#654

THE STATE of OHIO,
: SS:
COUNTY of LUCAS.

IN THE COURT OF COMMON PLEAS

THOMAS G. BALDWIN,
plaintiff,

vs. : Case No. 96 2365

MARK E. REARDON, M.D., et al.,
defendants.

Deposition of ROGER A. TRUE, M.D., a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Kris Adorjan, a Notary Public within and for the State of Ohio, at the offices of Jacobson, Maynard, Tuschman & Kalur, 333 North Summit Street, Toledo, Ohio, on THURSDAY, JANUARY 16TH, 1997 commencing at 2:04 p.m. pursuant to notice.

FLOWERS, VERSAGI & CAMPBELL
COURT REPORTERS
Computerized Transcription
Computerized Litigation Support
THE 113 SAINT CLAIR BUILDING · SUITE 505
CLEVELAND, OHIO 44114-1273
(216) 771-8018
1-800-837-DEPO

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

Ann M. Garson, Esq.
Donna Taylor-Kolis Co., L.P.A.
1015 Euclid **Avenue**
Cleveland, Ohio 44115
(216) 861-4300.

ON BEHALF OF THE DEFENDANTS:

John F. Bodie, **Jr., Esq.**
Jacobson, Maynard, Tuschman & Kalur
333 **North Summit Street**
Toledo, Ohio 43604-2619
(419) 249-7373.

I N D E X

WITNESS: ROGER A. TRUE, M.D.

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

(Dr. True Deposition Exhibit 1
marked for identification.)

ROGER A. TRUE, M.D.

of lawful age, a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MRS. GARSON:

Q. Would you please state your name for the record?

A. Roger A. True, T-r-u-e.

Q. Dr. True, my name is Ann Garson. I am here today to take your deposition with regard to the case of Thomas Baldwin.

My purpose today is not to trick you or to cause any confusion. My purpose is to try to understand the facts of the case as they have been recorded in your notes; and to ask for a clarification on the entries that you have made in your chart.

If I ask a question that makes no sense either grammatically or medically, let me know, stop and just say break that down, or let me know where it doesn't make sense, and I will attempt to clarify my question.

If at any time you need to take a break or you want to have a conference with your attorney, that is entirely acceptable to me; and I think that is probably it.

I am sure your attorney has given you the ground rules in terms of making your answers verbal so the court reporter can get everything down.

I have your CV here. I don't want to go through it too painstakingly so we can save some time. Let me just make sure that I understand basically some of your history.

Currently you are employed where?

A. Bedford Medical Arts, PC.

Q. What is PC?

A. Professional corporation, actually the PC was just recently dropped.

Q. That is located where?

A. At the address there, 3175 Smith Road.

Q. In Lambertville, Michigan?

A. Correct.
Q. What do you do there?
A. Family practice physician.
Q. Prior to November of 1993 you were in a different location; is that correct?
A. Right next door.
Q. Down the hall?
A. No, a different building.
Q. Was that a different kind of practice?
A. Still family practice, a private practice.
Q. So you still currently have a practice operating at those offices?
A. Just at the one, Bedford Medical Arts.
Q. Just at the one?
A. The same practice, just moved.
Q. Prior to that you were employed where?
A. Prior to that I was a resident at Flower Hospital.
Q. When you did your residency training at Flower Hospital that was in family practice?
A. Correct.
Q. Have you had any other specialty training other than family practice?
A. No.
Q. Are you Board certified in family practice?

A. Yes.
Q. I see, okay, there it is, that was in 1983?
A. Initially and recertified in 1990.
Q. Well, what is your current relationship with Flower Memorial Hospital?
A. I am on the medical staff there.
Q. What does that entail?
MR. BODIE: Ann, are you asking whether he is an employee at Flower?
MRS. GARSON: Right.
A. I am not an employee at Flower, just on the medical staff there.
Q. Was your relationship with Flower Memorial Hospital any different from 1990 through '92, or was it the same then?
A. The same.
Q. I see you have active privileges at the Toledo Hospital and Saint Vincent Medical Center, courtesy privileges; is that accurate?
A. Correct.
Q. Is there anything on there that is missing from your CV or is this the most current, updated?
A. I don't think there is anything missing, this is the most current updated one.
Q. Has your medical license ever been suspended

or revoked?
A. No, it has not.
Q. Have you ever been the defendant in a medical malpractice lawsuit before?
A. No, I have not.
Q. Did you review any documents in preparation for today's deposition?
A. The patient's chart.
Q. Which chart is that?
A. The office chart that I kept of the patient.
Q. Your office chart of the patient?
A. Correct.
Q. As part of that chart does that include Dr. Reardon's records?
A. No, I do not believe.
Q. Let me go back a little bit, let me make sure I understand this.

In February of 1992 you were practicing at the 6588 Secor address in Lambertville, Michigan?
A. That is correct.
Q. Was Dr. Reardon practicing there with you as well?
A. No.
Q. He had left the practice prior to that time?

A. We have never been associated in practice.
Q. Then I misunderstood.
You have never been associated in any practice with Dr. Reardon?
A. I don't ever recall meeting Dr. Reardon.
Q. When did you first see Mr. Baldwin?
A. Let me look at my chart.
According to the chart the first time I saw Mr. Baldwin, February 18th, 1992.
Q. When you first saw him what information or what knowledge did you have about his prior medical treatment?
A. The information solicited from him, his history.
Q. Did you seek to obtain any of his prior medical records?
A. Routinely when patients come to the office we ask them if they have any records that are appropriate they can send for, since the patient's information is privileged information we cannot obtain it ourselves, and we routinely ask that.
Q. If you felt something was relevant you could ask the patient to sign a release so you could obtain records, couldn't you?
A. Correct.

Q. Were any of his prior medical records obtained?

A. The only record we obtained pertaining prior to his visit of February was an emergency room visit that I alluded to in my note.

Q. That would have been the February 16th visit at Flower Memorial Hospital?

A. Correct.

Q. I am going to back up a little bit.

Doctor, do you consider yourself qualified to diagnose an appendicitis?

A. Yes.

Q. Can you tell me some of the signs and symptoms that usually present with a case of appendicitis?

A. Some of the signs and symptoms of acute appendicitis include fever, pain, usually initiating in the periumbilical radiating to the right lower quadrant; along with that is nausea, vomiting, there may be diarrhea, those are the usual symptoms that occur with it.

Q. What role, if any, does the symptom of constipation play in that constellation?

A. Extremely variable.

Q. Sometimes it's there, sometimes it's not; is

that what you mean?
A. It's true with all the symptoms I just reviewed.
Q. Same question with regard to rebound tenderness, is that within the constellation of symptoms that indicate --
A. Actually rebound tenderness is a solicited sign rather than a symptom, but that is a finding that is compatible but not exclusive to acute appendicitis.
Q. We have just gone through some of the symptoms.

