1 The State of Ohio, ) County of Cuyahoga. ) SS: 2 IN THE COURT OF COMMON PLEAS 3 BESSIE M. BROOKS, 4 INDIVIDUALLY AND AS ADMINISTRATOR OF THE ESTATE OF LEE THOMAS BROOKS, 5 б Plaintiff, 7 Case No. 397309 - V -8 THE CLEVELAND CLINIC FOUNDATION, ET AL., 9 Defendants. 10 11 DEPOSITION OF AARON BRZEZINSKI, M.D. Thursday, June 29, 2000 12 13 Deposition of AARON BRZEZINSKI, M.D., called for 14examination by the Plaintiff under the Ohio Rules 15 16 of Civil Procedure, taken before me, Robert A. 17 Cangemi, a Notary Public in and for the State of 18 Ohio, at The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, commencing at 19 20 2:45 p.m., the day and date set forth. 21 22 - - - -CORSILLO & GRANDILLO 23 COURT REPORTERS 950 Citizens Building 24 Cleveland, Ohio 44114 216-523-1700 25 - - -

> Computer-Aided Transcription By Corsillo & Grandillo Court Reporters

Thursday, June 29, 2000

Deposition of AARON BRZEZINSKI, M.D., called for examination by the Plaintiff under the Ohio Rules

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1 of Ci	ivil Procedure, taken before me, Robert A.	1	On Behalf of the Defendants:	9
	emi, a Notary Public in and for the State of	2		
	, at The Cleveland Clinic Foundation, 9500	3	JAY M. KELLEY, III, ESQUIRE	
	d Avenue, Cleveland, Ohio, commencing at	4	THOMAS B. KILBANE, ESQUIRE	
	p.m., the day and date set forth.	5	Reminger & Reminger	
5 2.45 6	p.m., the day and date set forth.	6	Suite 700	
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			The 113 St. Clair Building	
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9	COURT REPORTERS	9		
.0	950 Citizens Building	10		
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LE	APPEARANCES:	15		
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7		17		
8	On Behalf of the Plaintiff:	18		
19		19		
211	HOWARD D. MISHKIND, ESQUIRE	20		
21	Becker & Mishkind	21		
22	Skylight Office Tower	22		
2:3	Suite 660	23		
24	Cleveland, Ohio 44113	24		
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3 Oh 4 firs 5 exa 6 7 E 9 BY 10 Q 11 rec 12 A 13 spe 14 Q 15 A 16 Q 17 Mi 18 Mr 19 per 20 21 tha 22 for 23 of 24 oka	AARON BRZEZINSKI, M.D. led by the Plaintiff for examination under the io Rules of Civil Procedure, after having been at duly sworn, as hereinafter certified, was unined and testified as follows: EXAMINATION EXAMINATION CONTROL IN CONTROL IN CONTROL IN CONTROL MR. MISHKIND: Would you please state your name for the ord? Aaron Brzezinski. Would YOU like me to ell it? Yes, please. A-a-r-o-n, B-r-z-e-z-i-n-s-k-i. Dr. Brzezinski, my name is Howard shkind, I represent the estate of Brooks in connection with the lawsuit that's nding. I am sure I am not telling you anything t is a mystery to you. I have some questions you relative to your involvement in the care Mr. Brooks back in June of 1998,	$\begin{array}{c} 1 \ Q \\ E \\ 2 \ that's \\ 3 \ corrected \\ 4 \ A \\ 5 \ Q \\ 6 \ A \\ 1 \\ 7 \ raised \\ 8 \ Q \\ 10 \ educa \\ 11 \ A \\ 5 \\ 12 \ Mexi \\ 13 \ Q \\ 14 \ A \\ 15 \\ 16 \ medic \\ 17 \\ 16 \ medic \\ 17 \\ 18 \ Universec \\ 19 \ vario \\ 20 \\ 11 \ R \\ 19 \ vario \\ 20 \\ 21 \ fellow \\ 22 \ is \ cal \\ 23 \ Q \\ 24 \ A \end{array}$	By Virtue of your accent, I detect that not a Northeastern Ohio accent, is that ct? That is correct. Where are you from? am originally from Mexico, born and d in Mexico. Really. Vould you briefly trace for me your ational background? Sure. I went to medical school in co. Which school? The National University in Mexico. Then I did an internship and two years of cine in Mexico. Then I moved to Canada and I was at the ersity of Toronto from 1985 through 1992 in us positions. did my training in medicine and a wship in gastroenterology, which in Canada led a residency. What?	

