Doc. 161

STATE OF OHIO,)
COUNTY OF CUYAHOGA.) ss:

IN THE COURT OF COMMON PLEAS

CARL J. WILLIAMS, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 253137
) Judge Brian J. Corrigan
JONATHAN C. BOYD, M.D.,)
et al.,)
)
Defendants.)

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THE DEPOSITION OF DR. DONALD EDWARD FUERST
WEDNESDAY, MARCH 13, 1996

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The telephonic deposition of DR. DONALD EDWARD FUERST, a witness herein, called by the Plaintiff for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Darlene Lowe, Court Reporter and Notary Public within and for the State of Ohio, taken at the offices of Becker & Mishkind, Skylight Office Tower, Suite 660, Cleveland, Ohio, commencing at 3:35 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff:

John A. Lancione, Esq.
Becker & Mishkind
Skylight Office Tower, Suite 660
Cleveland, Qhio 44113

On behalf of Defendant Dr. Jonathan C. Boyd:

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

On behalf of Defendant Meridia Huron Hospital:

Christine Reed, Esq.
Reminger & Reminger
The 113 St. Clair Building
Cleveland, Ohio 44114

DR. DONALD EDWARD BOYD

of lawful age, called by the Plaintiff for examination, pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, was examined and testified as follows:

EXAMINATION OF DR. DONALD EDWARD BOYD

BY MR. LANCIONE:

Q Doctor, would you please state your full name for the record?

A Donald Edward Fuerst, F-u-e-r-s-t.

Q Doctor, my name is John Lancione. I'm one of the lawyers representing Carl Williams in this case. We've never met. This is the first time we've spoken, so I'm going to go through some rules for you for the deposition and then we'll get into some of the questions.

A Okay, fine.

MR. LANCIONE: We're doing this deposition pursuant to agreement of counsel, I take it, Anna. Is that accurate?

MS. CARULAS: Correct.

MR. LANCIONE: And Chris?

MS. REED: Yes.

Q Okay. Doctor, during the deposition, if you don't understand a question or if for some

reason because of the transmission of my voice signal, please tell me you don't understand or you didn't catch the question, I'll rephrase it and ask it again and make sure that you understand it and you've given an answer to a question that you understand. Is that fair?

A That's fair.

Q Also, Doctor -- well, we don't have to tell you about gestures, because the court reporter can't see you so you have to give us verbal answers.

A I understand.

Q Doctor, what is your professional address?

A My office address now is 1218 North Florence, F-l-o-r-e-n-c-e, Claremore, Oklahoma, 74017.

Q How long have you been in Oklahoma practicing medicine, Doctor?

A Since the 10th of January, 1996.

Q And what is the reason for your move out to Oklahoma, Doctor?

A I was offered the position of starting up and running the department of urology for the hospital here.

Q What hospital is that, doctor?

A Claremore Regional Hospital.

Q Is that affiliated with any university?

A No, it's part of the Columbia Hospital Corporation -- System.
Q Is that a teaching hospital?
A No.
Q Doctor, previous to going out to Oklahoma, you were practicing medicine in Akron, Ohio?
A Correct.
Q Okay. And how long were you practicing in Akron, Ohio, in private practice?
A Approximately 15 years,
Q Doctor, have you given a deposition before as an expert witness in a medical malpractice case?
A Yes, I have.
Q On how many occasions have you been deposed as an expert?
A Probably about two or three.
Q Have you ever been deposed in a case with a similar fact pattern to this case?
A No.
Q In addition to the deposition you've given in those cases, have you reviewed cases in which you have not been deposed?
A Yes.
Q How many medical malpractices have you reviewed?
A Two, that I can think of.

Q For the cases in which you gave depositions, were you acting as an expert for the plaintiff or the defendant?

A One for each.

Q What about the cases that you did not give a deposition in?

A One for each.

Q Doctor, in any of those cases in which you've been an expert for the defendant, were you engaged by the law form of Jacobson, Maynard, Tuschman & Kalur?

A No, I think I was opposing them the last time I testified.

Q So you've never been retained by that law firm as an expert witness?

A Never before this, no.

Q When you were practicing in Akron, who was your medical malpractice insurance carrier?

A PICO.

Q Were you ever insured by PIE?

A No.

Q Doctor, what are your rates for depositions? I understand it's a 600 flat fee. Do you charge an hourly?

A If it goes beyond four hours, it's $150 an hour.