Let me ask you, what are some of the physical findings that might be consistent with appendicitis?
A. Rebound tenderness, the patient may or may not have a positive psoas sign or obturator sign, the patient may have pain on rectal examination, the patient frequently is feverish.
Q. What is McBurney's point?
A. The area in the right lower quadrant, that is a frequent sign of the place where pain is initiated with, the right lower quadrant: symptoms.
Q. Is it synonymous with right lower quadrant pain or is it something different?

A The point is just an anatomical point, so the point itself is not synonymous with pain, just the location where pain is sometimes solicited.

Q Is it in the right lower quadrant?

A. Correct.

Q This obturator's sign and the psoas sign, and the pain at McBurney's point, these are findings?

A. Correct.

Q What does that mean?

A Those symptoms indicate --

MR BODIE: What does that mean? What does 'findings' mean or --

Q What does findings mean? In other words, the patient doesn't come in and say I have an obturator sign.

A Those are things obtained through examination of the patient.

Q. Moving their body a certain way or palpating a part in way?

A orrect.

Q hat role, if any, does an increased white blood count play in the constellation of physical findings or lab findings for diagnosing appendicitis?

A. Elevated white blood cell count would be

consistent with acute appendicitis.
Q. Why is that?
A. The elevated white blood cell count is an indication of some type of underlying infection, either viral or bacterial. So if there is an infection of the appendix or inflammation, there may or may not be an elevation.
Q. Do you know what retrocecal appendicitis is?
A. Yes.
Q. Can you tell me what that is?
A. When the appendix is located in a less than usual position, although not rare, the appendix is then behind the cecum for the first portion of the lower intestines, and if the appendix is inflamed and is positioned behind the cecum then it's retrocecal appendicitis.
Q. If a person has appendicitis and the appendix is in the retrocecal position -- did I correctly state that? You can have appendicitis and the appendix is in the retrocecal position, it's behind the cecum?
A. You may have that situation.
Q. Can that change any of the symptoms or physical findings?
A. The symptoms and the findings for retrocecal

appendicitis are more variable than for appendicitis that is not retrocecal.

Q. In which aspects would it be more variable?

A. In essentially all of the findings, but especially in the signs we talked about earlier.

Q. I would like to go through each one.

For example, is it true that the finding of abdominal pain might be more diffuse as opposed to always a very pointed right lower quadrant pain; is that one example of the variable symptoms if it's a retrocecal --

MR. BODIE: As to retrocecal only, versus just in general any type of abdominal pain or abdominal findings?

MRS. GARSON: Right.

A. In all situations appendicitis symptoms are variable, so there is never something true for all appendicitis.

Notoriously in retrocecal appendicitis the variability is increased as opposed to nonretrocecal appendicitis, including findings of right lower quadrant pain.

Q. Let me make sure I understand, and correct me if I am wrong, I am not trying to put words in your mouth.

The signs and symptoms of appendicitis include a list of various symptoms and findings. You don't necessarily have to have all of them in order to make the diagnosis of appendicitis or to have appendicitis, but there are certain ones you look for and some may be present or may not, correct?

MR. BODIE: Objection, form. Doctor, if you can, answer.

THE WITNESS: I don't understand

MR. BODIE: If you understand the question you should answer. I am doing that for the record

A. Can you restate the question? I forgot it.

Q. I can understand, that was very poorly stated.

If you take an x-ray and see someone has a broken bone, that is a diagnostic film and you can see what the problem is; but appendicitis isn't really like that, correct?

A. Neither of those things are like that actually. There is nothing quite that clearcut and objective.

Q. A person presents with certain signs and

symptoms, and when the diagnosis of appendicitis is suspected some of those signs and symptoms are variable, correct?

A. All of them have variables, and while compatible with appendicitis they are also compatible with other diagnoses.

Q Right, and I was simply trying to understand more clearly what you meant with retrocecal appendicitis that those signs and symptoms might be more variable.

When you say "more variable," what does that mean?

A. That the findings may vary from the list you referred to, even more often than in nonretrocecal appendicitis.

Q. When you say "vary," does that mean more of them may be present, more of them may be absent?

A. That they may be present or absent, in increased or reduced amounts, correct

Q Is there any aspect of variability that you mean other than presence or absence; or is that what you mean by variability?

A. That's what I am referring to.

Q. Are there certain methods or tests which you consider valuable in diagnosing appendicitis?

A. The first method that is valuable is soliciting a history of the patient of his acute symptoms, and then performing a physical examination.

Q. What would that physical exam involve?

A. It would involve an abdominal examination, depending on the findings of the history; and the examination of the abdomen may involve other areas of exam based off the previous findings.

Q. What's involved in an abdominal examination?

A. Observation, auscultation, and palpation, possibly depending on previous findings, percussion of the abdomen.

Q. If a person presents with some of the signs and symptoms of appendicitis, is a psoas sign and/or an obturator sign helpful or is that included in your physical exam?

MR. BODIE: Objection, form. Go ahead.

A. Those exams would be extensions of an abdominal exam, that would be precipitated based off of findings in the initial exam.

Q. So we have a history of physical exam and the physical exam involves an abdominal exam, correct?

A. Correct.

Q. Are there any other kinds of diagnostic tests that are helpful in diagnosing or ruling out appendicitis?

A. For evaluating or possibly ruling out of appendicitis the use of a CBC is usually quite helpful.

Q. Is that all?

A. In addition to the physical exam and history that is most often all that is necessary to get an appropriate diagnosis.

Q. Does a normal or abnormal CBC in and of itself necessarily rule out appendicitis?

A. It neither rules in or rules out appendicitis.

Q. Is that another one of the variable findings that might be present?

A. Correct.

Q. What role, if any, do x-rays play in the diagnosis or the ruling out of appendicitis?

A. Essentially none.

Q. So it's not diagnostic at all, or only is there a percentage, does it have a diagnostic accuracy or inaccuracy?

MR. BODIE: Objection. I think that is unfair to ask the Doctor, He is not

a radiologist in that regard about the accuracy in that regard.

Doctor, if you understand what she is asking you, and you are able to answer that, please go ahead.

A. I would not utilize that, x-rays are not utilized in diagnoses of acute appendicitis.

Q. What about CAT scans, are those diagnostic or helpful in the diagnosis in ruling out appendicitis?

A. I have never used a CAT scan for the diagnosis of appendicitis.

Q. I heard your answer and I am just going to ask it again.

Are you saying to me it's nondiagnostic, it's not useful? I heard you say you have not used a CAT scan to diagnose or rule out appendicitis. My question is: Is a CAT scan useful?

