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)
County of Cuyahoga.) - - -

IN THE COURT OF COMMON PLEAS

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CARL J. WILLIAMS, et al.,)
)
Plaintiffs,)
) Case No. 253,137
vs.)
)
MERIDIA HURON HOSPITAL, et al.,)
)
Defendants.)

- - -

DEPOSITION OF JOHN PAUL CONOMY, M.D.
Monday, April 1, 1996

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The deposition of JOHN PAUL CONOMY, M.D., a witness, called for examination by the Plaintiffs under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the state of Ohio, by agreement of counsel, at the offices of Reminger & Reminger Co., LPA, The 113 St. Clair Building, Cleveland, Ohio, commencing at 9:50 a.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

John A. Lancione, Esq.
Becker & Mishkind Co., LPA
Skylight Office Tower
1660 West 2nd Street, Suite 660
Cleveland, Ohio 44113

On behalf of the Defendant,
Meridia Huron Hospital:

James L. Malone, Esq.
Reminger & Reminger Co., LPA
The 113 St. Clair Building
Cleveland, Ohio 44114

On behalf of the Defendant, Dr. Boyd:

Anna L. Carulas-Moore, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114

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JOHN PAUL CONOMY, M.D.

A witness, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. LANCIONE:

Q. Would you state your full name for the record, Doctor.

A. My name is John Conomy.

Q. Doctor, you know the rules. If you don't understand a question I ask you, please tell me, and I will rephrase it *so* that we can be sure that you give an answer to a question you understand.

A. Yes.

Q. Doctor, you are a neurologist?

A. That's correct.

Q. Board certified?

A. Yes.

Q. When were you certified, Doctor?

A. In 1972.

Q. Doctor, could you tell me the nature of your current clinical practice?

A. I see patients on an outpatient schedule three

days per week. I see between 30 and 70 persons per week, depending on the nature of the schedule that week. I see patients in consultation and in hospital, as well.

I also do some administrative work in the medical group that I am in. I am the Director of the Office of Professional Affairs for Innova Medical Services.

Q. What hospitals do you currently have admitting privileges?

A. University Hospitals of Cleveland, Deaconess Hospital, Southwest General Hospital.

Q. Where is your clinical office where you see patients on an outpatient basis?

A. My primary office is at the Ridgepark Medical Building on Northcliff Avenue.

Q. This Health Systems Design at 75 Quail Hollow Drive, first of all, what is Health Systems Design?

A. Health Systems Design is a consulting corporation of which I am the president, the only employee, chief cook and bottle washer and cleaning service. It deals with all of those things that I do outside of the practice of medicine, particularly consulting work with medical institutions

and medical groups, teaching, writing, lecturing, and the occasional law-related work that I do.

Q. What percentage of your professional time is dedicated to the active clinical practice of neurology?

A. Approximately 80 percent or more.

Q. What percentage is dedicated to teaching, if any?

A. Well, it is variable, and it is hard to estimate. But I think over the year probably it averages 10 percent or so.

Q. And administrative and other matters related to Health Systems Design would constitute the other ten percent?

A. Generally evenings and weekends, five or ten percent. It is not a major activity.

Q. What about research, do you do any medical research?

A. Not any longer. I did for a period of time. I was heavily involved in research relative to Alzheimer's and epilepsy, and occasionally stroke-related studies now. But I am not heavily involved in research any longer.

Q. In your clinical practice, do you have any partners or people that you practice with?

A. I am a member of a medical group. There are

approximately 60 members within that group. They are people with whom I am closely associated.

Q. What is the name of that group?

A. It is called Innova Medical Services.

Q. Does that provide a large or a broad spectrum of medical services in different specialties?

A. Yes, it does.

Q. So in addition to you, as a neurologist, there are other subspecialists?

A. About half of the group are primary care specialists, and the other half are a variety of medical and surgical specialists.

Q. How long have you been affiliated with Innova?

A. For the past three years.

Q. Prior to that, who were you with?

A. I was Chairman of The Cleveland Clinic Department of Neurology for 18 years prior to that. And through the course of time I have also been associated with University Hospitals of Cleveland. I hold a Professorship of Clinical Neurology at that institution.