Q What about your rate for reviewing medical records, what's your rate for that?
A $100 an hour.
Q Doctor, in preparation for this deposition, have you conducted any research?
A I just reviewed urology literature; nothing specific, no,
Q What type of literature in urology did you review?
A Just literature regarding implants, complications of implants.
Q Did you look into any other literature concerning ileus?
A Not specifically because I found no reference to ileus as a complication of an implant.
Q Okay. In preparation for your deposition, did you review any documents -- any medical records or depositions?
A Yes, I reviewed the office records of Dr. Boyd, the hospital records of Dr. Boyd and the implant procedure, and Mr. Williams' hospitalization subsequent to that, as well as reports -- the original reports I believe of the expert witness on your side.
Q Did you look at any deposition transcripts

previous to today?

A I did not look at any depositions.

Q Have you discussed this case with any colleagues either here in Ohio or out in Oklahoma?

A No, sir.

Q In your report you said you've done thousands of implants, penile implants?

A Actually thousands.

Q I'm sorry, you're right. Thank you, Doctor. Have you ever had a patient who suffered adynamic or paralytic ileus after penile implant surgery?

A Never.

Q Doctor, what textbooks in urology do you refer to in your practice?

A What? I'm sorry, I didn't hear you.

Q What urology textbooks do you refer to in your practice?

A Oh, several textbooks. One is Campbell's Textbook of Urology, there's also British Textbook of Urology.

Q And when you did your basic research, did you consult those two books?

A I looked through them, yes.

Q The only purpose of your consulting them was to

see if ileus was a documented complication of penile implant surgery?

A That is correct.

Q Okay.

MS. CARULUS: The doctor's secretary just came in. She just needs to talk to him for a quick second.

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(Recess taken.)

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Q Could you describe the nature of your current practice?

A Right now it's generally urology, all facets of it.

Q Does that include surgery?

A That includes surgery as well as the medical side of it.

Q Is that the same back in 1991?

A Yes.

Q Doctor, when you have a patient -- strike that.

Have you ever had a patient in your practice develop an ileus after any type of surgery?

A Yes, I have.

Q And did you treat that yourself or did you call

in a gastroenterology consultation?

A No, I had a surgeon see the patient.

Q And how did the -- did the ileus resolve in this patient without a need for surgical intervention?

A He put in a tube to depress the intestines and the patient responded very nicely to that, he recovered very well.

Q What type of surgery precipitated the ileus?

A Kidney stone surgery.

Q Is that an intra-abdominal surgery, Doctor?

A It's not intra-abdominal; it's retroperitoneal, behind the peritoneum.

Q Doctor, are you of the opinion that the ileus can only develop after intraperitoneal surgery?

A No, it can develop from other types of surgeries, also.

Q Are you of the opinion that it is impossible for an ileus to develop after penile implant surgery?

A Considering that I've never seen it happen in any of my patients, and I never read about it happening to anybody else.

Q Well, do you think that it's impossible for it to occur after penile implant surgery or that it

is possible?

A I won't say that it's impossible or that it's possible; I've just never seen it happen. There's multiple factors that can occur to cause an ileus from any type of procedure. But whether -- E can't say possible or impossible. I can't say. Anything is possible.

Q Okay. Doctor, have you maintained a file on this case?

A Have I maintained a file on it?

Q Yes.

A Just the packet of information that I was sent,

Q Which includes the records you've already described for us that you've reviewed?

A Yes.

Q Your report dated February 6, 1995, Doctor -- I'm sorry -- yes, February 6, 1995, is that the only report you've authored in this case?

A Yes.

Q Did you do any draft reports?

A No.

Q Doctor, you were Board certified in 1983?

A Correct.

Q Was there a requirement at that time to recertify periodically?

A No, sir.
Q Okay. Did you take your boards only once?
A Yes.
Q Doctor, from your report I take it you see constipation develop in patients on a regular basis?
A Constipation?
Q Yes.
A Yes, it does happen. Anybody given pain medication, that's one of the side effects of it.
Q Would you agree that a distended abdomen can be a symptom of constipation?
A It can be.
a And abdominal distension could also be a symptom of ileus?
A It could be.
Q Doctor, are you of the opinion that in order for the diagnosis of ileus to be made, that you must have absent bowel sounds?
A I believe it would be important that there be absent bowel sounds before you could call it an ileus, yes.
Q Well, as part of your practice, do you on a regular basis screen your surgical patients

postoperatively for the development of ileus?

A Usually not as a routine practice, no.