A. A CAT scan is not a useful diagnostic tool for acute appendicitis.

Q. Why is that?

A. Because it has a tremendously high false negative findings rate.

Q. Do you know what that is, just approximately;

when you say "tremendously," are you saying 30 percent?

A. No.

Q. Are you saying 80 percent?

A. No, I couldn't give you a percentage. It's tremendously high enough that it's not a useful test for the diagnosis of appendicitis.

Q. Same question with regard to ultrasounds: Is an ultrasound a useful tool in diagnosing or ruling out appendicitis?

A. Ultrasound is not a useful tool in diagnosing acute appendicitis.

Q. Can you tell me why?

A. Again, it does not have effective diagnostic value.

MR. BODIE: As to appendicitis?

THE WITNESS: As to appendicitis, correct.

Q. What about barium enema?

A. Again, radiographic procedures are not useful in the diagnosis of acute appendicitis.

Q. So let me make sure I understand then before we go on, the methods and procedures that you would use or the tests to diagnose or rule out

appendicitis involve a history, and a thorough physical exam, and a CBC?

A. Yes.

Q. How did you come to see Mr. Baldwin in February of 1992; do you know?

A. He made an appointment, came to our office.

Q. You don't know if he was referred there --

A. I do not know.

Q. -- how he made it there?

I understand that when you first saw Mr. Baldwin you did not have and did not review any of his prior medical records?

A. When I first saw Mr. Baldwin I did not have any of his prior medical records.

Q. With the exception we talked about, at some point you did have the emergency room visit from two days prior to his first visit with you?

A. I did not have that at the time I first saw him.

Q. Let me make this clear.

What if any records of Mr. Baldwin's have you reviewed prior to February 16th of 1992, if any?

A. At the time I saw him?

Q. No, right now.

A. The only thing I reviewed of Mr. Baldwin's was in the chart, since I have seen him, not prior.

Q. In your office chart.

You haven't seen Dr. Reardon's records?

A. No.

Q. You haven't seen any prior emergency room records?

A. No.

Q. I thought I understood you to say your only knowledge of Mr. Baldwin's prior medical history is what he told you on his first visit with you at that time?

A. On 2-18-92 prior past medical history information, what he related to me.

Q. What is that information? Perhaps you can read the handwritten portion of your note so that I can know what it says.

A. Did you want me to read the handwritten portion or answer your question?

Q. Maybe my question would be answered if you read this handwritten portion.

A. It reads "Stomach problems, constipation, cold symptoms, fever, congestion, started Thursday with abdominal pain, seen in emergency room, Flower

Memorial Hospital; Sunday, some nausea, vomiting, and diarrhea; no bowel movement since a while, last bowel movement yesterday, normal, severe cramps; upper GI and lower GI passed last time one year ago; Bentyl, 20 milligrams, t.i.d."

Q. Did you have any other medical information from Mr. Baldwin, other than at that time?

A. I had my examination.

Q. Did you conduct a physical exam at that time?

A. Yes, I did.

Q. What did your physical exam involve?

A. Physical examination involved an abdominal examination.

Q. What did the abdominal examination involve?

A. Palpation and auscultation of his abdomen.

Q. Is that in your note? I have read your note, I didn't see that.

A. No, that is not there in the note.

Q. What else did your physical exam include?

A. Nothing else I recollect.

MR. BODIE: Ann, so I am clear, do you mean "him" in person or in general, because there is a notation they took his weight, blood pressure.

MRS. GARSON: I actually am

talking about size from the weight and blood pressure. I am talking about the actual physical exam Dr. True conducted.

Q. You are saying it involved observation and auscultation?

A. And palpation of his abdomen.

Q. What were your findings at that time?

A. His abdomen was benign and asymptomatic. He was having --

Q. Where does it say it was benign and asymptomatic in the note?

A It does not

Q. Is there any reason why it doesn't say that?

A You usually chart positive findings.

Q Patient has symptoms of FBD?

A Functional bowel disease

Q Can you define that for me?

A. Function bowel disease is a symptomatic disease of the GI tract that is unaccompanied with anatomical abnormalities

Q. You are saying hat he had no symptoms at the time you examined him, correct?

MR. BODIE: That's not what he said.

A. No.

Q. I thought you said that.

Tell me what symptoms did he have when he came to visit you.

A. At the time he was in our office he was asymptomatic at that time.

Q. The exam, that was when you palpated him, and he did not feel pain; is that what you are saying?

A. That was also true.

Q. Because if he did you would have charted a positive finding?

A. Correct.

Q. Did you at that time make a diagnosis?

A. Yes.

Q. Was functional bowel disease your diagnosis?

A. Functional bowel disease was the diagnosis at that visit, correct.

Q. Tell me why you made that diagnosis.

A. Because of his history and physical findings that I had solicited from the patient, specifically his association with the symptoms, with his lifestyle, the stress he was under, and the relief he obtained from his symptoms, and from his examination.

Q. What was the relief he obtained from his symptoms?

A. He said he obtained relief from his emergency room visit that he had prior to coming into the office.

Q. I don't see that in the notes either; am I missing it?

A. No, it's not written expressly in the notes.

Q. Is it written implicitly in the notes? I am trying to understand, do you have an independent recollection of that?

A. He was asymptomatic at this time. He was symptomatic when in the emergency room, therefore his symptoms were resolved.

Q. Functional bowel disease, what is the cause of it?

A. We do not know the cause of functional bowel disease.

Q. What is the pathology of it, if you will?

A. There is no actual pathology. There is no anatomical abnormality of the bowel, it's a collection of symptoms usually associated by the patient with stress and anxiety, and the symptoms vary with the stress and anxiety.

Q. You are not saying there was nothing, that there was no problem there?

A. No.

Q. What kind of treatment did you recommend?
A. I used Bentyf, 20 milligrams, t.i.d., and Xanax, 0.5 milligrams.
Q. What was the purpose of that?
A. The Xanax was to help relieve the anxiety and the stress that the patient related with his symptoms. The Bentyl was to relieve the cramping resulting in his abdominal pain, and that he also related with this episode.
Q. Now, I see in your chart you have the Flower Memorial Hospital chart, or some pages from February 16th of 1992?
A. Correct.
Q. Do you have any knowledge when you obtained that or when that became a part of your record?
A. No, I do not.
Q. There is no date on it or anything?
A. Right.
Q. At some point though that became a part of your chart, correct?
A. At some point, correct.
Q. Do you know how that would happen?
A. The emergency room would send us this material.
Q. When these records come in do you review

them?
A. Yes.
Q. Do you recall reviewing this document?
MR. BODIE: Meaning what by "this document"?
MRS. GARSON: This document.
Q. I am talking about the records from Flower Memorial Hospital from February 16th of '92. I think it's just two pages.
A. I do not recall reviewing them specifically.
Q. Based upon your practice in the way that you cared for your patients in their charts, do you believe you would have reviewed it?
A. Yes.
Q. You did not change your treatment for Mr. Baldwin or do anything differently after this arrived in your office?
A. That is correct.
Q. Let's see, I assume at that time -- I shouldn't assume anything.
Was appendicitis within your differential at that time?
MR. BODIE:. At what time,, Ann?
Q. I am sorry. As of February 18th, 1992?