Q. Do you currently hold any administrative positions now?

A. As I said, I am Director of the Office of Professional Affairs for our medical group.

Q. Other than Innova?
A. No.
Q. Doctor, what professional societies or associations do you belong to?
A. I belong to many of them. I will mention some. The American Medical Association, the American Academy of Neurology, the American Neurological Association, the Society for Neuroscience, Clinical Neuroscience Society, and Society of Clinical Neurologists. I am a member of the Stroke Council of the American Heart Association, as well.
Q. Has the topic of strokes been a specialty area of interest for you in your practice?
A. Yes, it has been.
Q. I don't have your CV, *so* I haven't had a list of your peer review publications, but approximately how many publications of that nature have you authored?
A. There are approximately **150** publications, I think half a dozen books, and perhaps a dozen more book chapters.
Q. Any books specifically dedicated to the topic of stroke?
A. Yes.

Q. Which ones?
A. There is one on cerebrovascular disease. I was a series editor. It was written by me with colleagues of mine. That was published by Elsevier, E L S E V I E R, North Holland Press, I believe, in the early 1980s. And there are several book chapters dealing with stroke and stroke-related problems, also, in addition to a number of clinical papers.
Q. Are the stroke chapters identified in your CV?
A. Yes, they are.
Q. Doctor, in your career as a neurologist, how many medical malpractice cases have you reviewed for attorneys?
A. I think over the years, Mr. Lancione, I have probably been asked to look at 100 cases.
Q. Over what period of time would that involve?
A. Well, since I have had a medical degree.
Q. Which was when?
A. 1964.
Q. During that same time frame, Doctor, how many depositions have you given in medical malpractice cases?
A. I suspect I have given about 50.
Q. How many times have you testified at trial,

either bench or jury trial?

A. Far fewer. Half a dozen or less.

Q. Doctor, as far as parties for whom you testify, what is the ratio of plaintiff versus defendant?

A. Well, it is quite easily split, but I want to tell you that not all of those are malpractice cases, in fact, the minority of them are. A lot of them have to do with other issues in medicine other than medical malpractice.

Q. Which cases are we talking about, the 100 or so cases you have been involved in as an expert, or the 50 or so depositions, or the six or fewer trial testimony?

A. All of the above.

Q. My initial question was specifically directed to medical malpractice cases.

A. I would say of the court appearances, half of them it seems to me have involved medical malpractice, perhaps two-thirds. I don't know precisely. Of the depositions, I would think, again, about half or less have involved medical malpractice.

Q. And of the overall cases you reviewed involving litigation, about the same, about half?

A. About the same, yes.

Q. And as far as in medical malpractice cases alone, what is the percentage of cases you have done for plaintiff versus defendant?
A. It is evenly divided.
Q. I thought you said "easily divided" before.
A. Evenly.
Q. Okay. Approximately how many cases, medical malpractice cases, have you reviewed for my old firm, Spangenberg, Shibley, Traci, Lancione & Liber?
A. I suspect I have reviewed a half a dozen. 1 hope you don't ask me to name them all. I can't.
MR. MALONE: Actually, you probably shouldn't name them. Some of them might be cases that you haven't been disclosed as a reviewer, unless you testified.
A. Fortunately, I have a faulty memory and couldn't do it even if you asked.
Q. Have you reviewed any medical malpractice cases for Howard Mishkind of my firm?
A. Yes, I have.
Q. How many, approximately?
A. I don't know if I have done any since he has been with your current firm. He asked me to look at one case recently, but I didn't feel I could be

helpful to him.

When Mr. Mishkind was with Mr. Weisman, I had one. Perhaps it was more than one, but I recall one case with him.

Q. How about for the Reminger & Reminger law firm, how many medical malpractice cases have you reviewed for them?

A. I suspect half a dozen over the years.

Q. What about for the firm of Jacobson, Maynard, Tuschman & Kalur?

A. They have become associated with Physicians Insurance Companies, so I am not sure about them. I would be guessing to tell you six, but I think it is probably somewhere in that range.

Q. With whom do you have your medical malpractice insurance?

A. PIE.

Q. Have you had any contact with Anna Carulas concerning testifying in this case in the event that Meridia Huron Hospital is dismissed from this lawsuit?

A. No, I have not.

Q. Doctor, what is the rate scale that you use for your work in medical malpractice cases and testifying and reviewing?

A. It is $350 an hour for any purpose.

MR. MALONE: That is in good weather. But this is a blizzard, so we are probably going to have to add on a little bit to compensate for the hassle.