1Q       I ve gotit.       1 asstroametory bowel disease.         3 Institute of Medical Sciences in Toronto, a year       You performed the percutaneous endoscopic         4 of resarch.       You performed the percutaneous endoscopic         5 And lastly 1 was working at Sumy       The obstal as part of the University of         7 Brook Hospital as part of the University of       The hospital?         9 Q       When did you first become affiliated with         10 the Cleveland Clinic Foundation?       The hospital?         11 A November, 1992.       The hospital?         12 Q. Arroy ou full-time staff member here at       The hospital?         13 A Moyen way ou ever had your deposition taken       To fave you ever had your deposition taken         19 O Are you in full-time staff member here at       The hospital?         20 Are you a full-time staff member here at       The hospital?         21 A The is correct.       The way our ext had your deposition taken         19 O The way our ever had your deposition taken       The third one was as an expert withess in the         20 Are you in how many occasions?       The third one was as an expert withess in the         21 A The is correct.       The way our involvement as in relates to some         22 What year approximately would that have       The way our involvement as in relates to some         32 What year approximately would that have			
<ul> <li>2 A Then I had a year of training at Masters 5 Institute of Medical Sciences in Toronto, a year 4 of research in inflammatory bowel disease, and 5 clinical research.</li> <li>3 And lastly I was working at Sunny 7 Brock Hospital as part of the University of 8 Toronto.</li> <li>9 When did you first become affiliated with 10 the Cleveland Clinic Foundation?</li> <li>10 A Ves, I am.</li> <li>12 Q Are you a full-time staff member here at 13 the hospital?</li> <li>13 A November, 1992.</li> <li>14 A Yes, I am.</li> <li>15 Q Since November of 1992?</li> <li>16 A That is correct.</li> <li>17 A That is correct.</li> <li>19 A Yes, I have.</li> <li>20 Q And on how many occasions?</li> <li>21 A Three.</li> <li>22 Q Your area of specialty is 23 gastroenterology?</li> <li>24 A Yes.</li> <li>29 Do you have an area of subspecialty within</li> <li>25 Q Do you have an area of subspecialty within</li> <li>26 Do you have the to do with inflammatory bowel sitting to remember.</li> <li>29 A Maybe 1987, 1988. I really can't recall 4 the exact year.</li> <li>20 What year approximately would that have 2 been?</li> <li>20 Mak you involvement as it relates to some 6 gastroenterological issue?</li> <li>20 Do you have to do with PiG tube 19 placement?</li> <li>21 And she had a procedure at a different 29 placement?</li> <li>21 Marken ad.</li> <li>22 Marken ad.</li> <li>23 Maybe 1987, 1988. I really can't recall 4 the exact year.</li> <li>24 A Yes.</li> <li>25 A Maybe 1987, 1988. I reality can't recall 4 the exact year.</li> <li>26 Was your involvement as it relates to some 6 gastroenterological issue?</li> <li>24 A Yes.</li> <li>25 A Maybe 1987, 1988. I reality can't recall 4 the exact year.</li> <li>26 What year approximately would that have 19 placement?</li> <li>26 A Maybe 1987, 1988. I reality can't recall 4 the exact year.</li> <li>27 A Tor, I have to do with PiG tube 19 placement?</li> <li>28 A Maybe 1987, 1988. I reality can't recall 4 the exact year.</li> <li>29 Did that matter go to trial?</li> <li>20 And you have served a</li></ul>	10 I've get it	Page 6	Page 7
3 Institute of Medical Sciences in Toronto, a year of or research.       3 (a) You performed the percutaneous endoscopic 4 gastrostory on Mr. Brooks?         4 of research.       6 (b) That is for same thing as a PEG tube 7 placement?         7 Brook Hospital as part of the University of 8 Toronto.       7 (b) That is the same thing as a PEG tube 7 placement?         9 (c) When did you first become affiliated with 10 the Cleveland Clinic Foundation?       11 (c) The building lawsuit, were you testifying experience, 12 (c)			
4 of research in inflammatory bowel disease, and 5 clinical research.       4 f astrostomy on Mr. Broks?         5 A That is correct.       6 A Na lastly I was working at Sunny         9 O When did you first become affiliated with 10 the Cleveland Clinic Foundation?       7 hat is the same thing as a PEG tube         10 A Yees, I am.       9 O The building as an expert witness in the 14 other three occasions where your testifying experience, 17 were you testifying as an expert witness in the 14 other three occasions where your testifying as an expert witness in the 14 other three occasions where your testifying as an expert witness.         10 A Yes, I have.       10 A No. They were variable. One of them was 17 in Toronto.         10 A Yes, I have.       0 And no how many occasions?         21 A Three.       0 The situation in Toronto, were you a 23 defendant in that matter?         22 A Tree.       20 The situation in Toronto, were you a 23 defendant in that matter?         23 at year.       20 The situation in Toronto, were you a 23 defendant in that matter?         24 A Yes.       20 The situation in Toronto, were you a 23 defendant.         20 D you have an area of subspecially within       20 A The were you bringing a 2 claim, or was         3 A Maybe 1987, 1988. I really can't recall the exact year.       3 a Yes.         3 Q Did it have to do with milammatory bowel 9 disease?       10 The building lawsuit, were you bringing a 2 claim, or was         3 A No.       19 And she had a procedure at a different 21 farti			2
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8 Toronto.       90 When did you first become affiliated with 10 the Cleveland Clinic Foundation?       90 When yen a full-time staff member here at 13 A roys. 1 am.       90 Go wen the transcript shorter, I will 10 refer to it as PEG tube.         12 O Are you a full-time staff member here at 13 the hospital?       11 A Sounds good.         14 A Yes, I am.       12 O Going back to your testifying experience.         15 Q Since November of 1992?       16 A No. They were variable. One of them was 15 taken?         16 A That is correct.       16 A No. They were variable. One of them was a building lawsuit. And 19 the third one I am trying to remember.         10 A do no how many occasions?       16 A No. They were variable. One of them was a building lawsuit. And 19 the third one I am trying to remember.         20 Your area of specialty is 23 gattorenterology?       22 A Yes.         24 A Yes.       20 Do you have an area of subspecialty within       23 A I was one of the defendants.         25 Q Do you have an area of subspecialty within       24 Yes.         20 Did it have to do with PEG tube 19 pacement?       10 The building lawsuit, were you bringing a 24 Yes.         10 Did it have to do with PEG tube 19 pacement?       10 Did it have to do with PEG tube 19 pacement?         13 A No.       16 A Twas translating for a hisparic patient 17 form English to Spanish, so that she would 18 understand.         19 And she had a procedure at a different 21 family decided to sue the University of Toronto, 19 A And she had a procedure at a different	7 Brook Hospital as part of the University of		
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15 Q       Since November of 1992?         16 A       That is correct.         17 Q       Have you ever had your deposition taken         18 before, sir?       16 A         19 A       Yes.         20 Q       And on how many occasions?         21 A       Three.         22 Q       Your area of specialty is         23 gastroenterology?       24 A         24 A       Yes.         25 Q       Do you have an area of subspecialty within       20 The situation in Toronto, were you a         20 Was your involvement as it relates to some 6 gastroenterological issue?       20 And on with inflammatory bowel         3 Q       Did it have to do with PEG tube       20 The uilding lawsuit, were you bringing a         20 Tell me what it had to do with. Was it is relating to you?       24 A         13 A No.       Q       Yes.         14 Q       Tell me what it had to do with. Was it is relating to you?       5 Q         13 A No.       Yes.       Q         14 Q       Tell me what it had to do with. Was it is relating to you?       3 (acse?)         15 A I was translating for a hispanic patient in the zinstitution, and subsequently the patient and the 21 family decided to sue the University of Toronto, acreasion or 19 the hospitals, fitty physicians.       10 Did you testify attrial?         14 A	13 the hospital?		
16 Å       That is correct.         17 Q       Have you ever had your deposition taken         18 before, sit?       I A         19 A       Yes, I have.         20 And on how many occasions?       Diff on how many occasions?         21 A       Three.         20 Your area of specialty is       Diff on how area of subspecialty within         21 Q       The situation in Toronto, were you a         22 Q       The situation in Toronto, were you a         23 Q       Do you have an area of subspecialty within       Diff on the situation in Toronto, were you a         24 A       Yes.         30 Maybe 1987, 1988. I really can't recall       He exact year.         50 Was your involvement as it relates to some 6 gastroenterological issue?       Page 8         10 Did it have to do with inflammatory bowel       9 A Yes.         10 Did it have to do with PEG tube       Did it have to do with PEG tube         12 placement?       I was translating for a hispanic patient         15 A       I was translating for a hispanic patient         17 from English to Spanish, so that she would       Iso and you have served as an expert witness         16 A       No.         19 Amd she had a procedure at a different       In the wort made it to court,         24 becauset he court fei that there was non merit to <td></td> <td></td> <td>3</td>			3
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Notes