A. As of February 18th, 1992 acute appendicitis would not have been a differential, the symptoms the patient came in with.

Q. Let me ask you something, what is the definition of mesenteric adenitis?

A. Adenitis is an inflammatory response of lymphoid tissue, mesentery adenitis is the same response in the lymphoid tissue in the mesenteries.

Q. What are some of the presenting signs or symptoms consistent with mesenteric adenitis?

A. Fever, abdominal pain, nausea, vomiting, diarrhea, localized or generalized tenderness.

Q. Is that it?

A. Those would be some of the signs and symptoms.

Q. On February 18th of '92 did you consider mesenteric adenitis as a differential diagnosis?

A. That would not be compatible with what I saw at that time.

Q. How do you clinically distinguish between mesenteric adenitis and appendicitis?

A. Presence of rebound tenderness would be helpful., but not diagnostic.' The type of white blood cell count elevation that may be present would be helpful, but not diagnostic.

Presence of abnormal rectal exam might be helpful, but again not diagnostic. and the patient s history of initial periumbilical pain that migrates to the right lower quadrant after a period of time would be helpful

Q That would be more indication of appendicitis?

A. That would be more indication of acute appendicitis

Q. By the way, have you reviewed Dr. Reardon's deposition prior to today?

A. I haven t read his deposition.

Q You saw Mr Baldwin again, let's see, when was it, August 3rd of 1992?

A. Correct.

Q What were his presenting complaints as of that visit?

A. He stated that he felt fine at that time, that he had had GI symptoms prior to this visit

He stated he had taken himself off of the pentyl and Zantac He stated he was there essentially to get refills of those medications

Q. At that visit you were aware he had been to the emergency room prior, correct?

A. Correct

Q. Do you know whether or not at the time of that visit you had his emergency room records as a part of your chart?
A. I do not know for sure if they were part of his chart at that time or not.
Q. Eventually did the emergency room records from July 25th of 1992 become a part of your chart?
A. Yes.
Q. Can you tell from your records when they became a part of your chart?
A. No, I cannot.
Q. Again, do you know whether or not you reviewed those records once they came in?
A. As per my customary practice I would have used those records as part of the chart.
Q. In those records, if you reviewed them, you are aware that -- my copies are so bad, I believe that he had -- no, I have my typed ones, they are okay.

Actually, do you know what his blood count, white blood count was in the July 25th hospitalization?
A. I have the emergency room report that has some of that material here, yes.
Q. What was that?

A. It states the white blood count was 6,000.
Q. What were the findings of his physical exam?
A. The emergency room record reads: "On physical exam is tender in the right lower quadrant without rebound, guarding or rigidity, bowel sounds active, rectal exam shows no tenderness, stool negative for blood."
Q. Is this picture consistent with appendicitis, those physical findings?
A. These physical findings do not express a picture of acute appendicitis.
Q. Why is that?
A. There is a lack of enough findings or symptoms consistent with appendicitis to make the correlation.
Q. Well, let me ask you this then: How many findings do you need in order to make the correlation?
A. It's not just a matter of quantity but also quality of the findings. So there may be a small number of findings, if they are quite significant they may very well confirm a high suspicion for the diagnosis. So it's not really quantity, it's more overall exam.
Q. Right lower quadrant pain was present, that

you stated as one of the indicators for appendicitis, correct?

A. No, I stated that was one finding, one symptom that is compatible with appendicitis.

Q. I don't mean to misstate you.

He also had some nausea, correct?

A. The record states he had some nausea, but no vomiting.

Q. Are there any other physical findings or symptoms in that chart that are consistent with appendicitis?

A. There are no other findings or symptoms listed in this chart that would add to the diagnosis of acute appendicitis.

Q. This hospital chart was from July 25th of '92?

A. Correct

Q. Obviously it didn't become a part of your chart on that day, but at some point thereafter, correct?

A. Correct.

Q. But no doubt by the time this was a part of your record you would have already reviewed the February 16th hospital records?

A Most probably, yes.

Q. That makes sense they would have been in your chart by then?
A. Yes.
Q. I would like to look at the February 16th typewritten page of the Flower Memorial Hospital record, that is a part of your chart.
I am trying to go here kind of fast, so instead of you reading the whole thing in that visit, the history he gave or what was included in that history was right lower quadrant pain for two days, with some nausea and vomiting; is that correct?
A. Yes.
Q. He always had tenderness noted in the right lower quadrant on physical exam.
A. The report reads there is some tenderness noted in the right lower quadrant.
Q. Right.
A. No specific point tenderness.
Q. Are those symptoms that we just described, are those consistent with appendicitis?
A. The symptoms could be but the lack of point tenderness would not be consistent..
Q. Are you saying there is always point tenderness?

A. I am not saying always, as we mentioned earlier there is never always symptoms.
Q. Especially if it was a retrocecal appendicitis?
A. With retrocecal appendicitis symptoms are even more variable.
Q. What was his blood count, his white blood count, on that admission or that emergency room visit?
A. His white blood count was 5,100.
Q. Did you make any note or was it of any concern to you that the white blood count had gone up from the February emergency room visit to the July visit?
A. The blood counts are not appreciably different. Both blood counts, total white blood cell count numbers are within normal limits, so there was no increase in terms of pathological changes in the white blood cell count, total white count.
Q. I appreciate what you are saying, but as a more general statement, just because a white blood count remains within normal limits doesn't mean a change of the white blood count is not necessarily significant; isn't that true?

MR. BODIE: Objection. In any situation or in this situation?

Q. In a situation where a person may have an infection.

MR. BODIE: Objection, form. Go ahead.

A. An increase in the white blood cell count, in total white count, while the numbers are remaining within normal limits --

Q. Right.

A. -- that would not indicate pathology.

Q. As long as it's within normal limits?

A. That is true most of the time, yes.

Q. So we were on your August, 1992 visit, what were your physical findings, if any, on that visit?

A. Patient had no abnormal physical findings at that visit.

Q. Did you have any physical findings for him?

MR. BODIE: Other than what is noted?