Q. What about trial testimony; is that the same?

A. The same.

Q. Can you tell me the percentage of your income that is derived from work in medical malpractice cases?

MR. MALONE: I will show an objection. Doctor, you can answer that if you wish. I mean, it is up to you. I don't think you have to answer it.

A. It is about five or six percent of my income every year.

Q. Thank you. In this case do you plan on testifying live in trial?

A. If I am asked to do so and it is possible for me to do so, yes.

Q. Doctor, let's turn now to your report and your opinions in this case concerning Carl Williams.

MR. MALONE: Everybody has a copy of the record.

Q. In the second full paragraph on the first page

you just mention some things, gonorrhea, duodenal ulcer disease, and allergy to aspirin as far as his history. What is the significance of those, if any, with respect to his current problems?

A. Well, it is simply a review of his health. Those things were noticed as part of his history. He has duodenal ulcer disease, which is a factor in treating people prophylactically for arterial disease, because many of the agents used to do it can irritate that.

The history of gonorrhea may or may not have had something to do with the reason he was being treated, the mechanical penile prosthesis. The allergy to aspirin becomes figurative in the prophylaxis of vascular disease.

But the most important point in that history is his long-standing history of heavy cigarette smoking and very serious chronic obstructive pulmonary disease or emphysema.

Q. You note that his blood pressure at the time of admission was 116 over 80. Do you consider this to be a baseline normal blood pressure for this patient?

A. It is hard to say what his baseline normal blood pressure was because there is some variability in

blood pressure. Suffice it to say there is no clear evidence in the record of severe or constant or outstanding hypertension. His blood pressure did fluctuate, however, from numbers slightly lower than this to many that were somewhat higher.

Q. During what period of time?

A. During both his hospitalizations.

Q. Do you have any information about his blood pressure prior to his admission on December 19, 1991?

A. No, I don't.

Q. The nursing note that Mr. Malone referenced in his letter to you on page two at 1:45 where his blood pressure was 170 over 106, pulse was 120, and his respirations were 37, do you consider those to be abnormal vital signs for this patient?

A. They are abnormal for any patient.

Q. Do you have an opinion as to the cause of those abnormal vital signs?

A. I would have to turn to the note. Mr. Malone's introductory letter to me is not part of the medical record. While introductory, it is not a source document.

Q. All right. That is 12/21/91 at 11:45?
A. Yes.
Q. The ones that I have highlighted in blue?
A. Yes.
Q. Do you have an opinion as to the cause of those abnormal vital signs?
A. Well, he was extremely short of breath. I suspect that the elevation of blood pressure, tachycardia, and increased respiratory rate have to do with a manifestation of his lung disease.
Q. Doctor, is there any other note in the chart besides the note for this December 19 to December 21, 1991 admission that indicates that the patient was ever short of breath?
A. I believe on that entry there is clear notation.
Q. My chart may not be organized as well as yours, so if you want to go into yours or work with Jim -- in fact, that is my daughter's note right there from vacation.

MR. MALONE: It says, "I love Dad." That was part of the hospital chart.

A. I suspect that that is true, informative, and I compliment you, and I will turn to my chart, which does not contain such things.

Again, without belaboring every time it is

mentioned, I am looking at the discharge summary from the first admission. There is a history of shortness of breath, *so* those terms are used.

And his history of chronic obstructive pulmonary disease is noted in that record. It was noted at the time of admission, as well.

Q. As far as a nursing note or a finding by any of the medical staff that was caring for the patient during that hospital stay -- I know that it may be part of his history prior to going into the hospital that may indicate some shortness of breath, but as far as any indication by a nurse or an observation by a nurse, can you point to any in the chart?

A. Well, there is observation by doctors. Do you want to count those, or just nurses?

Q. Let's start with the nurses first.

A. Do you want to hand me the nursing note *so* --

Q. Well, I have tabs and notes all over mine.

A. Well, then let me see what you are looking at.

Q. I am asking you -- I don't find any. I would like to know where you are finding these notes of shortness of breath.

A. I have already mentioned to you I think a doctor is as credible as a nurse of shortness of breath.

It is mentioned repeatedly. This man had chronic obstructive pulmonary disease and is a smoker for 50 pack years. That is good enough for me.

Q. On page two of the surgical history and physical as far as under the heading of "Present Illness," there is a note there that the patient denies complaints of shortness of breath?