Q Because you find that urological surgical patients do not typically develop postoperative ileus?

A Not necessarily. It depends on the procedure that's being done. Implant patients, usually no, you don't screen them for ileus. If we've done intra-abdominal procedure -- surgery, yes, then we do.

Q Well, would you exclude ileus as a diagnosis -- if you had an individual. who had not moved his bowel in three or four days, had a distended abdomen, had not had any flatus, but had bowel sounds, would you exclude ileus as a diagnosis?

A On what basis?

Q Because of the presence of bowel sounds, would you automatically exclude ileus because of the presence of bowel. sounds?

A I would be less likely to think it was ileus because of that.

Q Would you include that in a differential diagnosis, however?

A Possibly.

Q What would make you want to include ileus in

your differential diagnosis under those circumstances that I just described?

A If the bowel sounds subsequently faded and the patient didn't start responding, or was being less distended, then I would have to definitely consider ileus, With bowel sounds, it could be catching an early phase where you can't make a diagnosis.

Q If you were to make the diagnosis of ileus in a patient, would you treat it yourself or would you call in a consultation?

A No, I would call in a general surgeon.

Q I know you said you've done it on one patient previously?

A That's what I would do again.

Q That's what you would do again, that would be your routine decision?

A Yes.

Q Okay. Doctor, let's turn to Carl Williams for a minute -- actually, for the balance of the deposition, the first admission from December 19 to December 21st, 1991.

A Okay.

Q I take it you undertook a careful review of the records prior to writing your report and prior

to being deposed today?

A Yes.

Q Doctor, is there any indication that Mr. Williams had a bowel movement or passed flatus during that first hospitalization?

A Could I review it just to be sure?

(Witness reviewing documents.)

I'm still reading.

Q Take your time.

A Yes. As a matter of fact, the 12-21-91 nurse's notes says that he had been to the bathroom, passed liquefied suppository stool.

Q And based on that note from the nurse, you are accepting that and describe that as a bowel movement?

A I would consider that to be a return of bowel. function at that point.

Q Can you quantify the amount of stool that was contained in that passage?

A I didn't see it.

Q Did you also see where that -- was that the nurse's 11:45 a.m. note that you just read?

A Yes.

Q Doctor, is it reasonable to assume that if a suppository is given to a patient, that

something -- that suppository will motivate the rectum to discharge the liquefied suppository and whatever is at the end of the rectum?

A As the suppository melts, it will liquefy and cause the patient to pass the liquefied material with the stool, whatever was in the rectum, yes.

Q In your opinion, that constitutes the return of bowel function?

A Well, it constitutes probable return of bowel function.

Q Wouldn't you expect a much more significant amount of stool in a patient that hadn't moved a bowel since the Wednesday before his admission?

A Probably not because he hadn't eaten that much either and he hadn't eaten at least the night before surgery itself, probably didn't eat much in the hospital either and it takes a while for that to get down. When bowel function does return, chances are he doesn't have that function.

Q What if he had been eating in the hospital, would you expect more stool?

A No. As I said, it would still take time to get down. And if bowel function is returning, it's going to take a while longer for it to get down

there.

Q Up to that point in time on the 21st, is there any indication in the chart that he's had effective movement of bowel content?

A I don't believe so.

Q Now, on a --

A There is note that he had positive bowel sounds, bowel sounds were present during 12-20.

Q The data collection sheet, 12-20-91?

A Correct.

Q It shows bowel sounds present on all three shifts on that day?

A Yes.

Q Then there's a note on the data collection sheet for 12-21-91, Doctor, that says bowel sounds were sluggish. Do you see that?

A Yes.

Q Would you agree that represents a change in the status of his bowel sounds compared to the previous day?

A It's hard to make anything out of one single interpretation of sluggish because that's a subjective evaluation on the person who's listening to it and making that judgment. It's their judgment. Somebody else might listen to

it and say, no, those are perfectly normal.

Q Is the slowing of bowel sounds an indicator of the development of an ileus?

A You can't say just on one shift and one person reporting it, you can't make a diagnosis on that basis.

Q Doctor, is nausea a symptom of ileus?

A It's also the symptom of a lot of other things; it's a nonspecific complaint.

Q Well --

A Not that alone.

Q In a patient with ileus, would a complaint of nausea be consistent with an ileus in a patient with ileus?

A It could be,

Q Okay. And it could also be consistent in a patient with ileus if the patient had constipation, too, true?

A It could be.