MRS. GARSON: Yes.

A. No abnormal ones, no.

Q. Going back to the July, 1992 record, in the history it indicates that this gentleman had complaints of right lower quadrant abdominal pain

off and on over the past year or so, and has been worked up in the past with no definite diagnosis found?

A. That's the way it reads, correct.

Q. How do you account for, if you do account for it, the right lower quadrant pain that he had off and on for over a year as accounted for in that note?

MR. BODIE: Objection. I think it's unfair to ask this doctor about accounting for a period of time he didn't even see or treat the patient. I think that is unfair.

Q. You had this record as part of your chart, right?

A. Correct.

Q. You reviewed it when it came in?

A. Correct.

Q. Did it give you any concern as to Mr. Baldwin's care and treatment, that he had right lower quadrant pain off and on for a year?

A. It gave me no concern that he had any problems in terms of abnormal or inappropriate care of treatment, no.

Q. Well, that wasn't what I was asking about, his prior treatment. I was just asking in terms of

your treatment of him.

A. It gave me no concern that there was any problems in terms of inappropriateness of my treatment either, no.

Q. The functional bowel disease that you diagnosed, would that account for right lower quadrant pain off and on for a period as long as a year?

A. That can go on for much longer than that, however, that was not necessarily directly related to this emergency room visit.

Q. I understand, but I am asking whether the functional bowel disease that you diagnosed, can that account for right lower quadrant pain off and on over a year, that specific pain?

A. Yes, it can and much longer.

Q. How is it that it is localized like that?

A. It wasn't localized, the note specifically says there was no point tenderness.

He also included in the note he had upper abdominal pain, so he did not have exclusive right lower quadrant pain.

Q. However, you do feel that the functional bowel disease could account for consistent right lower quadrant pain?

A. Yes.

Q Did you do any further tests in August to rule out or diagnose any other condition, other than the functional bowel disease?

A The patient did not have an indication for any further work.

Q Did functional bowel disease remain your diagnosis as of August, 92?

A Because of his onset of upper abdominal pain and the improvement with Zantac, it also included superior gastritis as well

Q Now, you did not prescribe that Zantac, that was prescribed by the emergency room or in the emergency room?

A. I did not prescribe it initially

Q That did you renew that prescription for him?

A. At that visit.

Q. The purpose of renewing that was for what symptoms?

A. The symptoms from his superior gastritis, which he said improved with the medication

Q Did you have any evidence or information in your mind as of August of 1992 that Mr. Baldwin had appendicitis?

A. That visit there was absolutely no indication

that he was suffering from acute appendicitis.
Q. Were there any indications that he might be suffering from an abscess?
A. At that visit he was totally asymptomatic, in his own words feeling fine.
Q. Well, let's back up.

What is the usual course for acute appendicitis?
A. The usual course for acute appendicitis is the initial symptoms that we discussed earlier, followed by continuing unrelenting progression of those symptoms, worsening, elevation of the white blood cell count well above normal, persistence of the fever, and the general malaise and nausea, vomiting; and then at that point surgical intervention if the patient has been evaluated, and the symptoms have been persisting.

Untreated without surgery those symptoms continue to progress to the point the patient has peritoneal symptoms, ruptured viscera resulting in widespread peritonitis, resulting in possibly sepsis and even death, that is the usual progression of acute appendicitis..
Q. That progression you talked about, in some point in there, there is a rupture, correct?

A. That can be part of the progression, right.
Q. That course you just explained had a rupture involved?
A. Correct, a ruptured viscera.
Q. It's that rupture that causes the sepsis?
A. No, the sepsis is when the bacteria enters the blood stream, that can occur with or without ruptured viscera.
Q. Is it unusual for there to be a relenting of the symptoms subsequent, immediately subsequent to the rupture?
A. I don't understand. Run that by me again.
Q. You explained the course of an appendicitis. My question to you is: Is it unusual for in the course whether there is a rupture, that subsequent to the rupture there will be a brief relenting of the symptoms?
A. The symptoms may wax and wane minimally, but for progressing to a rupture, symptoms are usually unrelenting and persistent.
Q. Are you aware that an appendicitis does not necessarily have to completely rupture at all, correct?
A. That is correct.
Q. An abscess can form?

A That is one possibility

Q Would the course of what you have just explained be different where there is an abscess that forms and not a complete rupture?

A Yes.

Q How would that course be different?

A Usually the severity of symptoms continues to waxing and waning, with frequent often monthly recurrences or persistence of symptoms.

Also, there is usually signs of persistent infection; again, sepsis may or may not be involved in that

Q Is it fair to say that altered course also has variables just the same?

A. All disease has variables.

Q In your August 3rd, 1992 visit did you say that you did a physical exam because, again, I didn't see any notations of what you actually did in your physical exam, and you so said there were no positive findings, so?

A. I said there were no abnormal findings

Q. Did you do a physical exam on that visit?

A. Yes.

Q. Do you know what you did?

A Examination for that visit would have

included palpation of his abdomen also, not just lower abdomen, but also upper abdomen because of his gastritis symptoms.

Q. That is not in there, right, I am not missing anything?

A. No, there is no mention of any abdominal findings, because there were none.

Q. Did Mr. Baldwin mention to you the right quadrant pain that he reported to the emergency room on July 25th?

A. At that time he reported no pain.

Q. But I am asking you whether he gave you the history of right lower quadrant pain.

A. I do not have a note of any specific right lower quadrant pain history.

Q. Did you see him only one more time?

A. In my office?

Q. Right.

A. Correct.

Q. That was on October 9th?

A. Correct.

Q. As of that visit were you aware that he had had an emergency room visit from October 7th?

A. Yes.

Q. Can you read the handwritten report of your

note?

A. "205 pounds, stomach problems, Zantac worked, out of pain medicin-e, pain right lower quadrant, CBC, Zantac."

Q. At this point you knew that he was in the emergency room, do you know whether you had the emergency room record in your chart or not?

A. No, I do not know.

Q. Because it's not date stamped, right?

A. Correct.

Q. Can you read the first part of your typed note?

A. To where?

Q. The first sentence.

A. "He needs refill on his Zantac, this has helped his right middle and lower quadrant pain, not sure why; his previous upper GI and gallbladder were all negative."

Q. That's enough. I am not sure I understand your note.

Can you explain what you meant when you said "not sure why," does that relate to the Zantac or the previous studies?