A. Also states chronic obstructive pulmonary disease, 50 pack years.

Q. You are saying just because he has COPD and has smoked 50 pack years he is going to have shortness of breath?

A. Yes, I go to the cross, absolutely.

Q. In a patient with COPD, can abdominal distension cause shortness of breath?

A. Well, if abdominal distension is severe enough, it can cause shortness of breath in anyone.

Q. In your report in the third full paragraph you said in the third sentence, "At the time of his discharge, asthma was again noticed, and he was visibly short of breath."

A. Yes.

Q. Did this patient have asthma, as well?

A. Yes, he does.

Q. Could this shortness of breath be due to his

distended abdomen?
A. I think not.
Q. Why not?
A. Because abdominal distension is not a necessary condition in a person who enters the hospital with a history of 50 pack years of smoking, is known to have chronic obstructive pulmonary disease, and has wheezes and rales when he is examined. So I don't think it is necessary to read in another factor. That is enough.
Q. Well, didn't this patient have abdominal distension at the time of discharge?
A. Yes, he did.
Q. So you are saying you don't believe that his abdominal distension had anything to do with the shortness of breath at the time of the discharge?
A. No, not at that point I don't believe it did.
Q. Do you have an opinion as to the cause of his abdominal distension that was noted at the time of discharge?
A. Yes.
Q. What is that?
A. Well, he had an illness. I suspect it had to do with the medications that he was given for discomfort after his penile surgery. It may have

had to do with manipulation during the surgery itself. It is a common condition following pelvic and abdominal surgery.

Q. Do you have an opinion as to when the ileus developed?

A. During his first hospitalization, yes.

Q. So it is your opinion that prior to his discharge on December **21, 1991**, he had post-operative ileus?

A. Yes. In retrospect I would say that, yes.

Q. In retrospect?

A. Yes.

Q. As far as there being sufficient signs and symptoms of post-operative ileus prior to his discharge on December **21, 1991**, do you feel that that was a diagnosable condition prior to his discharge on the 21st?

A. Yes, I do. It is a common condition diagnosis.

Q. In this patient, was it diagnosable in this patient?

MS. CARULAS-MOORE: Note my objection.

A. Yes.

Q. Are you critical of anybody for not making the diagnosis of post-operative ileus prior to his

discharge on December 21, 1991?

A. Well, although the words aren't used, he is known to be uncomfortable, distended, he is given a suppository, so although the word "ileus" may not have been used, I think the condition was recognized, and he was treated for it. He was given a suppository.

Q. Is that an acceptable treatment for ileus, the administration of a suppository?

A. Again, you are dealing with an area of the human body that is about four feet south of where I spent most of my professional career, thank you.

But I am aware of it as a universal source of complaint and discomfort, and it is extraordinarily common to be a bit constipated and a bit bloated after a surgical procedure such as this.

Q. Do you feel that you can give opinion testimony based on a reasonable medical probability concerning ileus -- do you feel you possess the expertise to opine about that to a jury?

A. It is a general medical problem. I don't profess to be a medical expert in gastroenterology or urology, but it is a common problem in hospitalized patients to be constipated and bloated. That is not a reason, in my opinion, to keep

people in the hospital, standing on its own.

If the inability to have a fulfilling bowel movement were a condition of retaining people in the hospital, every bed in the United States of America would be filled today and never empty for the rest of eternity.

Q. Is ileus a good condition to keep a person in the hospital, post-operative ileus?

A. It depends. I mean, ileus, as I said, is an extraordinarily common event. Most ileus will solve itself without the necessity of intervention, and certainly without the sorts of extraordinary illness that arose here.

Q. So would you feel that it would have been acceptable, had the diagnosis of post-operative ileus been made, for Dr. Boyd to discharge this patient even though he had made a definitive diagnosis of post-operative ileus?

A. Yes, I do.

Q. In a patient with a post-operative ileus, will bowel sounds be audible?

A. It depends on the degree of ileus, its intermittency or constancy. It might be hypoactive. It may be absent. They may be rushed from time to time.

