told me that they had pain in the neck, I would take their history, I would examine them and I would get some routine radiographs.
Q. What's a radiograph, an x-ray? Just a regular x-ray? Yes or no.
A. I can't answer that *yes* or no. Oh, yes, I

can answer that yes or no, The answer is no.
Q. What would be a radiograph?
A. Okay. A radiograph is,the film that's produced when you have a machine generate some x-rays. It's like the stuff that you get back from Fotomat when you take your film in for developing, okay? Those are called radiographs.
And I'd obtained some routine radiographs.
Q. What would be a routine radiograph?
A. The radiographs that I order routinely. I mean, I don't understand your questions.
Q. Are you talking about a regular -- are you talking about an x-ray that shows density of the bone?
A. I just explained to you that an x-ray is the thing that the x-ray machine generates, okay? A radiograph, hell, we'll pull out 8,000 of them, that's the picture you look at.
Q. That's the actual film?
A. That's right, and those are called radiographs.
Q. And that could be an MRI?
A. No, that's a radiograph.
Q. All right.
A. It's a regular, routine radiograph, okay?

Q. All right.
A. And you look at those. And there are standard ones of the cervical spine.
Now, if the patient says that they've got a pain in the neck and they've got a normal physical exam and their routine radiographs are normal, then I would have no explanation for what their pain in the neck would be from. And then you take all the various permutations from there on.
Q. Which would be what?
A. Well, let's assume they have a complaint of pain in the neck and they have nothing on physical examination but they have some degenerative disk disease on the routine radiograph, some narrowing of one of the disk spaces. Then I could say well, their pain in the neck is probably coming from their degenerative disk disease, That's a disk problem.
Q. What other methods do you use to make that diagnosis of a disk problem?
A. You use the methods that you need --
Q. Doctor, I understand this is very elementary to you, okay, but I'm going to pay you for this --
A. I don't care whether you pay me or not, and I'm not trying to give you a hard time. But you're asking me questions that I can't possibly answer.

Because a disk problem is so nonspecific, there's everything from degenerative disk disease through herniated disk.

Now if you ask me a specific problem I'm happy to give you a specific answer.

Q. All right. How would you make a diagnosis of a herniated disk in the cervical spine?

A. Okay. I would make the diagnosis of a herniated disk in the cervical spine by obtaining a history and specifically looking in the history for complaints of pain radiating down one arm or the other arm in a dermatomal pattern.

I would perform a physical examination. And during the physical examination I would look for findings which would indicate that there was a problem with one of the nerve roots specifically supplying one of the dermatomes.

Then I'd get some routine cervical radiographs. And those, in fact, might look normal. They might, on the other hand, show some evidence of degenerative disk disease. But the routine films wouldn't demonstrate whether or not the patient had a herniated disk.

Q. What would demonstrate 'that?

A. Well, wait, I haven't finished. Finally gave

me a question I could answer and then you cut me short. That's not fair.

And then I'd treat the patient nonoperatively, okay? And after a period of time if they didn't get worse then I'd start exploring whether, in fact, they had a herniated disk.

And in 1992 I would order an MRI of the cervical spine.

Q. Has Mr. McPherson had an MRI of the cervical spine?

A. Not that I'm aware of.

Q. Have you recommended that an MRI be performed?

A. No.

Q. Do you think that would lead us to any, I mean, do you think that would assist in making a proper diagnosis of the condition that he's experiencing with his cervical spine?

A. No.

Q. Why do you say that?

A. Because I don't believe that his complaints are on the basis of a herniated disk.

Q. What do you base that on?

A. The history that I obtained from him, the examination that I performed, the review of the

radiographs taken at the time of the accident and the review of the radiographs that were taken some three years later as well as the material that I reviewed.

Q. What's the difference between a herniated disk and a bulging disk?

A. A herniated disk in 1992 has almost become a wastebasket term. That is to say it is a term that is used with very little specificity.