A. That relates to the Zantac.

Q. So are you saying you are not sure why the

Zantac helped with the right lower quadrant pain?
A. I am saying I am not sure why this helped with his right middle and right lower quadrant pain.
Q. Why aren't you sure why?
A. That would be a less than typical response with that medication.
Q. What was the purpose of prescribing Zantac to Mr. Baldwin?
A. It was previously mentioned from his last visit for his severe gastritis.
Q. Why would that be inconsistent with relieving the right lower quadrant?
A. That would be possibly inconsistent with right middle and lower quadrant pain relief, and those are not generally symptoms exclusive to gastritis.
Q. So the "not sure why" does not refer to the upper GI and the gallbladder?
A. That is correct.
Q. The next part of your note you indicate or in the last sentence, "May need more aggressive therapy like a BE," is that; barium enema?
A. Yes.
Q. Can you explain to me why you wrote that?

A. At this time the patient presented to my office three times with variable complaints of abdominal discomfort. So at that time I discussed with him that we should consider additional workup, although he indicated to me he had extensive abdominal workup.

Q. What would a barium enema tell you or what would you use that for, as a tool to diagnose or rule out?

A. A myriad of problems, it could be used specifically looking into evaluate the anatomical integrity of his large intestines or colon.

Q. Not for appendicitis, correct?

A. That is correct.

Q. When you say "May need more aggressive therapy," is that contingent upon something else happening?

A. His agreeing to it

Q. That's all?

A. That would have been the factor at that point, yes.

Q Did you discuss it with him or --

A. Yes, that's why the notation is there.

Q Do you know by looking at your note why he agreed to it, or if you had an additional claim to

it?

MR. BODIE: Agreed to what, the barium enema evaluation, and whatever the findings were?

MRS. GARSON: Yes, I am asking if his agreeing to more aggressive therapy was the only prerequisite. I can't tell from the note what happened.

A. It was not done.

Q. So are you saying that you discussed with Mr. Baldwin that he may need more therapy?

A. Discussed with him that he may need the barium enema, and that would be helpful in further evaluating his symptoms.

Q. Then do you recall what he said?

A. Not specifically, but a barium enema was not scheduled and not set up.

Q. Are you drawing a conclusion from that?

A. If he agreed it would have been set up.

MR. BODIE: Ann, in light of the time frame from the 9th to the 10th and everything else, I think the circumstances such that Mr. Baldwin didn't have a chance to get back to him, given what happened thereafter.

MRS. GARSON: Maybe, by

looking at this note it doesn't say a lot of that. I am trying to understand, I wasn't there.

MR. BODIE: Oh, sure, nor was I.

MRS. GARSON: So I want to make sure I understand.

Q. When you say "May need more aggressive therapy," like a barium enema, what that implies, you had a conversation with Mr. Baldwin that he would need it, that it would help in assessing his ongoing abdominal complaints, correct?

A. That it may be helpful, yes.

Q. Because it was not set up, it just didn't happen, correct?

A. Correct.

Q. Are you assuming that he refused it, do you remember that he refused it?

A. I do not remember specifically, it's not uncommon that the patients want to consider these matters, think about them.

Q. Did you have any discussions that you recall with Mr. Baldwin regarding appendicitis being a possible diagnosis?

A. Not based off of this record, no.

Q. You don't recall it independent of this record, correct?
A. No.
Q. Did you have any conversations with Dr. Reardon about Mr. Baldwin's care at any point?
A. No.
Q. Have you had conversations with Dr. Husted about Mr. Baldwin's care?
MR. BODIE: Since the filing of the lawsuit or during the time he was treating him?
MRS. GARSON: I will ask both.
Q. First, have you spoken with Dr. Husted since the filing of the lawsuit?
A. About this case?
Q. About this case.
A. No.
Q. Have you spoken with Dr. Husted with regard to Mr. Baldwin during your care and treatment of him?
A. Yes, but not at or prior to 10-9-92.
Q. I understand.
When you said that he "May need more aggressive therapy," were you thinking that

Mr. Baldwin may have some medical condition that had not been diagnosed?

A. As per my note I thought that the patient did not have adequate explanation for his relief of symptoms.

Q. Right.

A. And that was the reason I suggested the barium enema.

Q. Did you have in your mind any possible differentials that the barium enema could assist in diagnosing?

A. Yes.

Q. What are some of those?

A. Those would include obstructive disease, tumors, polyps, and inflammatory bowel disease. Occasionally functional bowel disease can be demonstrated due to decrease spasm, or at least alluded to or if not confirmed.

Q. You never made a diagnosis of an ulcer; is that true?

A. That is correct.

Q. Did you rule out an ulcer or did you consider that a possibility?

A. Based off of his exams, his possibility for ulcerative disease as opposed to gastritis was very

unlikely, so no further workup was indicated.
Q. Were the symptoms that Mr. Baldwin presented to you consistent with peptic ulcer; if you know?
MR. BODIE: On what day, Ann?
A. There are three different dates.
Q. Well, let's see, over the period of time that you treated him, I guess. There is three dates, I will ask you for each one.
In February?
A. There was not an indication for peptic ulcer disease, no.
Q. In August?
A. No, only his gastritis.
Q. And October?
A. No.
Q. What would be the indications for peptic ulcer?
A. Severe mid epigastric pain, possibly associated with bleeding, usually triggered by certain foods, but not exclusively; severe epigastric tenderness on examination, with possible radiation of that pain and to the chest:; many other possible signs and findings; those would be the most common ones.

Q Is right lower quadrant pain consistent with peptic ulcer?

A While not a usual finding with peptic ulcer disease, the presence of right lower quadrant pain does not exclude the possibility, because pain may be more generalized.

Q. It s certainly not a usual --

A. No

Q. Would you be offering any opinions with regard to when and whether surgery is indicated for appendicitis?

A. Yes

Q. What symptoms and physical findings would there be for surgery to be indicated?

MR. BODIE: I object as is not a surgeon in that regard to make a surgical decision. I think that is more for a surgeon; but Doctor, if you have an opinion in that regard feel free to expound.

A. I could give you my opinion as to when I would consult a surgeon.

Q. That's fair.

A. That would vary from patient to patient, depending on the quantity and quality of presenting symptoms that we reviewed earlier on.

The alterations and variations and abnormalities of the patient's blood count; but generally it's with the unrelenting abdominal right lower quadrant pain that is unrelieved with therapy and continues to be unrelenting.

Fever is persistent, elevated white counts exceeding the normal limits are persistent and continuing to increase, or pain becomes increasingly worse.

Q. Let me ask you this: What is the normal blood count range?

A. It varies, depending on the test used by hospital to hospital. For most facilities between the area of 4,000, 5,000 on the lower portion, up to 10 to 11,000 on the upper portion.