Q We already talked about abdominal distension, that is a symptom that's consistent with both an ileus and constipation?

A It could be.

Q Doctor, in the 11:45 a.m. note on 12-21, there's a note that the patient is short of breath. Is

there any other note in the chart before that that indicates the patient became short of breath?

A I don't believe so, but I'm just checking.

(Witness reviewing document.)

Not that I see. Not that I see, no.

Q Okay. Doctor, there's no note of abdominal distension on the data collection sheet for 12-20-91.

A I'm sorry?

Q There's no note of abdominal distension on the data collection sheet from 12-20-91, would you agree?

A 12-20? It doesn't actually --

Q But it's not noted, is it?

A Not that I see, no.

Q And if you turn to the narrative notes in the nurse's notes for 12-20-91 -- actually, 6:30 a.m. on 12-21-91, there's a note of a complaint of nausea and that the abdomen is slightly distended. Do you see that?

A Yes. Okay.

Q And the patient states, "I haven't moved my bowels since Wednesday"?

A Um-hum.

Q Okay. And the 21st, are you aware is a Saturday?

A Yes.

Q Okay. As you move along to the data collection sheet for 12-21-91, at the top under the category of well-being in the subcategory of comfort, it says, "Abdomen hard and distended." Do you see that?

A Yes.

Q There's a complaint of pain?

A Okay.

Q Would you agree that that represents a change in the amount and level of distension of his abdomen from the previous note'?

A Again, you can't make a judgment on that unless you're examining the patient yourself because that's a subjective description.

Q Okay. Well, nonetheless, that note is from 8:30 a.m., correct, that hard distended --

A Yes.

Q And the narrative note, which in my chart is the next page for 12-21-91, 9:30, Nurse Bully notes -- she reported the hard distended abdomen to Dr. Boyd. Do you see that?

A Okay. Right.

Q And she also noted an alteration in comfort due to pain related to the constipation?

A Right.

Q Now, is the finding of painful, hard, distended abdomen consistent with an ileus?

A It could be.

Q Doctor, had you seen this patient during those three days, would you have considered ileus as part of your differential diagnosis?

A Not at this point, no.

Q And why not?

A Because I haven't seen anything to suggest yet that he's having that much trouble and that much of a problem anymore than I would have expected to see from somebody who had been on pain medication, who hadn't eaten yet. There's nothing there that would make me say, "Oh, this guy has got an ileus, let's keep him."

Q Well, had the patient been eating, you would have discharged him anyway?

A Especially if he had been eating. Usually, they lose their appetite if they have an ileus.

Q Would you have given the patient any instructions?

A Excuse me for a second.

Q Okay.

(Recess taken.)

A All right.

Q Would you have given this patient instructions, Doctor, to call if he had not moved his bowel the next day?

A I would have given him general instructions, I think, if he was feeling worse to let me know.

Q Are you aware that the patient did try to contact and had contacted Dr. Boyd on the 22nd?

A I was aware that he had contact with Dr. Boyd and he was trying different things to get him to move his bowels.

Q Would you agree that giving Milk of Magnesia to a patient with ileus would be contraindicated?

A If you have a definite diagnosis --

Q Right.

A -- of an ileus?

Q That's what I'm saying.

A It might be.

Q It might be or would be?

A It would be worth while to give him if he definitely had a diagnosis.

Q Couldn't it worsen the ileus?
A I really couldn't answer that.
Q Would you defer that to a gastroenterologist, that issue?
A Yes.
Q Is instructing a patient to take in food orally contraindicating the patient with a diagnosis of ileus?
A With a diagnosed ileus?
Q Yes. You wouldn't want that patient eating?
A Right.
Q Doctor, let's turn to your report.

MS. CARULAS: John, he doesn't have a copy in front of him and I didn't bring one.

MR. LANCIONE: Do you want me to fax you one?

Off the record.

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(Recess taken.)

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Q While it's coming through, Doctor, let me ask you a question: Would you agree that it's the obligation of the physician to include within a differential diagnosis --

A Hold it a second.

Q Doctor, would you agree that when a physician makes a differential diagnosis, that he must rule out the most life-threatening condition first and move down the line to the less serious conditions?

A In general, yes.

Q Do you have your report now, Doctor?

A Yes, I do.

Q In the third full paragraph on the first page, you say, "It's not unusual for a patient to have decreased bowel motility in the immediate postoperative period due to pain medications required to keep him comfortable"?

A Um-hum.

Q Can pain medication also cause ileus?