	Page 1(		Pag
1 A D'Angelo. I don't remember the names of	I ugo I(	1 A Yes, I have.	1 40
2 the defendants. There are five defendants.		2 Q Published articles	
3 Q D'Angelo is the plaintiff?		3 A Yes.	
4 A Yes.		4 Q in various journals and textbooks?	
5 Q Is it a local defendant?		5 A That is correct.	
6 A Yes.		<sub>60</sub> Have you published or written any chapters	
7 Q Would you be able to check the name of the		7 in any textbooks?	
s defendant in that case, or perhaps, if you		8 A I have.	
9 remember the name of the attorney that you are		<sub>9 Q</sub> Have you written any textbooks or edited	
0 serving as an expert for?		10 any textbooks?	
1 A Mr. DiCello.		11 A No. Chapters, no textbooks.	
2 MR. KELLEY: You know		$_{120}$ Do any of the articles or	
3 what		13 chapters in the textbooks have to do with PEG	
4 BY MR. MISHKIND:		14 tube issues?	
5 Q His deposition has been taken?		15 A No.	
6 MR. KELLEY: Let me have		160 Would it be too much of a problem for you	
7 30 seconds to think.		17 to provide a copy of your curriculum vitae to	
8		18 either of these gentlemen, and they in turn will	
9 (A discussion was had off the		19 provide me with a copy?	
0 record.)		20 A No problem.	
1		21 Q Thank you.	
2 MR. MISHKIND: Back on the		22 You are board certified, I presume?	
3 record.		23 A That is correct.	
4 BY MR. MISHKIND:		24 Q In internal medicine?	
5 Q Have you done any writing?	***	25 A In internal medicine and gastroenterology,	
t in the U.S. and in Canada	Page 12		Pag
1 in the U.S. and in Canada.	Page 12	1 A That is correct.	Pag
2 O Have any of the chapters that you have	Page 12	<ol> <li>A That is correct.</li> <li>I can't remember off the top of my head</li> </ol>	Pag
<sup>2</sup> Q Have any of the chapters that you have 3 written or participated in been included in the	Page 12	<ol> <li>A That is correct.</li> <li>I can't remember off the top of my head</li> <li>3 the other ones. There's two or three.</li> </ol>	Pag
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## TM

i-Page <sup>TM</sup>	
<ul> <li>1 his myositis, his polymyositis?</li> <li>2 A I believe it was.</li> <li>3 Q Were you involved in any other aspects of</li> <li>4 Mr. Brooks' care other than the PEG tube</li> <li>5 placement?</li> <li>6 A No, I wasn't.</li> <li>7 Q Have you had a chance to review the record</li> <li>8 on Mr. Brooks?</li> <li>9 A I have briefly reviewed the record in the</li> <li>10 past hour.</li> <li>11 Q And you have probably counsel's copy in</li> <li>12 front of you, right?</li> <li>13 A Yes. That is available to me.</li> <li>14 Q You didn't review the actual the</li> <li>15 original records from The Cleveland Clinic</li> <li>16 chart?</li> <li>17 A No, I haven't.</li> <li>18 Q Feel free to refer to the records, even</li> <li>19 though they would tell to you do so. It is not a</li> <li>20 memory contest.</li> <li>21 I want to ask you some questions about the</li> <li>22 indications for the PEG tube placement.</li> <li>23 Then I want to ask you about the</li> <li>24 risks and complications associated with PEG tube</li> </ul>	Page
25 placement. tes ***	
5 1 A Is the question, what would have been the 2 prognosis of his polymyositis?	Page
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50 In a patient that has developed dysphagia, 6 one of the concerns is continued aspiration,

7 correct?

