IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ROSE DAWSON, etc.,

Plaintiff,

-vs-

JUDGE CHRISTOPHER BOYKO
CASE NO. CV-04-534481

OHIO PERMANENTE MEDICAL GROUP, et al.,

Defendants.

- - - -

Deposition of EDWARD F. HAWKINS, M.D., taken as if upon cross-examination before Susan M. Cebron, a Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, 1400 Midland Building, 101 Prospect Avenue, West, Cleveland, Ohio, at 10:25 a.m. on Wednesday, December 22, 2004, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

- - - -

MEHLER & HAGESTROM
Court Reporters

CLEVELAND
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

AKRON
1015 Key Building
Akron, Ohio 44308
330.535.7300
FAX 535.0050
800.562.7100

APPEARANCES:

Donna J. Taylor-Kolis, Esq.
Friedman, Domiano & Smith
600 Standard Building
Cleveland, Ohio 44113
(216) 621-0070,

On behalf of the Plaintiff;

John S. Polito, Esq.
Bonezzi, Switzer, Murphy & Polito
1400 Leader Building
Cleveland, Ohio 44114
(216) 875-2767,

On behalf of the Defendant
Ohio Permanente Medical Group;

William A. Meadows, Esq.
Reminger & Reminger
1400 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115
(216) 687-1311,

On behalf of the Defendants
Edward F. Hawkins, M.D. and
Medina Emergency Associates, Ltd.

- - - -

EDWARD F. HAWKINS, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF EDWARD F. HAWKINS, M.D.

BY MS. TAYLOR-KOLIS:

Q. Doctor, good morning. Officially for the record, my name is Donna Kolis, and I've been retained to represent the Estate of Herbert Dawson.

I would like for you to state your name and your professional address for the record.

A. Edward F. Hawkins, M.D. I work at Medina General Hospital in the emergency room.

Q. Doctor, you are a member of what physicians group? What's the name of the group that you practice with?

A. Medina Emergency Associates.

Q. Does Medina Emergency Associates provide emergency room services any place other than Medina General Hospital?

A. No.

Q. Okay. How long has your entity been in existence, if you know?

A. Oh, just since, I think it's April 7th of 2002.
Q. Okay.
A. It used to be part of a bigger group that did all of Cleveland, and I was a partner in that group, and then we broke off from that group and formed our own group.
Q. I recall that group quite well.

Is Dr. Rowbottom in your group?

A. Not in the current group, no.
Q. Who is?
A. Eric Brown, Doug Drenth, Kim Bowen, myself, Dave Levine. Those are the members of the board.
Q. Great. All right.

Unfortunately, I forgot to serve a Notice of this deposition on your counsel. So I wouldn't have reminded him to ask you to bring a CV. So I'm going to bet you don't have one?

MR. MEADOWS: We will get you one. I thought I might have one, and I don't, but we'll get you that.

MS. TAYLOR-KOLIS: No problem.

Q. Just briefly, so I have some context to work from, where did you go to medical school?
A. Medical College of Wisconsin, Marquette School of Medicine.

Q. The year you graduated?
A. '83.
Q. Following medical school I'm going to guess that you entered some residency program?
A. Right. University of Virginia residency program.
Q. Residency in emergency room medicine?
A. It was in family practice. When I was --
MR. MEADOWS: Just answer her question.
A. All right.
Q. Did you complete that residency in family practice?
A. Yes, I sure did.
Q. What year did you finish the program?
A. '86.
Q. Okay. Did you enter into any fellowship programs following that residency program?
A. No.
Q. Okay. Doctor, are you board certified in any specialties?
A. Family practice.
Q. What year did you obtain your family practice certification?
A. '86.
Q. Are you board certified in any other specialties?

A. No.
Q. Are you board eligible in any other specialties?
A. No.
Q. Okay. Following the completion of your residency in 1986, would you briefly take me through your work history?
A. From '86 until present I've been full-time at Medina emergency room.
Q. Okay.
A. And I've worked in emergency rooms in Cleveland, Huron Road Hospital. I worked in Amherst. I worked in what used to be St. Alexis and then it was St. Michael, I think. I don't know if it's open now.