Q. Sluggish, that is hypoactive?
A. It is hard to sound sluggish.
Q. Did you note in the chart --
A. Hypoactive, yes.
Q. Did you note sluggish bowel sounds?
A. Yes.
Q. The passage of the glycerin suppository tweaked with minimum amount of stool, does that constitute a bowel movement in this patient?
A. Well, it is a disgusting notation, it is not a bowel movement. It is the anal expectoration of something that was put there in an effort to have him move his bowel. It is not a bowel movement.
Q. Do you have an opinion as to the cause of this patient's respiratory decompensation?
A. Yes.
Q. What is it?
A. Severe long-standing chronic obstructive pulmonary disease.
Q. Do you have an opinion as to the cause of this patient's left lower lobe pneumonia?
A. The same. He doesn't aerate or ventilate his lungs in anything approaching normal fashion. He is a sitting duck for pneumonia.
Q. Do you believe that this patient was septic at

any time during his second hospitalization?
A. Yes, I do.
Q. Do you have an opinion as to the cause of his sepsis?
A. Again, his lungs are less than a sterile field, and I suspect the source of the sepsis was his respiratory tree.
Q. Did his respiratory acidosis and carbon dioxide retention have anything to do with the sepsis?
A. They have everything to do with the lung disease. They grow as branches of the same tree, if you will.
Q. Do you have an opinion as to the cause of his neurological complications, the seizure and the stroke?
A. Well, you have just precluded my answer, so I will agree with your summary, he had a stroke.
Q. Do you agree that he had seizures?
A. Yes.
Q. Do you agree that he had a stroke?
A. Yes.
Q. What kind of stroke?
A. The kind that comes from arterial occlusion, a vessel in his brain.
Q. What was the cause of the arterial occlusion? Do

you have an opinion as to that?

A. Yes, I do.

Q. What is the opinion?

A. Well, he is not young. He stands on the brink of being elderly. He may or may not be hypertensive, Based on a review of his blood pressures, I don't know. It is extraordinarily likely that he has coronary heart disease, based on his cardiograms.

So the combination of those things and heavy cigarette smoking, all of which are risk factors for stroke; age, heart disease, smoking, possibly his blood pressure, form the substrate for stroke in him as they do for most other patients who have strokes.

Q. As far as the actual mechanism, was it a clot or was it some other obstructing mechanism for this stroke?

A. That is a bit more difficult to say. But under these circumstances, the usual cause is obstruction of an extracranial blood vessel. The same obstructive process may happen to vessels inside the brain. I am not able from this record to say which is more likely.

Q. Do you have an opinion as to whether his neurological problems are permanent?

A. Yes, I do.
Q. What is your opinion?
A. I have not seen him, but I suspect that some degree of paralysis and other neurologic impairments are likely to be permanent.
Q. Doctor, are you saying that even had this patient not had his penile implant surgery that he would have had a stroke in 1992?
A. What I am saying is this: He is a person that comes loaded with risk factors for stroke. It is not possible for me to link up the events of his ill health, penile implant, ileus, repeated pulmonary decompensation, and sepsis that ends in stroke. Whether he would have or would not have, I don't know.

But I don't believe that this series of events is causally linked to his stroke.

Q. Would you agree that it would be impossible to predict prior to his penile implant surgery that he was going to have a stroke?

MR. **MALONE:** Objection. He has already answered this at length. He is loaded with risk factors for stroke. He can answer. I am sure he can handle the question.

A. Would you mind restating the question?

Q. Do you agree it was impossible to predict that this patient was going to have a stroke in January of 1992 prior to having his penile implant surgery?

A. It would be impossible to predict time. I don't think it would be entirely impossible to predict likelihood, given the risk factors that I have already mentioned. He is a candidate for stroke and for heart attack, given his history. Now, when those things could have happened could have been at any time.

Q. It could have been ten years from January of '921

A. No, I don't think ten years, if you add in advancing age with all of the other risk factors, it shrinks things down, it enlarges the likelihood from a lower to a higher risk number.

Again, he is laden with risk factors for vascular disease, of which stroke is one manifestation.

Q. So it is your opinion that at some time in this man's lifetime he was going to have a stroke had he not had one in January of 1992?

A. Again, that would be knowledge in the mind's eye of The Almighty alone. It is more likely that he would drop dead of a heart attack. But stroke is

not unlikely, either, In fact, it is very likely. In fact, which one when, I can't tell you.

Q. Was the complication of a stroke a foreseeable event prior to this implant surgery?

A. I believe not.

Q. I am sorry?

A. I believe not.

Q. These risk factors for stroke, were they factors that should have been taken into consideration by Dr. Boyd prior to this penile implant surgery?

A. They have been, and there is no reason for me to think that they are not. These risk factors are, in general, not a contraindication for a local operation for the insertion of a penile prosthesis, or procedures like it.