That is one of the concerns. 8 A

What are some of the other 90

10 concerns?

Malnutrition. 11 A

Weight loss. 12

Unable to maintain hydration. And all of 13 14 the consequences of malnutrition. 150 As it relates to the history of 16 polymyositis and the course that a patient

17 follows in terms of morbidity, are you an expert

18 in that particular area?

No, I am not. 119 A

20 Q So as relates to what the long-term 21 prognosis would have been for Mr. Brooks had he 22 not experienced the hypovolemic complications 23 following the PEG tube placement, are you in a 24 position to say what type of morbidity he would 25 likely have sustained?

13 A No. There was another doctor referenced in the 14 O

8 a neurological diagnosis?

- 15 procedure, a Dr. Janis Ong?
- That is correct. 16 A
- 117 O Who is Dr. Ong?
- Dr. Ong is a fellow in gastroenterology. 18 **A**

Is that type of a situation, in terms of

7 polymyositis, is that either a rheumatological or

Usually rheumatologist would look after

6 the prognosis for a patient that has

10 most of the parents with polymyositis.

11 Neurologists become involved, as well.

That's not your subspecialty?

- 19 At the time he was doing consult for
- 20 gastroenterology.
- Is she still here? 21 Q
- Yes, he still is. 22 A
- 23 Q I apologize on the record for referring to
- 24 Dr. Ong as a female.
- 25 He is a male?
- Notes \*\*\*

5 Q

9 **a** 

120

Multi	-Page <sup>TM</sup>
Page 18 1 A That is correct. 2 Q Is Dr. Ong still here at the 3 Clinic? 4 A For another two days, I believe. 5 Q And where is Dr. Ong going on July 6 Ist? 7 A To the NIH. 8 Q Would that be in Atlanta? 9 A Maryland. 10 Q What aspect of the PEG tube placement did 11 Dr. Ong perform, and what aspects did you 12 perform? 13 If you can tell from the record 14 itself. 15 A Well, you want only the specific 16 technical aspect of the PEG or the involvement in 17 the PEG? 18 Q I am not sure. Tell me what 19 specific technical aspect that Dr. Ong 20 performed. 21 A I can't recall if he did the scope or the 23 endoscopy. 24 I can't recall who did which. 25 Q What I would like you to do for me in a **** Not	Page 19 I brief fashion, because, believe it or not, I have 2 studied a little bit, so I am somewhat familiar 3 with the procedure. 4 But just in a relatively simple manner, 5 perhaps in a manner that you would explain to a 6 Mr. Brooks, when you are performing the insertion 7 of the PEG tube or about to perform it, how would 8 you explain it in a simple fashion, what the 9 mechanical aspects of the procedure are going to 10 be? 11 A Okay. 12 I explain to the patient that 13 we will be giving intravenous medication for 14 sedation, so the patient will be relaxed. And 15 that we will spray the throat, and we usually 16 use a term such as nasty tasting spray all 17 of them have agreed so far to numb the throat, 18 to prevent the gagging reflex during the 19 procedure. 20 Q Let me stop you. 21 Continue. 22 A So I explain, if I am dealing 23 specifically with the technique of the procedure, 24 I tell the patient we will be giving intravenous 25 medication, spraying the throat.
Page 20 1 Then doing an endoscopy. That 2 involves introducing a tube that has a camera 3 and a light, through the mouth, into the 4 esophagus, into the stomach; examining the 5 stomach to make sure there's no significant 6 lesions in the stomach. 7 Examining the outlet of the stomach, 8 which is the pylorus, and going to the second 9 portion of the duodenum where the small intestine 10 begins. 11 If no lesions are identified, then the 12 skin is cleaned with an iodine solution. A site 13 where insertion of the tube will take place is 14 identified, and the area is numbed with a local 15 anesthetic. 16 And during that process, they may feel 17 like a stinging sensation, like a bee sting. And 18 after that is done, then a small incision is 19 performed, and a trocar is inserted through the 20 skin into the stomach. 21 A guide wire is advanced through the 22 trocar, and with forceps we put the instrument 23 through the endoscope. 24 We grab the guide wire and pull the 25 endoscope out. And then that guide wire is	Page 21 1 attached to what will actually become the feeding 2 tube. 3 And then we gull the guide wire out. We 4 pull it out, and that will pull the PEG tube, the 5 feeding tube will pull and come out through the 6 abdomen. 7 Then we put in a buffer to keep it in 8 place. After that we apply a local solution, a 9 topical antiseptic, a bandage, and the patient 10 will go to the recovery area, and subsequently to 11 the floor. 12 Q In this particular case, do you know who 13 made the incision into the abdomen? 14 A That I can't recall. 15 Q It might have been you and it might have 16 been Dr. Ong? 17 A That is correct. 18 Q Do you use the same general location for 19 the incision everytime that you perform PEG tube 20 placement? 21 A You try to go at least two or three finger 22 breaths, which is about four to six centimeters 23 below the costal margin, preferably on the left 24 side, and preferably on the line of the rectus 25 muscle.