A No, they don't usually cause ileus, They cause stalling of the bowel motility, but pain medication does not usually per se cause ileus,

Q Can the symptom complex of abdominal distension -- and let's talk about Carl Williams specifically -- strike the question.

Do you have an opinion, Doctor, that his abdominal distension caused a respiratory embarrassment leading to the decrease in

oxygenation that resulted in an ileus? Is that what you think caused the ileus?

A No, I'm not following you on that one at all.

Q Well, you state that, "In a patient with a compromised pulmonary function" -- this is on the second page, second last paragraph -- "abdominal distension will further embarrass the respiratory system. This leads to decreased oxygenation of all tissues and can cause the gastrointestinal tract to have more difficulty returning to normal motility."

A Right.

Q Do you have an opinion that this phenomenon caused his ileus, this lack of oxygenation of the tissues?

A Lack of oxygenation of tissues can lead to an ileus.

Q Is it possible, reasonable that that was the cause of his ileus?

A Mr. Williams' ileus?

Q Yes.

A No.

Q Do you have an opinion as to the cause of his ileus?

A I do.

Q What is it?
A I believe his ileus was caused by decrease in blood -- blood pressure at the time of surgery, compromised with the pain medication and just general body impetus that led to the subsequent development of the ileus. I think that was due to the impairment of the pancreas.
Q You're talking about the decrease in blood pressure during the penile implant?
A Right.

Can we take a break for a second?

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(Recess taken.)

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Q We're almost done, Doctor. Is it your opinion that he was developing ileus during the first hospitalization?
A No, I don't think you can say that.
Q When do you believe his ileus developed?
A I believe his ileus was a progressive thing that developed over the course of several days from the time actually -- probably it originally started after he left the hospital or possibly even maybe when he was getting ready to leave the hospital he suffered it. No one can say for

sure one way or the other, but I think over the next 24, 48 hours is when it became obvious this was a problem. That's when he was sent back to the emergency room and readmitted.

Q All right. Is it your opinion that he had diagnosed ileus in the emergency room on the 23rd of December?

A Did I think he had diagnosable ileus at that time?

Q Yes.

A I think it was very suspicious. I think it would have been top on my list then.

Q Okay. Would you agree that at the time of his discharge, or in the morning hours of the 21st of December, that all of his symptoms with the exception of positive bowel sounds were consistent with the diagnosis of ileus?

A I wouldn't have thought of ileus at all in his situation at that time, no.

Q Because of the passage of the stool with the suppository and the bowel sounds?

A Because of that, because of the fact that he was on pain medication, it could have slowed him down. That could have been causing that. He was eating at that time. Ileus would not have

been one of the things that I would have thought of at that moment.

Q When would you have thought of ileus?

A When he didn't get better, continued to get more and more distended, wasn't passing anything at home. And in spite of all the other treatments that were tried to get him to start to have bowel movements, then it became apparent there was something else going on.

Q Well, assume the patient had called Dr. Boyd on the 22nd, which was Sunday, and said, "I still haven't moved my bowels. I'm still distended," would you have told him to come into the emergency room at that time?

A Not necessarily. I probably would have tried some other things, or laxatives or more suppositories, other suppositories --

Q Okay.

A -- could have stimulated it.

Q Do you have an opinion one way or the other whether the insertion of a nasogastric tube on the 21st of December would have made a difference in his outcome?

A On the 21st?

Q Yes, in the hospital on the 21st.

A No way you can say anything about that.
Q Doctor, in that second last paragraph on the second page --
A Of my letter?
Q Of your letter, yes.
A Okay.
Q What you say in that paragraph leads me to believe that you think that he would have had these complications even if he didn't have penile implant surgery. Is that your opinion?
A I think he may have. With any type of procedure, he could have had the same complications, yes.
Q Let's assume, though, that he never had any surgery on the 19th of December. Is there any way to predict whether this gentleman's demise would have occurred?
A No. I'm not God, no.
Q Doctor, did this patient -- did he become septic at any time during the second hospital admission?
A It appears from some of the reports that he found -- he became septic and he was in septic shock, but I cannot read any of the culture reports to support that. We've asked for copies

of those reports and we don't have any so, you know, it would be a guess at this point from my standpoint because I don't have any positive data to support it.

Q Okay. Certainly his elevated white counts and elevated temperature --

A I suspect you're right, but again there's no support that I can read in the chart that I have.

Q Okay. Let's just assume that they were right and there's several references to sepsis.

A Right.