Q. Do you feel that his respiratory decompensation put him at higher risk for a stroke than he had before he had respiratory decompensation?

A. Well, he has apparently had respiratory decompensation going right along. It happened during his first hospitalization.

The respiratory decompensation itself is not going to cause the arterial lesions that lead to stroke, A combination of events that may occur during the course of respiratory decompensation,

profound prolonged hypotension may, but that didn't happen to him, either.

Q. Hypotension does increase the risk for stroke?

A. Yes, it does.

Q. Does sepsis increase the risk for stroke?

A. It may if, again, it is associated with profound and prolonged hypotension, hypertension, or associated with infection of a heart valve, which, again, are not conditions pertinent to Mr. Williams.

Q. Can sepsis lead to hypercoagulation?

A. It may.

Q. Doctor, have you reviewed any of the reports of any of the plaintiffs' experts in this case?

A. Mr. Malone showed me a report or two. I have not reviewed them. I came in and saw I think reports obtained by you from various people. I have not studied them.

MR. MALONE: I showed him a report by the guy from Baltimore, Marguilies, and from Dr. Sodeman, the guy from Toledo. But that was showed to him this morning.

I said, "Here, this is what they seem to say happened." Surprisingly, he didn't change his opinion when he glanced at them.

BY MR. LANCIONE:

Q. Doctor, did you do any research in any literature prior to rendering your opinions to Mr. Malone in this case?

A. No, I didn't, Mr. Lancione.

Q. Is there anything in any medical literature that supports your opinions that you can specifically point to here today?

A. Other than pointing to a body of it, no.

Q. Doctor, had this patient not had respiratory decompensation beginning around the 23rd of December of **1991**, would he have had a stroke in January of **19921**

A. That is impossible for me to say. It is nice and somehow rational to think that the so-called "stress," I put that in quotes, of severe and recurrent illness, as well as other stresses, lead to stroke.

When that hypothesis is put to the test, it tends not to bear up. Strokes, it would appear, can, even under these circumstances, be random and unconnected events in a person who is prone to having them.

Q. I am just having a little difficulty understanding your opinion as to why you do not feel there

is any causal relation between the complications this gentlemen had after his penile implant surgery and the stroke.

Are you saying, and I asked this before, but I really don't understand your answer, I am going to ask he again --

MR. MALONE: I am going to object to the speech by counsel.

MR. LANCIONE: I am trying to get to the bottom of it.

MR. MALONE: I understand what you are doing. Let me protect the record. Those kinds of speeches have no places in the transcript You can ask your questions, and give final argument to the jury.

MR. LANCIONE: All right, Jim.

MR. MALONE: Thanks.

BY MR. LANCIONE:

Q. Now, had the patient not had his respiratory decompensation and not had this septic picture that we were shown, are you saying that he still would have had a stroke in January of 19921

A. I am saying for the following reasons -- again, I am not sure of January of 1992. He could have had one in January of 1991 or never. I don't know

that -- the cause of stroke is arterial obstruction. Its basis is atherosclerosis. That is not caused by sepsis and not caused by pulmonary decompensation.

Mr. Williams has a set of illnesses, all of which are severe, but not necessarily connected.

Q. Assuming that he would have had an uncomplicated post-operative course following the penile implant surgery, was discharged without any complaints, without post-operative ileus, can you say, based upon reasonable medical probability, that he would have had a stroke in January of 1992?

MR. MALONE: Object. Again, this has been asked and answered I think several times. But please, Doctor, go ahead.

A. Well, he is just as stroke-prone without the ileus and without the penile prosthesis as he was with those things. I can't say for sure.

Mr. Williams carries a heavy pack of risk factors for stroke and heart disease.

Q. And it was these risk factors and not any of his complications, including the respiratory decompensation, the sepsis, that caused the stroke?

MR. MALONE: Do you want to read it?

THE WITNESS: Yes, please.

- - -

(DEPOSITION CONCLUDED.)

JOHN PAUL CONOMY, M.D.

- - -

CERTIFICATE

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

I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, JOHN PAUL CONOMY, 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 by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by him as aforesaid.

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

I do further certify that I am not a relative, employee or attorney of any party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 10th day of April, 1996.

Diane M. Stevenson

Diane M. Stevenson, RPR, CM
Notary Public in and for
The State of Ohio.

My Commission expires October 31, 2000.