Mul	ti-Page <sup>™</sup>
Page 2	
1 But that is just a general area where you	1 place?
2 start looking for optimal position. In every	$2 \hat{A}$ Which in this case was inability to
3 patient, given anatomical variations and all	3 maintain nutrition. I explain the risks of the
4 other conditions, you have to identify an optimal	4 procedure and the potential benefits or
5 site.	5 alternatives to the procedure.
6 Q You recognize that you are essentially	6 Q Do you remember Mr. Brooks at
7 making an incision somewhat blindly into the	7 all?
8 area, correct?	8 A I do.
9 A The incision is not blindly. The incision	9 Q Tell me what you remember about
10 of the trocar is.	10 him.
<sup>11</sup> Q And the hope is that you are	11 A He was not very communicative on the day
<sup>12</sup> not going to, in inserting the trocar, that you	12 when he came down for the procedure.
<sup>13</sup> are not going to involve any major blood vessels,	13 He appeared to be an elderly, thin,
14 correct?	14 African Âmerican male.
<sup>15</sup> A You expect to minimize complications.	15 Q When you say he was not very
<sup>16</sup> Q Now, as far as the potential risks and <sup>17</sup> complications, I believe somewhere in your notes	16 communicative, did he have someone with him at
17 complications, I believe somewhere in your notes	17 the point in time that you were explaining the
18 it indicates that the risks and benefits were	18 risks and benefits and alternatives?
<sup>19</sup> discussed.	19 A Not in the room.
<sup>20</sup> A That is correct.	20 Not a member of the family.
<sup>2</sup> 1 Q Is that your normal procedure to do	21 O Even though he was not communicative, was
<sup>2</sup> 2 that?	22 he able to, in your opinion, to appreciate what
<sup>23</sup> A I always discuss the procedure with the	23 it was that you were saying to him?
24 patient.	24 A I remember going and speaking to the
$25 \overline{Q}$ And the risks that may take	25 family
*** N	otes ***

Page 24 Page 25 1 Q Okay. 1 concerns I expressed to the family is that there -- given that I wasn't sure, and I 2 is an increased risk of complications from 2 **A** 3 explained to them the procedure. This had 3 sedation, and generally in a person like Mr. 4 already been explained also at length by Dr. Ong 4 Brooks. 5 to the family. What kind of concerns did you have with 5 Q 6 regards to Mr. Brooks? How do you know that? 6 Q 7 A Because when Dr. Ong presented the patient They are more prone to agitation. 7 A 8 to me, I asked him if he had explained the 8 Sometimes when they become agitated, you have to 9 procedure to the family, because he expressed his 9 use more sedation. <sup>1</sup>0 concerns about whether Mr. Brooks really was There can be a higher potential for 10 11 respiratory complications, respiratory I understanding or not. And he told me again that he spoke with 12 12 depression. 13 the family. 13 Q This is intraoperatively? <sup>1</sup>4 Q There is no question in your mind that,  $14\,\mathrm{A}$ During the procedure, mostly. <sup>1</sup>5 based upon the history that was provided to you, That did not take place in this case, 15Q 16 correct? 6 as well as your experience, that from a <sup>1</sup>7 standpoint of nutrition, the PEG tube was an No. 17A 8 appropriate means of providing nutritional 18 Q So the concern that you had relative to 9 support to this gentleman, correct? 19 sedation in this type of patient did not come to 2:0 MR. KILBANE: objection. 20 fruition. correct? 2:1 A That is correct. Correct. 21 A Would you agree there was no clinical 2:2 Q Do you remember talking with the family, 22 Q 23 contraindication to proceeding with PEG tube 23 also? 24A I do. 24 placement for this gentleman? 2:5 A There was no contraindication. One of the 25 Q Tell me, was it Mrs. Brooks that you spoke Notes

## m

	Multi-Page <sup>m</sup> Page 26 F	Page 2
<ul> <li>1 to?</li> <li>2 A I can't remember who it was from the</li> <li>3 family. There were two people, and I remember</li> <li>4 speaking to them before and at the end of the</li> <li>5 procedure.</li> <li>6 Q Can you tell me whether it was a male or a</li> <li>7 female that you spoke to?</li> <li>8 A Female.</li> <li>9 Q As to whether it was his wife, you don't</li> <li>10 know?</li> <li>11 A I can't recall.</li> <li>12 Q Was it someone of compatible age?</li> <li>13 A I cannot recall if it was</li> <li>14 a wife or a daughter or another member of the</li> <li>15 family.</li> <li>16 Q Are you able to formulate</li> <li>17 any type of a picture in your mind of that</li> <li>18 individual?</li> <li>19 A The individual, no. I recall very well</li> <li>20 the moment when I spoke to them.</li> <li>21 Q When you spoke to the family?</li> <li>22 A Before and after, yes.</li> <li>23 Q I am going to ask you to tell me what you</li> <li>24 told them. Are you able to in addition to</li> <li>25 remembering what you said, are you able to</li> </ul>	<ul> <li>1 describe for me their appearance?</li> <li>2 A No, I can't recall the description. I</li> <li>3 do remember the indication for the</li> <li>4 procedure.</li> <li>5 I did explain to them that there is a</li> </ul>	
<ol> <li>MR. KILBANE: Objection.</li> <li>Your question assumes that there are</li> <li>reliable texts.</li> <li>MR. MISHKIND: Of</li> <li>course.</li> <li>MMather and a second seco</li></ol>	<ul> <li>1 textbooks or journals or articles, that you are</li> <li>2 aware of, that you consider in your opinion to be</li> <li>3 reliable sources of information as it relates to</li> <li>4 the complications that are acknowledged in the</li> <li>5 medical literature associated with PEG tube</li> <li>6 placement?</li> <li>7 MR. KILBANE: objection.</li> <li>8 A I cannot quote a single one. You</li> <li>9 have to read in between the lines in all of these</li> <li>10 papers or book chapters, because you cannot</li> <li>11 generalize what happens from one institution to</li> <li>12 the next.</li> <li>13 You cannot generalize what happens in a</li> <li>14 tertiary care center to what happens in a</li> <li>15 community center.</li> <li>16 You can have a series of one</li> <li>17 hundred patients, and the complications from a</li> <li>18 small town, where they do one PEG once a week, i</li> <li>19 not going to be the same as if you read a series</li> <li>20 of one hundred patients in a major tertiary care</li> </ul>	Page 2