Q. Does a white blood count within that range rule out appendicitis?

MR. BODIE: In and of itself?

Q. In and of itself?

A. No, there is no findings in and of itself that would rule out appendicitis.

Q. Are you aware of the negative exploration rates with regard to appendicitis?

A. Only vaguely.

Q. In what regard?

A. Could you be more specific in your question?

Q. In general is there a negative exploration rate which is acceptable when we are talking about diagnosing appendicitis?

MR BODIE: Objection. I think that goes to the standard of care for a general surgeon, with respect to you saying it's acceptable.

Again, I think it's unfair. Doctor, go ahead, if you know.

A. I am aware there is a level of explorations for a possible abdominal pain etiology, uncertain or negative findings do occur. I know that varies depending on the surgeon and the facility The number I was taught back in medical school is around 12 percent.

Q. I looked at the literature, it's actually even higher for appendicitis

A. As I mentioned it depends on what facility and the surgeon.

Q. Of course.

To what extent were you involved with Mr. Baldwin's care after October 9th of 1992?

A. My recollection at that point on I was

involved only in terms of the inpatient care

Q You had no more office visits with him?

A. That is correct.

Q. He was an inpatient at Flower Memorial Hospital?

A. Correct

Q Do you know in general for what procedure he was there in October of '92?

A I would have to look at the chart to give you that.

MR BOYD: Hold on one second. Off the record

(Discussion had off the record)

A. On October 11th according to the record I have before me, the patient was admitted to Flower Hospital.

MR. BOYD: Hold on, one second.

(Interruption in the proceeding)

R. BOYD: Go ahead, Doctor. I am sorry

A. The admission of 10-11-92 at Flower Hospital. According to the records I have where he was admitted and taken to surgery by Dr Hustead, with what he described as ill defined excruciating abdominal pain, with few symptoms, without clearcut peritoneal signs, patient underwent surgery.

Q. What were you just referring to as far as the physical findings?

A. This was the history and physical dictated by Dr Hustead, 10-11-92

Q. The history of his present illness was multiple bouts of intermittent abdominal pain, correct?

A. That's how it reads.

Q. When it says with maximal tenderness in the right lower quadrant?

A. If you start in the middle of the sentence, it reads: "He describes it as rather sporadic, but now primarily maximal tenderness in the right lower quadrant."

Q. 'The patient denies any fever or chills and does note some nausea secondary to pain and no emesis"?

A. Correct, that's how it reads

Q. Is this picture in your assessment consistent

with appendicitis?
A. With the limited information in that amount of information there, this could be consistent with appendicitis and several other abdominal problems, yes.
Q. As a result of that, that history, and as a result of the physical findings that Dr. Husted made, Dr. Husted determined that he was going to take him to the OR for an appendectomy; is that correct?
MR. BODIE: Objection. I think that is the question better posed to Dr. Husted as to why he did that.
Q. The assessment plan on the next page states: "The patient potentially with retrocecal appendicitis, will take to the OR for appendectomy"; is that how it reads?
A. That is how it reads.
Q. Eventually were you aware that Dr. Husted diagnosed there was a chronic abscess formation?
A. What part of the record are you referring?
Q. One more.
A. It's not in his history and physical, no.
MR. BODIE: Are you looking at the path report?

MRS GARSON: What do I have?

MR DODIE: What are you looking at there, Ann?

MRS GARSON: It's a medical records multipurpose form, discharge summary

MR. DODIE: I don t have a copy of that here.

You are referring to a discharge sheet.

(Dr True Deposition Exhibit 2 marked for identification)

Q I have marked this as Deposition Exhibit 2, it is a portfolio -- well, it's a medical records multipurpose form, discharge summary

MR. DODIE: Okay.

Q Do you see on that form that Dr Husted made a diagnosis, one of his diagnoses was a chronic abscess formation?

A. That's how it reads, yes

Q. Let me skip all of this and ask you: Do you have any disputes or differing opinions regarding Dr. Husted's diagnosis or Dr. Husted's treatment of

Mr. Baldwin?

MR. BODIE: Objection, form.

Q. Do you have any criticism of the care Dr. Husted rendered?

A. No.

Q. Do you have any dispute or differences in terms of the diagnoses he made?

MR. BODIE: Objection, form.

A. I have no basis for that, no.

Q. If Dr. Husted said that the diagnosis, based on the surgery and the pathology, that there was a chronic abscess, would you dispute that?

A. I would have no reason to at this point, no.

Q. Can you define chronic in the way you use that term?

A. Chronic means not acute, that can go on for a period of a day, several days, weeks, months, years.

Q. In your opinion did Mr. Baldwin have an appendicitis, did he have an appendicitis on August 9th when he last saw you in your office?

A. I saw him on August 9th, he had no symptoms of acute appendicitis in my office.

Q. In your opinion did he have any signs or symptoms of an abscess, an appendiceal abscess on October 9th in your office?

A. When he was in my office on October 9th, 1992 he was without symptoms of any type.

Q. Let me ask you, aside from what his specific symptoms were on August 9th, take --

MR. BODIE: October 9th.

Q. October 9th, 1992, take into consideration your prior two office visits with him, and the hospital records from February and July of '92 that were a part of your record at that time; and let me ask you, as of October 9th, 1992 did Mr. Baldwin have signs and symptoms of an appendiceal abscess?

A. Based off of the three visits I had with him and off the information that I had from the emergency room visits, prior to those visits and subsequent I had available, I had no findings of any symptoms at that time.

So only in as much that the lack of symptoms is compatible with any disease, was there compatibility with any disease state.

Q. Is it your opinion or do you have any opinion as to whether the chronic abscess diagnosed by Dr. Husted began before or after October 9th

of 1992?
A. I do not know when the chronic abscess discussed by Dr. Husted began, and I have really no way of pinpointing that date.
Q. Well, when you say you don't know, I can only assume that it's entirely possible it began while he was under your care and/or prior to that, correct?
MR. BODIE: Objection.
A. I can only repeat and say I have no idea when that was there, there was no way to tell.
Q. It's not your testimony then that this abscess was formed after October 9th, correct?
A. My testimony is we do not know when this abscess was, and I already stated that two, three times.
Q. Dr. Husted diagnosed that ruptured of course, what is your testimony in terms of when that rupture occurred, if you have an opinion?
A. There is no way to tell, anyone's guesstimation would be that, a guess.
Q. Is there any period of time that you feel comfortable absolutely ruling out when that rupture occurred?
A. There is no way at any time to decide when

the rupture occurred.

Q. Why is that? I don't mean pinpointing it to a precise second in time, I am talking about based on --

A. But --

MR. BODIE: Let her finish the question.