But during that time the whole time I was working full-time in Medina because I was part of that large group of Lakeland, and I worked in other ERs.

Q. Wherever so required?
A. Right, if they needed somebody.

MS. TAYLOR-KOLIS: Off the record.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

MS. TAYLOR-KOLIS: Back on the record.

Q. Dr. Hawkins, at any time since you finished your residency program have you published any articles in contribution to the medical literature?

A. No.

Q. Okay. In anticipation of today's deposition, can you tell me what materials you reviewed?

A. I just reviewed the record provided to me by Mr. Meadows.

Q. Okay. And what records would those have been?

A. The Medina General Hospital, whatever is in his book there, and I think I saw some Kaiser.

Q. Okay. That's my question.

You, obviously, would have reviewed your involvement in the care of Herbert Dawson, correct?

A. Correct.

Q. And do you have a belief that you in some fashion reviewed the subsequent treatment records from the Kaiser emergency room department?

A. Yes, I reviewed that with Bill.

MR. MEADOWS: She doesn't want to know what we talked about.

Q. I just want to know if you looked at the records.

A. Uh-huh.
Q. When I received these records, and this isn't a criticism, I preface this so nobody gets defensive, do you not dictate a discharge summary from emergency room visits?
A. No. We write it down in longhand.
Q. Okay. That's all I wanted to know.

It is not the practice of your group to dictate and have transcribed a discharge summary?

A. I wish it was, but we don't have that.
Q. Okay. No problem. I just want to make sure I wasn't missing a piece of paper, all right?

Do you have an independent recollection, outside of looking at medical notes, of Mr. Dawson or his family?

A. Well, of course, parts, like, you know, in my memory, yes, sure.
Q. Okay. Let's sort of go through just the basics, this is very, very easy. I'm going to confirm what you documented, okay?
A. All right.
Q. And if at any time you feel the need to, you certainly can refer to the medical records because this is not a memory contest.

Asking you the question this way, on October

31, 2003, do you recall how it was you staffed the emergency room in terms of timing?

In other words, were you on 12, were you on 24, how did they do that at that time, if you know?

A. I'm not sure if I was like -- because we change our staffing based on the patient volume, and it has been fluctuating. Sometimes we start at 9:00, sometimes we start at 7:00.

So I would suspect that I started at 7:00 a.m., because I was there at 8:00.

Q. Right. Because the first notation I have is at 0818. I believe that you would have seen Mr. Dawson at or around that time.

So that would tell you that you probably got to work at 7:00 that day?

A. Right.

Q. And you hadn't been working the previous night. You believe you actually came in that morning?

A. Right.

Q. Does your group, or did your group at that time do 12-hour shifts?

A. I'm not sure if it was a 12 or an 8 that I was working, or 9.

Q. So it could have been 12, 8 or 9, but certainly

not 24?

A. No.

Q. Okay. Mr. Dawson, according to medical records that are available, arrived at Medina Hospital via Westfield EMS. Is that your recollection?

A. Yes.

Q. Okay. When Westfield EMS would have brought the patient to the hospital, would they have called ahead to tell you that they were bringing a patient?

A. Yes.

Q. Would they have spoken directly with you, or would they have advised the personnel in the emergency room?

A. Usually the nurse takes the call.

Q. Okay.

A. Unless there's a reason to intervene.

Q. Do you have any way of knowing based upon the Westfield -- have you seen the Westfield Fire & Rescue EMS report?

A. Right.

Q. Does that company, or did that company provide you with a copy of the document that they generated from their transport of Mr. Dawson?

A. It should be in the -- the run report should be

in the records.

Q. And that's why I'm asking the question. You would have had access to this document when you first met with the patient, correct?

A. Correct.

Q. My understanding, as best I can read it, and this is, fortunately, good handwriting, in summarizing what Westfield Fire & Rescue did is that they had established an IV, given Mr. Dawson oxygen, administered an ASA and one nitro sublingual to help his chest pain.

Have I accurately, and you can look at the document, summarized the interventions that were performed by Westfield EMS?