Q If he did, in fact, have sepsis, do you have an opinion as to the cause of the sepsis?

A It could have come from several areas. It could have come from the lungs. If he had inflection in his lungs from the distension and uncompromised pulmonary function, that we know that he had, that he was on a respirator of€ and on during the hospitalization. It could have come from the intestinal tract if there was compromise of the intestines due to other things, poor blood supply. Bacteria could have entered that way. Also, from the urinary tract. Although, again, without a culture, you can't

say where it came from. Apparently CAT scan did not find any abscess anywhere or any other distension.

Q Okay. Is it fair to say you don't have an opinion based on a reasonable medical probability as to the most likely cause of the sepsis?

A That is fair, I cannot give you an opinion,

Q Do you have an opinion based on a reasonable medical probability as to the most likely cause of his seizures?

A No, I cannot.

Q What about his cerebral vascular accident?

A No, I cannot.

Q Doctor, just because some kind of medical event is not published in the literature doesn't mean it can't happen?

A No, it doesn't mean it can't happen.

Q Okay.

MR. LANCIONE: Now, Anna, you may want to object to this question since you did it before.

Q Doctor, I have a hypothetical question for you. First, I want you to assume some facts. Assume that I'm driving my car down the street and I

come to an intersection and another driver at the crossing road runs a stop sign and hits me broadside. I break my arm and I have an open fracture on my arm, and I go to the hospital for an open reduction internal fixation. And due to no one's fault, I get a postoperative infection and I have to have my arm amputated. Would you agree that I would not have lost my arm but for the negligence of the person that ran the stop sign that hit me?

MS. CARULUS: I do object to this.

A Now do you want to repeat it?

Q Which part?

A The whole part because I lost my train of thought.

Q would you agree I would not have lost my arm but for the negligence of the person who ran the stop sign and hit me?

A You can't say that. You can lose your --

Q But I wouldn't have lost my arm on that day from an infection if I had not been in the hospital with an open reduction, would you agree?

A Yes, sir. Obviously, your arm is injured and therefore you did have something happen to it,

but that can happen from any number of things. You didn't have to have an accident to have it happen from the person hitting you. It could have happened from any number of things.

Q Well, I'm saying, I wouldn't have been in the hospital and gotten an infection in the hospital. I guess part of my -- what you may not have caught is part of my hypothetical. I got a postoperative infection in the hospital.

A Right. But had you not been injured, you wouldn't have been in the hospital?

Q Right.

A From that standpoint, you know, yes I would agree. Had it not been for the injury, you would not have been to the hospital and would not therefore have the infection at that point.

Q Okay. Doctor, are you critical of anybody in this case?

A No. Not really, no.

Q Do you think Dr. Boyd should have known that because of his chronic obstructive pulmonary disease that he was at a higher risk for developing respiratory compromise from a distended abdomen?

A I don't think it would have crossed Dr. Boyd's

mind because when Dr. Boyd was dealing with him, he had a distended abdomen.

Q Have you read Dr. Boyd's deposition?

A No, I have not.

Q Did you feel that you didn't need his deposition to render your opinions in this case?

A Yes, I didn't feel the deposition would change my opinions here.

Q Do you plan on reading it before trial?

A I probably will now that you ask about it.

Q Do you plan on coming to Ohio to testify at trial?

A If I'm asked to, I will come.

MR. LANCIONE: Okay. All right, Doctor. Thanks. I have no more questions.

Chris Reed may have some questions.

MS. REED: I don't have any questions, Doctor. Thank you.

MS. CARULAS: Thanks, Doctor.

(Signature not waived.)

(Deposition concluded at 4:25 p.m.)

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THE STATE OF _____)
) SS:
COUNTY OF _____)

Before me, a Notary Public in and for said state and county, personally appeared the above-named DR. DONALD EDWARD FUERST, who acknowledged that he did sign the foregoing transcript and that the same is a true and correct transcript of the testimony so given.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at _____, this _____ day of _____, 1996.

_____
DR. DONALD EDWARD FUERST

_____
Notary Public

My Commission expires:._____

THE STATE OF OHIO,)
COUNTY OF CUYAHOGA.) SS: CERTIFICATE

I, Darlene Lowe, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Dr. Donald Edward Fuerst was 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 on a computer/printer, and that foregoing is a true and correct transcript of the testimony so given by him, as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of either 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 28th day of March, 1996.

Darlene Lowe, Notary Public
within and for the State of Ohio
My Commission expires March 17, 1997.