There really is a spectrum of disk abnormalities that range from a bulge, which is akin to, best example -- which is akin to a tire that's got a little bubble on it.

The next more significant problem would be a protrusion where part of the nuclear material has left its confines within the center of the disk and is causing a little more protrusion of the posterior longitudinal ligament in the annulus.

The next more severe situation is an extrusion, whether it's an actual tear in the posterior longitudinal ligament and the annulus, but the nuclear material is still in contact with the nucleus.

And finally there's a sequestered piece of disk which is just like when you sequester a jury,

it's separated from the disk itself. And even with those findings the condition cannot be called a herniated disk unless the patient's symptoms and physical findings correlate with whatever's seen on the MRI.

Q. Can a bulging disk create a painful condition in the cervical spine?

A. Generally not.

Q. So generally a person would be symptom free if they had a bulging disk in the cervical spine?

A. Generally, yes.

Q. Because it's not coming in contact generally with the nerve ending or any nerves?

A. That's correct.

Q. What does it mean when a bulging disk, when you find bulging disk with tenting? Have you ever heard that terminology before?

A. I was going to say most bulging disks don't go out camping, but I don't know.

Q. Have you ever heard that phrase before?

A. No, I really haven't.

Q. Do you know Dr. Zelch?

A. Dr. Zelch is a radiologist, I know of him.

I'd be happy to read Dr. Zelch's report of the MRI that apparently has been obtained since I

examined Mr. McPherson.

MS. ROLLER: I was going to ask you, and this can be on the record, do you have an MRI or even a CT scan that I'm --

MR. LINNEN: I do. I assume you had it.

MS. ROLLER: I don't think, -- you examined him in May of this year, correct?

THE WITNESS: Right.

MS. ROLLER: This was July 1992.

THE WITNESS: I examined him in May of '92.

MS. ROLLER: Well, I have to tell you, Mr. Lemon --

MR. LINNEN: Linnen.

MS. ROLLER: Lennon, as in John.

MR. LINNEN: No, not as in John. As in cloth,

MS. ROLLER: Linnen?

MR. LINNEN: L-i-n-n-e-n.

MS. ROLLER: I should talk with a name like Roller.

In any event, Mr. Linnen, I'm here on behalf of Paul Eklund.

MR. LINNEN: I'm here on behalf of Mark Willis.

MS. ROLLER: And I can tell you that I'm aware that Paul Eklund does not have this, a report from the CT that -- oh, an MR of the cervical spine that was done at the Regional MRI Diagnostic Center on July 27th, 1992.

MR. LINNEN: What's your point?

MS. ROLLER: My point is that I would object to its use at the arbitration hearing. When is the hearing?

MR. LINNEN: I have no idea.

MS. ROLLER: Neither do I.

MR. LINNEN: I think it's first week in September.

MS. ROLLER: We have not --

MR. LINNEN: It might not have any significance, let's just give it to the doctor and see.

MS. ROLLER: Fine, let's give it to the doctor.

THE WITNESS: Off the record,

(Discussion had off record.)

MS. ROLLER: Do you have a report from this doctor or anybody --

MR. LINNEN: No.

MS. ROLLER: -- who ordered the MR; do you know?

MR. LINNEN: I'm not sure. I think maybe Lefkovitz did. They had trouble getting him in the tube originally.

MS. ROLLER: Yes, I saw that.

A. Okay.

MR. LINNEN: Can we mark this as an exhibit, 2?

MS. ROLLER: You wouldn't happen to have another copy, would you, so I can follow along?

(Exhibit 2 was marked for identification purposes.)