A. Gave him oxygen, put him on a 12-lead monitor, gave .9 normal saline IV through an 18-gauge antecubital, and gave him .4 milligrams of nitroglycerin sublingual. It states here that his wife had already given him two aspirins prior to EMS arrival.

Q. Okay. It indicates that his chief complaint was shortness of breath and chest pain. I gather that was communicated to you via this document, correct?

A. Right.

Q. Okay. When Mr. Dawson presented in the emergency room department, you would have had the opportunity to take an independent history, correct?
A. That's right.
Q. Can you indicate for me, let's see if we can find it, there's a nursing assessment that is done. Is that done before you see the patient?
A. It just depends on what the situation is.
Q. Okay. Do you have a way of knowing whether the nurse did her assessment first, or whether you did the assessment first?
A. It's not a hundred percent to know because of the fact that a lot of times we'll see them together, and I document in the record, usually I write the time that I'm actually writing, rather than the time I actually saw the patient.
Q. Okay. Fair enough.
What history did you elicit relative to why Mr. Dawson was presenting to your emergency room?
A. He had chest pain, chest pressure. He had pain in his arms.
Q. Okay.
A. That he had some risk factors for heart disease.
Q. Tell me what his risk factors were.

A. He's inactive secondary to his problem with his reflex sympathetic dystrophy and his chronic arm pain, and he had elevated cholesterol. His father had died of an MI. He's a nonsmoker and no history of high blood pressure. No history of diabetes.

Q. Okay.

A. Those were like what we call the main risk factors.

Q. Okay. Were you able to during your taking of his history distinguish whether the arm pain he was describing on the date of October 31, 2003 was different than his chronic pain from his RSD?

A. Could I tell if it was different?

Q. Did you ask him if it was different?

A. Yes.

Q. Okay.

A. And his chest pain was definitely different. That's why we gave him nitroglycerin, and we continued on the same thing from the EMS squad when he arrived.

Q. And you were giving him nitro because --

A. We suspected that he was having chest pain secondary to coronary artery disease.

Q. Okay. And you learned during that history taking

session from Mr. Dawson that he had not had chest pain previously?

A. Right.

Q. Doctor, can you find -- can you define for me acute coronary syndrome?

A. Acute coronary syndrome?

Q. Yes.

A. It would be, actually, it's a gradation of what people are usually familiar with being acute myocardial infarction.

In other words, somebody who has preexisting coronary disease usually, and then has maybe a small clot that was blocking the coronary artery can then produce pain and possibly produce ischemia, and being in an unstable situation, actually, we used to call it unstable angina before they redefined it to acute coronary syndrome.

Q. Did you, once again, based upon reviewing the records or your independent memory, advise Mr. and/or Mrs. Dawson that you felt that Mr. Dawson was having unstable angina?

A. At the point that he came in I couldn't really tell him for sure if he was having unstable angina or chest pain of other etiology. It was

possible -- that was our paramount concern at that point in time, of course.

Q. Was to rule out --

A. The acute coronary syndrome and, also, MI for that matter.

Q. Find out what was going on.

You had an EKG performed, correct, for Mr. Dawson?

A. Right.

Q. And your interpretation of that 12-lead EKG was what?

A. Well, on the EKG, itself --

MR. MEADOWS: She's asking you what your interpretation of the first EKG was.

MS. TAYLOR-KOLIS: Right.

Q. The EKG has an electronic read on it?

A. I was in agreement with the electronic read in that it was nonspecific as to ST wave abnormality, based on this, that the ST segments were less than a millimeter depression, but at the same time I was concerned about there was a slight depression on the ST segments that was less than a millimeter, and there's gradations in the EKG that we look at and decide, you call an

EKG nonspecific ST changes if it is less than a millimeter, and if it is greater than a millimeter in two continuous leads you can call it ischemic changes.

Q. Okay. The results that you saw on the EKG, what weight did -- I'm not going to ask you the weight question.

How did that contribute to you being able to arrive at a diagnosis? In other words, what information did it provide to you that either ruled in or ruled out an acute coronary syndrome?