0 Page
1 There is one or more sources that you
2 would suggest to someone that wants to look for
3 reasonably, reliable scientific information, that
4 you should look here, or look here, or you should
5 look here?
6 MR. KILBANE: Objection.
7 A I would recommend that they do a
8 literature search, Medline.
9 Q You are not able to tell me any
10 particular journal or book chapters that you
11 consider to be some of the better sources for
12 this information?
13 MR. KILBANE: Objection.
14 A Again, no.
15 Q Okay.
16 That's fine. If your answer is no, that's
17 all I want to know.
18 A You have to read each one of
19 them and take from each one of them what is
20 applicable.
210 Have you done any research in preparation
22 for this deposition, or within the last six or
23 eight months, as it relates to the issues of
24 complications that are acknowledged in the
25 medical literature to occur following PEG tube
1 are. This is the Ambulatory Clinic Procedure
1 are. This is the Ambulatory Clinic Procedure 2 Record?
<ol> <li>are. This is the Ambulatory Clinic Procedure</li> <li>Record?</li> <li>A Yes.</li> </ol>
<ol> <li>are. This is the Ambulatory Clinic Procedure</li> <li>Record?</li> <li>A Yes.</li> <li>How is it that you are looking</li> </ol>
<ol> <li>are. This is the Ambulatory Clinic Procedure</li> <li>Record?</li> <li>A Yes.</li> <li>Q How is it that you are looking</li> <li>5 at the same thing that I am looking at and you</li> </ol>
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	Page 34	Page
1 reasonable?	I ugo 5 i	1 Q All three of them?
2 A Possibly.		2 A Yes.
3 O Are you able to recall whose initials		3 Q Did this procedure on Mr. Brooks take
4 those might belong to?		4 longer than what is considered to be customary
5 A Actually, yes.		5 for this type of procedure?
6 Nurses signature and initials. It is DC,		6 A No.
7 Diane Cency, C-e-n-c-y.		
		7  Q It was within the standard deviation, if
8 Q Okay.		8 you will?
9 A And RM, Rosalyn McKeon, M-c-K-e-o-n.		9 A That is correct.
O Q There is another one also, a Deborah		10 Q Did the procedure to your knowledge go
1 Osborne, or something?		11 uneventful?
2 A Osborne.		12A Yes.
3 Q Osborne?		13Q No complications that you were aware of
4 A Yes.		14 during the procedure?
5 Q Would Deborah have been the		15 A That is correct.
6 nurse that would have been assisting during the		16Q Or immediately at the end of the
7 procedure?		17 procedure?
8 A No.		18 A That is correct.
9 Q Deborah Osborne?		19 Q You told me that you remember Mr. Brooks,
0 A Could be. Could have been.		20 and you remember having a conversation before and
1 Q Do you remember any of these women?	:	21 after with family members, correct?
2 À Yes.		22 A That is correct.
$_{3 \text{ Q}}$ Are they still working in this		23 Q Do you remember actually performing the
4 department?		24 PEG tube placement on Mr. Brooks?
5 A Yes.		25 A I do remember.
	*** No1	
	Not	tes
Dut you just don't remember whether you	Page 36	tes
1 Q But you just don't remember whether you	Not	Pag 1 Q Dr. Ong, have you talked with him at all
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Page 38	B Page 39	
1 A No, just for endoscopies, undifferentiated	1 recall.	
2 endoscopies.	2 Q Do you know how many PEG tube placements	
3 You can do upper endoscopies and lower PEG	3 you had scheduled on that day?	
4 tube placements, sigmoidoscopies.	4 Å I don't remember.	
$_{50}$ The conversation that you had with the	5 Q If a blood vessel is nicked or hit at the	
6 family would have been outside of that area,	6 time of insertion through the skin, is that	
7 correct?	7 something that you would normally appreciate at	
8 A That is correct.	8 the time that it occurs?	
9 Q Do you remember anything in particular	9 A We do take every possible measure to try	
9 Q Do you remember anything in particular 10 about the substance of the conversation with the	10 to detect it early on. We anesthetize as we are	
11 family beforehand?	II putting the needle in.	
12 A I recall that I asked if they had any	12 We want to see the needle entering into	
13 questions. I went over the risks.	13 the stomach. This is a thin needle, a relatively	
14 Upon finishing the procedure, I indicated	14 short needle. And that would confirm that it is	
15 that everything during the procedure went fine	15 in a good position, that you don't have to go	
16 and that he was stable.	16 through a lot of tissue, or you are likely to go	
17 Q What was their reaction?	17 through other organs with that syringe.	
18 A They were relieved that it was	18 After we put the anesthetic on, we pull	
19 over.	19 out by making suction. So if you are already in	
<sup>20</sup> Q Do you remember anything that they said to	20 the skin and you get a bloody return, you know 21 that you are in a blood vessel.	
21 you afterwards?	21 that you are in a blood vessel.	
22 Å No.	22 Q Ökay.	
<sup>23</sup> Q Did Dr. Ong come out with you at that	23 A If you are already in the skin and you get	
24 time?	24 air, you can suspect that you went through a	
25 A I don't believe so. I don't	25 different organ, such as the colon.	
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	Page 40 Page 41
1 So that is during anesthetizing the local 2 area. Then when we insert the trocar. We also	1 Q Okay. 2 And what about the trocar?
3 insert the trocar and do suction for the same	3 A It is the standard trocar that comes with
4 reason, if you are going through a blood vessel,	4 the kit.
5 the syringe would fill up with blood, until	5Q So there's a standard PEG tube kit that
6 going into the stomach. That's when you get	6 you use?
7 air.	7 A That is correct.
8Q Even though you take precautions, checking	8 Q You never met Mr. Brooks
9 to see whether you have air or any bodily fluids	9 or the family before June 4th, 1998, did
10 coming out, that doesn't guarantee that there	10 you?
11 hasn't been an incidental blood vessel, whether	11 A No.
12 it is superficial, or a larger vessel that was	12 No, I didn't.
13 nicked during the procedure, correct?	13 Q After you left the endoscopoy suite, after
14 A That is correct.	14 telling the family the good news, everything went
15 Q Sometimes you can experience	15 fine, et cetera, he is doing fine, did you have
16 bleeding as a result of the PEG tube placement	16 any further involvement with the family after
17 that you do not appreciate at the time, even	17 that?
18 though you pulled back on the syringe, or you	18 A No, I did not.
19 checked to see, it doesn't materialize until a	19 Q I want to talk a little bit about the
20 later point, correct?	20 potential risks and complications. You told me
21 A That is correct.	21 about respiratory problems
$2_{2Q}$ What gauge needle do you use? Is there a	22 A Yes.
23 standard gauge that you use for this type of	23 Q correct?
24 procedure?	24 A That is correct.
25 A I use a 23 gauge.	25 Q You told me about infection?
*	** Notes ***