Q. Doctor, you've been handed what's been marked as Plaintiff's exhibit 2 --

A. Yes.

Q. -- which is or appears to be an MRI of the cervical spine of Bob McPherson. Is that what you have in front of you?

A. Yes, sir.
Q. All right. Dr. Zelch's conclusion: Bulging disks with tenting of the posterior longitudinal ligament at three levels. What significance, if any, does that have?
A. Before I answer your question I'd like to preserve the record and read what Dr. Zelch said in its entirety.
And he said: Bulging disks (2.0 mm) with tenting of the posterior longitudinal ligament at three levels.
The reason I do that is that a two millimeter bulge has no clinical significance, it does not cause any clinical symptoms. And there are a number of articles that refer to that point.
What he is saying, and I don't know why he's using the word tenting, but the posterior longitudinal ligament is a structure that is at the most peripheral portion of the disk.' And what he's saying is that there's a little bulge that's causing the posterior longitudinal ligament to stick out, look more like a tent.
Q. Okay. I take it that you've never seen that type of conclusion before?
A. Not with that word, that's correct.

Q. Neither have I.

Well, would it be accurate to conclude that Dr. Zelch believes that a disk is coming in contact with the posterior longitudinal ligament? I mean, what conclusion would you draw?

A. It is fair to say that Dr. Zelch is making the conclusion that the disk is coming in contact with the posterior longitudinal ligament. In fact, all disks come in contact with the posterior longitudinal ligament.

Q. All right. But we're not quite sure what he means by tenting?

A. No. Maybe we ought to ask him.

Q. Looking at the rest of the MRI of July 27th. Do you see any other abnormalities in the report or anything that you would conclude to be an abnormality?

A. I want to be perfectly clear that I've not had the opportunity to review this myself so I'm just reviewing his description of this.

But in the second paragraph he says on T-2 analysis there is ridge-like indentation of the subarachnoid fluid column at C-3, C-4 and C-5, and that's probably abnormal.

Q. If that's probably abnormal, has it been your

experience that that type of condition would create any type of painful condition for a patient?

A. Not necessarily. That's an indicator of some arthritis. And the ridge that he's talking about is just a little bit of bony proliferation.

You notice that he says indentation of the subarachnoid fluid column and doesn't even say indentation of the cord. So this ridge is so small that all it's doing is causing a little, if you will, scalloping of the fluid column.

Q. All right. Would this MRI finding be consistent with any of the symptoms or complaints that Mr. McPherson had when he presented himself to you for examination?

A. No.

Q. Doctor, what does -- if you could explain to me what myofascial pain syndrome is. I'm not trying to be facetious, I'm not sure what it is.

A. Right. And I'm not sure what it is either, and that's why I was hesitating, okay? It's another one of those wastebasket type of diagnoses.

I mean, you can dissect it all out. Myo refers to muscle. Fascia refers to the covering of the muscle. So myofascial pain syndrome.

So what in essence it says is that somebody

has a set of symptoms for which there are really no physical findings and we've got to give it a name so we call it a myofascial pain 'syndrome.

Q. Is it referring to some sort of a membrane or covering of the muscle itself?

A. Well, you're absolutely right in that the fascia is the membrane or the covering over the muscle. But when you talk about myofascial you're talking about the muscle and the fascia. I mean, in the old days it used to be called myofascitis, but now we've gotten more sophisticated and called it myofascial pain syndrome.

MS. ROLLER: I must be getting old.

THE WITNESS: That's right.

Q. Let me ask you: When somebody experiences a routine, what is referred to as like a soft tissue injury of the neck, a sprain or a strain of the neck, in a situation like that many times it seems like the patient complains of pain and yet nothing shows up on radiograph or any other diagnostic test, but yet they're still experiencing pain.

A. That's true.

Q. In a situation like that if you had a patient in a situation like that, what type of diagnosis

would you make, just a sprain, strain of the soft tissues and they're expected to recover?

A. For the most part, yes.

Q. Have you seen situations or have you seen cases, have you treated patients where they had a so-called soft tissue injury and continue to have chronic pain without objective symptoms that you believed to be real?

I mean, many times it seems like people question a patient where nothing shows up objectively but they continue to complain of chronic pain.