A. The acute coronary syndrome can exist independent of EKG changes, but I would say if you have ST depression greater than a millimeter, then it's at a higher level than if you don't have it.

Q. Okay. What time were you aware of this --

A. Or ST segment elevation, then you would be looking for an MI.

Q. Sorry to interrupt you.

A. That's all right.

Q. At what time did you become aware of the EKG results?

A. It's probably within a minute or two of when I got the EKG. They usually just hand it right to me.

Q. Okay.

A. When somebody comes in with chest pain, that's the thing we look at first.

Q. And as part of your evaluation for -- I think we'll just stick with acute coronary syndrome for the moment, acute coronary syndrome and/or MI, you ordered cardiac markers, correct?

A. That's right.

Q. The results of those cardiac markers came back and were known to you before Mr. Dawson was transferred to Kaiser, would that be an accurate statement?

A. Yes.

Q. Okay. Did you find any of the cardiac markers to have abnormalities that suggested either an acute coronary syndrome or a myocardial infarction?

A. No. They're indeterminate. So that doesn't suggest anything.

There is gradations, once again, for enzymes, troponin or CK. If they are a certain level, or if they are greater than .04 in our institution they are indeterminate, which would mean --

MR. MEADOWS: You said greater than?

A. If it is greater than -- if it is less than, than

we know for sure it's negative.

Q. When you are saying, just so the record is clear, because sometimes we all talk at the same time, you're indicating .04, anything under .04 means nothing is going on?

A. Well, it doesn't mean that. It just means that it's less than .04, and it would be deemed to be no evidence for myocardial damage yet, but you can have a normal, a normal less than .04 troponin and still have an MI, but --

Q. Based upon the timing?

A. The timing of the pain, or it could just be that it just started an hour ago to actually infarct, to change from acute coronary syndrome to an infarct, and you still could be less than .04.

Q. And Mr. Dawson's troponin was .19, correct?

A. Right. That would be in the indeterminate range.

Q. Indeterminate not meaning that he isn't or didn't have an MI?

A. What it means, basically, is that it is not giving you information one way or the other. In other words, it is not helping you make the case that they're having an MI or that they are not. It just is not helpful at that point.

Q. Okay.

A. It--

MR. MEADOWS: You answered her. Wait for another question.

Q. All right. While Mr. Dawson was in the emergency department, did you continue to administer oxygen to him?

A. Yes.

Q. Okay. What other interventions or support did you provide to him besides the administration of 02?

A. Gave him two nitroglycerins.

Q. Okay.

A. Let's see here. We placed a nitro paste on him. Nitro paste is any nitroglycerin absorbed through paste.

Q. So you gave him two sublinguals and then nitro paste, is that right?

A. Right. And then after each nitroglycerin he received we reassessed his pain.

Q. If you administer nitroglycerin and there is a decrease in chest pain, medically what does that suggest to you?

A. It suggests that it could be coronary artery disease as the etiology of his pain, but once again, that's something that could get better,

even with a nitroglycerin can make reflux, gastroesophageal reflux disease better, too, and the patient had that.

Q. Based on anything that Mr. Dawson presented with that morning in terms of his historic information that he revealed to you and his complaints of pain at that point, did you at any point seriously entertain that this chest pain might have a gastroesophageal etiology?

MR. MEADOWS: Objection. Poor form.

A. There were things that suggested the possibility that he had some GI problems, too.

Q. Okay. Mr. Meadows is a very smart lawyer, and I asked the question that led to an answer that I wasn't really looking for.

My question was, based on how he presented on the 31st of October, did you believe at any time from the time you saw him until the time you discharged him that the cause of his chest pain that day had a GI etiology?

MR. POLITO: Objection as to form, again.

MR. MEADOWS: Same objection. You can answer.

A. Okay. I didn't know.

MS. TAYLOR-KOLIS: It may be the same answer.

A. I gave him some Maalox and Donnatal. I think that most of his chest pain was gone at that point in time, but when I asked him how he was doing, he told me that -- we usually rate chest pain on a 1 to 10 scale.

He was kind of joking around with me that it was a half, which was like almost zero, but he says well, I guess it would maybe be a little less than half.