	Multi-Page     Page $ge 42$ Page
A Correct.	Page 42 Page 1 itself, the insertion, have we pretty
2 Q You told me about bleeding?	2 much covered the recognized risks and
A Correct.	3 complications?
Q Are there others?	$4 \mathbf{A}$ Those are probably the main ones, the
5 A Well, there are others. I don't	5 important ones.
5 know that I can recall absolutely all of	6 Q Okay.
7 them.	7 A That deals With the endoscopy itself.
There can be inflammation at the site of	8 There's the risk of esophageal tears, perforation
the injection.	9 of the esophagus, perforation of the stomach with
There can be respiratory arrest or cardiac	10 the tube, with the scope.
arrest. There could be infection at the incision	11 Q All of these potential risks and
2 site.	12 complications, do you explain them to the
There could be peritonitis. If you go	13 patient, and if the patient doesn't
through an organ, you can create a fistula	14 appear to be coherent, to a responsible family
5 between one organ and another, such as the	15 member?
5 stomach.	16 A I tell them about the risk of bleeding,
7 There's always a potential that it is a	17 perforation, infection, cardiac arrest,
s failed PEG, that you cannot place the PEG	18 respiratory arrest, side effects from
successfully, the risk of bleeding	19 medications.
Q We talked about	$_{20 \text{ O}}$ Would you say that PEG tube placement is a
I A death.	21 relatively simple procedure with few severe
2 Q Okay.	22 complications?
A And the risk of aspiration, once you	23 MR. KILBANE: objection.
4 started using the PEG tube.	24 A It depends on who does it. I would say,
5 Q But as to the procedure	25 yes, if it is done by a gastroenterologist that
	* Notes ***
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1 Q And would that then carry back to your	1 mucosal site, there is usually going to be blood
2 experiences back in Canada, as well?	2 return.
3 A That is correct.	3 If that is the case, then there is
4 Q Would you agree that when complications do	4 some things that you can do, depending on the
5 take place, close attention to the signs and the 6 symptoms associated with the complications will	5 severity of the bleed, what you can do or what 6 you do.
7 minimize unsatisfactory outcomes?	7  Q Are there various clotting factors that
S MR. KILBANE: objection.	8 you can use to try to enhance the healing process
9 A As a general statement, treating	9 if it is from the gastric mucosa that the bleed
0 complications, yes, it improves outcomes.	10 is coming from?
1 Q Okay.	11 A I don't know what you mean exactly by
2 Do you have an explanation in	12 clotting factors.
3 Mr. Brooks' case as to why he had a serious	13 Usually clotting factor replacement is
4 complication?	14 effective when there is a clotting factor
SA Î do not.	15 deficiency.
6 Q If the bleeding is from the gastric mucosa	16 A person that has normal clotting factors,
7 of the stomach as opposed to intra-abdominally,	17 you cannot make him clot better by giving him
s are there certain standard techniques that you	18 more.
9 can use to try to treat the bleed? 0 A If a patient is bleeding, first	19Q Is it fair to say that did I cut you 20 off?
1 we would like to know number one, you have to	21 A No.
2 confirm that the patient is bleeding, and you do	22 Q Is it fair to say that when you lavage the
3 a lavage or an aspiration and see if there is	23 site, that if you do not get any return, that
4 blood returned.	24 that is a fairly good indication that if there is
15 If the patient is bleeding from the	25 a serious bleed going on, it is not coming from
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1 the stomach?	1 Q Or if you have reason to suspect, based
1 the stomach? 2 A It is fair to say that it is	1 Q Or if you have reason to suspect, based 2 upon a drop in hemoglobin and a hypotensive state
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Page 5		Page 5
<ul> <li>1 blood pressure as well, is that reason to be</li> <li>2 concerned?</li> <li>3 MR. KILBANE: objection.</li> <li>4 A I think that is reason</li> <li>5 to see the patient, examine the patient, consider</li> <li>6 all of the possibilities that can led to the</li> <li>7 picture.</li> <li>8 Q And one of the things that has to be high</li> <li>9 up on the differential is the possibilities to</li> <li>2 consider.</li> <li>3 Q Would that be high up in the</li> <li>4 differential? Should that be high up in the</li> <li>5 differential?</li> <li>6 MR. KILBANE: objection.</li> <li>7 A It is high.</li> <li>8 Q What other factors should be in the</li> <li>9 differential with that scenario that I</li> <li>20 described?</li> <li>21 A Well, if a patient has been receiving a</li> <li>22 very large amount of fluids, you can artifically</li> <li>23 drop the hemoglobin because you are diluting the</li> <li>24 blood.</li> <li>25 If the person has hypotension, and the</li> </ul>	<ul> <li>1 patient has been lying in the hospital for some 2 period of time, you have to think of 3 pulmonary embolism.</li> <li>4 Septic complications can give you a very 5 similar picture.</li> <li>6 Q Okay.</li> <li>7 A Myocardial infarction can give you a 8 similar picture.</li> <li>9 MR. MISHKWD: Do you need</li> <li>10 to get that?</li> <li>11 THE WITNESS: Yes.</li> <li>12</li></ul>	