Q. I am not asking you to be God and say you knew the exact second when it happened, because of course we don't; but in terms of clinical signs and symptoms, arid based upon your records and the records you have in your file, are you able to rule out at any point when that rupture would have happened?

A. There is no way to determine when that rupture would have happened.

Q. Is that in this case or is that in any case?

A. The only way to diagnose the moment when a rupture happens is by seeing it, everything else would be a diagnosis of estimation and suspicion.

Q. The estimation and the suspicion is based on clinical symptoms and physical findings?

A. That he did not have as 10-9-92, according to my prior discussion.

Q. To what degree were you involved in his care

while he was hospitalized in October of '92?
A. Can you be more specific?
Q. Yes.
You saw him on an inpatient basis?
A. Yes.
Q. What was the purpose of your seeing him?
A. To follow along for any medical problems, that would be appropriate for family practitioners to address in this situation.
Q. Can we go through this? You had noticed several places that your signature appeared. I would like you to read those notes for me.
A. Certainly.
Q. I think you said there were four of them?
MR. **BODIE:** That we saw when we were flipping through.
A. The first one in October, here is a notation from 10-21-92, it reads: "Overall doing well, no nausea, no bowel movement yet, flatus is going."
MR. **BODIE:** Let the record reflect this is the Flower Memorial Hospital progress note, and it appears to be identified by Dr. **True** with a **zero** with a **squiggly. line** in **it.**
A. The notation from "10-22-92, **BM** yesterday, up okay, discharge **if** okay with surgery, continue

Zantac, no antibiotics, dressing/surgery.

"10-12-92, patient status post appendectomy, with question mark, appendiceal mass, pathology pending, start incentive spirometry, increase I.V. fluids."

MR. BODIE: That's about the middle of the page on that note on 10-12?

THE WITNESS: Correct.

MR. BODIE: Thank you.

A. "10-13-92, patient continues febrile, vomiting some, path report pending, using PCA."

Q. What is PCA?

A. Patient control analgesia.

"10-14-92, sodium 135, potassium 3.9, chloride" -- I am having difficulty reading the Xerox copy. I believe it's "82; saline change, KCL.

"10-15-92, temperature down, feels better."

I am unable to read this date because of the xerox copy.

MR. BODIE: 10-17 -- I believe it's 10-16?

A. I am unable to read that for sure above "appreciated," and "continue I.V."

I cannot read the next word, it's in a black line from the Xerox, "overall, better yet.

"10-17-92, apparently wound drained of much material, attempts" -- I cannot read the next word. "Lower grade, will continue antibiotic therapy.

"10-18-92, doing well, feels much better, voiding.

"10-19-92, vital signs good including temperature, overall better yet, blood cultures in sensitivity, no growth.

"10-20-92, n.p.o., Augmentin, without fever, change to p.o., Zantac, doing well,"

That's all of the progress notes I have.

MRS. GARSON: That's fine, that's okay.

Q. Do you recall having any conversations with Dr. Husted during this admission regarding Mr. Baldwin?

A. It is customary for me to converse with him about a case. We have in the hospital, but I do not recall any specific conversations.

Q. Do you recall any general conversations at

All that discussed the nature of the abscess or the rupture?

A. I don't understand what you mean by "nature of the abscess '

Q. The chronicity of it?

A. No.

Q Did you ever discuss with Dr Hustead any of the care rendered by Dr Reardon?

A No

MRS GARSON: I don't think I have anything further for you. Thank you very much

---

(Deposition concluded; signature not waived)

ERRATA SHEET

NOTATION	PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.

ROGER A. TRUE, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

I, Kris A. Adorjan, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, ROGER A. TRUE, M.D., was by me first duly sworn to testify 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 onto a computer 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 JANUARY, 1997.

Kris Adorjan --

Kris A. Adorjan Notary Public/State of Ohio
Commission expiration: 12-14-97.

Look-See Concordance Report

- - -

UNIQUE WORDS: 1,055
TOTAL OCCURRENCES: 3,614
NOISE WORDS: 384
TOTAL WORDS IN FILE: 10,317

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

COVER PAGES = 4

- - -

INCLUDES ALL TEXT OCCURRENCES

- - -

DATES ON

- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE FORMS ON

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: 2

- - -

LIST OF THRESHOLD WORDS:

- - -

appendicitis [80]
symptoms [71]

* * DATES * *

* * 0 * *

* * 1 * *

* * 2 * *

* * 3 * *

* * 4 * *

* * 5 * *

* * 6 * *

* * D * *

* * E * *

* * F * *

* * G * *

* * Q * *

* * R * *

* * *

* S *

* *T* *

* U *

CURRICULUM VITAE
ROGER ALAN TRUE, M.D.

7625 Summerfield Road
Lambertville, Michigan 48144

EDUCATION

Undergraduate 1971 - 1974	Indiana University, A.B. Degree, Chemistry.
Post graduate 1974 - 1978	Indiana University School of Medicine, Indianapolis, Indiana, M. D. Degree, October 31, 1978.
1978 - 1981	Residency training November 1, 1978 through October 31, 2981, Flower Hospital, Family Practice Residency, Program Director, Roland Scherbarth, M.D.
1979 - 1981	Chief resident November 1, 1979 through October 31, 1981.
1983 & 1990	Board Certified in Family Practice by the American Board of Family Practice in 1983.
	Recertified in 1990.
	Status, Diplomat.
1981 - Present	Active - Family Practice, Private, *offices* located at:
1981-November 1993	6588 Secor, Suit6 #2, Lambertville, Michigan 48144 Schwa*nget* Chiropractic *and* Medical Building Phone (313) 856-5494
November 1993 Present	Bedford Medical Arts, P.C. 3175 Smith Road P.O. Box 291 Lambertville, Michigan 48144-0291 Phone (313) 856-5494

LICENSURE

February 13, 1981	State of Ohio State Medical Board
November 18, 1981	State of Michigan Department of Licensing and Regulation Michigan Board of Medicine

DEPOSITION EXHIBIT
1 1-16-97 TRUE

HOSPITAL PRIVILEGES

Active	Flower Hospital - Family Practice
Active	The Toledo Hospital - Family Practice
Courtesy	St. Vincent Medical Center - Family Practice

PERSONAL

Born	Kay 23, 1953
Family Status	Married September 1981, wife Julia; son David, born January 1, 1986.
Affiliations	Previous member Executive Committee at Flower Hospital.
	Previous Vice Chairman of the Department of Family Practice at Flower Hospital.
	Minister with Jehovah's Witnesses since January 1992.
	Acting Director of Flower Hospital's Bloodless Surgical and Medical *Care* Program.