So I took it to mean he had gone from crying to laughing and joking at that point in time. So I thought that his pain had gone away, but he said that his reflux might have been bothering him.

So we gave him the Donnatal and Maalox at that point, and as far as I can recall I think he was pretty much pain free after that.

Q. The fact that Mr. Dawson left Medina pain free does not mean that he didn't come in suffering from acute coronary syndrome, or a myocardial infarction in evolution, correct?

MR. MEADOWS: Objection to form

and otherwise. So ahead.

A. I would say that you can have acute coronary syndrome and be pain free for a short time, and usually you would expect it to start coming back, again, if that was the situation.

If somebody remained pain free for, say, like six hours, then I guess I would have to say that the probability is being reduced each second that it is acute coronary syndrome.

Q. Why did you call Kaiser?

A. When did I call Kaiser?

Q. I said why. We'll get to when, but why?

A. Well, when I talked with the patient when he initially arrived, he told me that his physician was through Kaiser, his primary care doctor was Kaiser.

And so when you have somebody with chest pain, like Mr. Dawson did, you know that they're going to have to be -- I knew he was going to have to be admitted to the hospital. I knew that he had chest pain, and I prefer to contact the primary care physician early to get things going in terms of getting a cardiology consult, or making a decision where that patient is going to be.

Q. Okay. Let me ask you a couple questions about that, and I know that all you got is the records to refer to.

Did you attempt to call his primary care physician, or did you call Kaiser's emergency department? Do you know what you did?

A. Well, I have his primary care doctor here written on the record. So probably what I usually do is, I call our operator and say get me Kaiser, this guy's name, and then his primary care doctor is Doug Fleming, it's about an admission.

Q. Okay. Do you know if you talked with Dr. Fleming?

A. I don't think I did.

Q. Okay. Had you transferred Kaiser patients to Kaiser before from Medina ED?

A. Right.

Q. You indicated in your answer when I asked you why you called Kaiser that you knew he had to be admitted to the hospital.

Tell me why you knew Mr. Dawson needed to be admitted to a hospital.

A. Well, in my mind, once the issue of chest pain, possible MI or acute coronary syndrome with the risk factors that he had and nonspecific ST

changes on his EKG, there's absolutely no way that I can send him home or say go somewhere else, plus you have to intervene early if you're going to, and the cardiologist, again, I want to talk to his primary care and see if I have to get my cardiology involved, keep him in Medina, or get them at Kaiser.

Q. I'm going to ask this question inartfully because I don't know an easy way to ask it.

Your familiarity with Kaiser, does it extend to Kaiser health care plans and what Kaiser wants its patients to do?

A. My answer to all the patients when they call me is that we're not going to worry about the insurance, we're going to worry about your problem, and we'll deal with that later.

Q. You did speak with a Kaiser doctor before you transferred Mr. Dawson, correct?

A. Right.

Q. Do you believe it was the emergency room physician?

A. I think so.

Q. Do you recall his name, or did you write his name in the record?

A. I don't know if I did write his name in the

record. I'm pretty sure it was Dr. Kaforey, though.

Q. Do you know Dr. Kaforey?

A. I've talked to him on the phone before. I don't think I've ever met him in person.

Q. Okay. What information would you have given Dr. Kaforey about Herbert Dawson?

A. The main information that he has to know, which he has a lot of risk factors, he has pain, he was relieved by sublingual, he has had two aspirins already. He had some EKG changes on the EKG that are nonspecific, but are at the same time a concern because he is having chest pain.

Q. Okay. The basis what you believe you would have told him, that is based on what you recorded on the chart, correct? Let me withdraw it.

I don't see a separate independent note, unless I'm just not reading this chart correctly, where you actually sit down and write spoke with Dr. Kaforey at this time, related the following information. This is a compilation of what you've documented in the examination portion?

A. I just pick up the chart when I call somebody and I read, basically, what I got here on this chart, and when I present it to him, it is pretty much

what I documented here. So I will tell them all the information that I have at that point in time.

Q. Okay.

A. You know, as much as they are willing to tolerate.

MR. MEADOWS: You answered the question.