Are there situations in your opinion that this could actually occur without any objective disk problem or neurological problem where the patient actually does experience pain as a result of some disorder?

A. I'm not trying to be facetious either, but you've asked me three questions, okay? Now which one do you want me to answer, the last one?

Q. Why don't you answer the last one.

A. Okay. I can't remember what it was.

The bottom line is have I treated patients who have complaints of pain and have no objective findings --

Q. Right.
A. -- following some kind of soft tissue injury.
Q. That's it.
A. And the answer is yes, I will treat them for a short period of time and that short period of time maybe four weeks, maybe six weeks.
And if they continue to have complaints of pain and there's nothing that I can find after doing routine studies, maybe even some more sophisticated studies, then I would say to them there's nothing more I can do for you and suggest if necessary they see a psychiatrist to help them manage whatever kind of nonorganic problems they're having.
Q. What do you mean by nonorganic problems?
A. Well, nonorganic means that the cause of their pain is really not in their body structures. 1 mean, this may have been a very -- it may have had a large psychological impact on somebody for whatever reason, okay? And so what they're doing is they are, what's called somatocizing, they're taking emotional feelings that they have, anger because they were in this accident, anger because they've lost their job, you know, whatever, and converting that into physical symptoms for which there are no physical findings, So they need to be able to first

recognize that and then deal with these things in the appropriate forum.

Q. Well is it possible that the soft tissues have been damaged such as ligaments or possibly muscles that injury itself would not show up on an objective test of any kind?

A. It is possible that ligaments and muscles can be damaged and that damage not show up on any objective test.

Q. I had a physician down in Akron, I won't give you his name, but he indicated that every time you had some type of a strain on the cervical spine or any part of the back for that matter that your body never fully recovered, that you would be, you can be more susceptible to injury but that it was never going to be completely the same before the accident even though you might not have symptoms. Would that be, I mean, is that an accurate statement? Is that an accurate philosophy?

A. I think it's true that once you're injured you never are again normal because you've always, you have some even microscopic remnant of that injury. But that doesn't necessarily mean that you're more susceptible to injury. And it certainly doesn't mean that you can go back -- that you cannot

go back and do what you were doing before the injury.

I mean, I tore my quadriceps so look at my thigh, it's not normal; and yet I can do all the things that I did beforehand.

Q. Well these types of soft tissue injuries that nothing objective can be found to make a diagnosis and sometimes they're labeled, you know, myofascial pain syndrome; do you believe that that type of syndrome actually exists? Have you ever made that type of diagnosis, I guess?

A. No, I've never made that type of diagnosis.

Q. I guess what I'm tryihg to get at is: Can a person experience a real pain without there being some objective neurological or orthopedic finding?

A. We're going to limit your question to injuries to the musculoskeletal system, right?

Q. Right.

A. People can voice pain or make complaints of pain when there are no objective findings either on neurologic examination or orthopedic examination.

Q. I understand that. But in situations like that even though I think you said people can voice pain --

A. Make complaints of pain.

Q. -- are you saying make it up?
A. No. No. It hurts. Walk in and say I hurt, that's voicing or making a complaint of pain.
Q. But I guess what I'm trying to find out is whether there could be a real physical problem without some objective determination either neurologically or otherwise.
A. Well, again, what I tried to say earlier is that I believe that initially there may be a real physical problem without any objective findings, but sprains and strains heal, they get better.
Q. They always heal?
A. The kinds of injuries that we're talking about that are limited to the soft tissues, okay, always heal.
Q. Without any residual problems or pain?
A. I believe so.

MR. LINNEN: I have no further questions.

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

I, Michelle A. Bishilany, a Registered Professional Reporter and Notary Public within and for the State of Ohio, do hereby certify that the within named witness, DENNIS B. BROOKS, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 20th day of August, 1992.

Michelle A. Bishilany, Holland & Associates, Inc.
520 National City - E. 6th Bldg., Cleveland, Ohio
My commission expires 1-11-96.