Q. Do you recall what Dr. Kaforey's response was to you on October 31, 2003?

A. I remember that I talked to him about chest pain, I talked to him about the EKG, and he asked me was it greater than a millimeter ST depression, and I said no.

Q. And was it your understanding that Kaiser wanted him transferred to Kaiser's emergency room?

MR. POLITO: Objection. Go ahead.

Q. If you know.

A. He was going to be transferred to see Dr. Kaforey at the Kaiser emergency room, as far as I knew.

Q. Did you advise Dr. Kaforey that it was your opinion that Mr. Dawson needed to be admitted to a hospital for a workup for coronary artery disease?

A. Before I could even tell him what I thought about that, he said well, he sounded like he needed to be observed and get serial enzymes, in view of the fact that I had nothing more than a little bit less than one millimeter ST depression, and he was going to minimally get the enzymes, that seemed standard care.

Q. When Mr. Dawson was getting ready for discharge, transport, I guess, is a better word, because you were transferring him to another facility, did you speak with the ambulance drivers for Kaiser?

A. You know, I don't recall, specifically.

Q. Okay. I couldn't make out one way or another. Let me just see.

A. If --

Q. That's all right. I got three minutes to look for it.

While I'm looking for it, because I don't always write down everything, did you indicate that you did tell Dr. Kaforey that the troponin was indeterminate at .19?

A. When I talked with Dr. Kaforey, that wasn't back yet. We called him up subsequently before the ambulance arrived.

Q. There's a nursing note that reflects that the

information was communicated to Kaiser, is that correct?

A. Yes, and it was communicated to me, also.

Q. Do you believe that you called Dr. Kaforey back, or did you allow the nursing staff to call Kaiser?

A. I asked the nurse to call -- Helen Japanowski was the nurse, actually.

Q. I did find the document I was looking for. You have an ambulance certification, and I was confused -- here, I can show it to you.

A. Right. That's basically --

MR. MEADOWS: Let her show it to you.

Q. Is this the document you would have signed? In other words, when you're releasing the patient, you don't just throw him in the ambulance and say good-bye?

A. Right.

Q. Is that the document you would have signed and handed to the Kaiser folks, right?

A. Right.

Q. And on that particular document, if I can read your great handwriting, it says, "Patient having chest pain, needs IV, 02," and then I can't make

out the very last word.

A. "Monitoring."

Q. Is that monitoring?

A. Yes. Now, what that means is, he is not necessarily having chest pain at that very moment, but that he had chest pain, and he could continue to have chest pain. It's the same kind of thing.

Q. So I don't want to misinterpret.

A. Well, see, my diagnosis is had chest pain when he arrived. So having chest pain, is he currently having chest pain when I pulled this out, probably not, because he said he was better, but just you have to put your diagnosis down that's consistent with that. So just to inform whoever the ambulance person is.

Q. So if I am interpreting this wrongly, you will tell me, you are indicating to the squad that while they are transporting, he should remain with an IV, remain on 02, and please monitor this patient, correct?

A. Right. ~~And then if --~~

~~MR. MEADOWS: You answered.~~

~~Q. You answered, that's great.~~

Q And then the second page I'm looking at is a

transfer form, and this simply is a listing of those things which you sent to Kaiser?

A. Yes. That's probably filled out by a secretary or nurse or something.

Q. Okay. Fair enough. You didn't fill this form out, but you're assuming that these are the documents that were -- documents and/or studies that were sent to Kaiser with the patient, right?

A. Right.

Q. All right.

MS. TAYLOR-KOLIS: Doctor, I don't have any other questions for you.

THE WITNESS: All right.

MR. MEADOWS: We will have him read it. Can we get 28 days, if that's okay?

MS. TAYLOR-KOLIS: That's fine.

EDWARD F. HAWKINS, M.D.

C E R T I F I C A T E

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

I, Susan M. Cebron, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 4th day of January A.D. 2004.

Susan M. Cebron

Susan M. Cebron, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 17, 2008

O

P

Q

R

S

T

U

V

W

Y

Z