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1 emergencies, correct?		1 A I may have seen him. I cannot place	0
2 A Correct.		2 exactly who he is.	
$_{3 \text{ Q}}$ Would you agree that if the cause of the		$_{3 \text{ Q}}$ The records indicate that	
4 hypotension is bleeding, and it is not just		4 at approximately 2:25 a.m. on June 5th Dr.	
5 superficial bleeding, it usually cannot be		5 Goldman was paged.	
6 corrected endoscopically?		6 A 2;25 a.m.?	
7 A If the bleeding is not within the stomach		7 Q Do you see the note, patient was	1
8 wall at the PEG site, and you cannot see it, you		8 complaining of pain?	
9 cannot correct it edoscopically.		9 A Yes.	
10  Q So a laparotomy is necessary to correct		10 Q Holding his chest, anxious, short of	
11 it, if it is not superficial and if it is not		II breath?	
12 within the stomach, is that correct?		12A Yes.	
13 MR. KILBANE: objection.		13 Q I think that says, taking clothes	
14A It is one of the possibilities, one of the		. 14 off?	
15 means of looking at the problem.		15A Yes.	
16 Q How can you resolve the problem if it is a		16 Q And then later on it says, Dr. Goldman	
17 serious bleed that's taking place as opposed to a		17 paged. Dr. Goldman in room?	
18 superficial bleed?		18  A Yes.	
19 A It depends on how you define serious and		19 Q Is Dr. Goldman a gastroenterologist?	
20 how much the patient is bleeding.		20 A Not to my knowledge.	
21 Sometimes an angio with embolization could		21 Q Do you have any knowledge as to what	
22 be helpful.		22 service Dr. Goldman was on?	
23 Q There is reference to a Dr. Goldman.		23 A On the primary team taking care of the	
24 A Okay.		24 patient.	
25 Q Do you know Dr. Goldman?		$25 Q_{**}$ What do you mean by primary	
	Not	tes	

		Da
team?	ge 54	Pag
	1 department should be paged or contacted?	
A That the patient was not under	2 A No. No. The understanding is that the	
gastroenterology. He was under internal	3 team taking care of the patient are the people	
medicine, the White team, which is one of the	4 that are contacted.	
internal medicine teams.	5 They make the decisions.	
5Q The White team?	$_{6 \text{ Q}}$ As to what type of further diagnostic	
A I can confirm that in a moment. That	7 studies or further consultation, if any, is	
should be in the medical note.	8 necessary?	
Q Okay.	9 A That is correct.	
A The patient had been admitted under the	10 Q When did you learn about Mr. Brooks'	
White team. That would be the primary team	11 death?	
taking care of the patient.	12 A I cannot tell you exactly the date, but I	
BQ Okay.	13 received notification of the mention of his	
When a bleed is suspected following a PEG	14 death. That is when I learned, certainly not	
tube placement, is there a procedure here at the	15 when it happened.	
5 Cleveland Clinic as to who the nurses are to	16 Q You received a?	
v contact?	17 A Expiration notification.	
3 A When a patient has a complication	18Q What does that mean?	
of whatever sort, the contact people are the	19 A That he had expired. When a patient	
people that are taking care primarily of the	20 expires, they notify physicians that have been in	
patient.	21 contact with them, within a certain period of	
$2_{\rm Q}$ Are there situations where you give orders	22 time, of the expiration.	
to the nurses or others that are caring for the	I don't know what the rules are, so you do	
a patient after PEG tube placement, that if a	24 not go unnoticed.	
5 complication occurs, that you or someone in your	$25 \mathrm{Q}$ Is this something that is issued by the	
	* Notes ***	
	ge 56	Pag
hospital?	ge 56	Pag
hospital? 2 A It is administrative.	ge 56 1 Q Her name is hypenated now? 2 A Broniatowski.	Pag
hospital?	ge 56 1 Q Her name is hypenated now? 2 A Broniatowski.	Pag
hospital? 2 A It is administrative.	ge 56 1 Q Her name is hypenated now? 2 A Broniatowski. 3 Q We will leave it at Grunfest for right 4 now.	Pag
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Page 51 1 A No, I don't believe so. Usually first you 2 have to stabilize the patient. 3 You have to assess the patient, stabilize 4 the patient, make sure that they have 5 circulation, adequate volume, breathing. And 6 then you make a determination as to what is the 7 best next step. 8 And the best next step is not necessarily 9 a CAT scan. There may be reasons not to do a CAT 10 scan. 11 Q Well, if you are having difficulty 12 stabilizing the patient even with fluids being 13 administered, but the patient is remaining 14 hypotensive, are there reasons not to proceed 15 with further diagnostic studies? 16 A Well, you have to proceed with diagnostic 17 tests, with particular studies. You have to 18 choose your diagnostic study. 19 Q You might not do a CAT scan, you might do 20 an ultrasound? 21 A Ultrasound? I don't know how an	Page 59 1 managing a patient that has a bleed following PEG 2 tube placement that is hypotensive, where fluids 3 are being administered, and the patient remains 4 hypotensive; how long is it reasonable to monitor 5 that patient without doing diagnostic studies or 6 without making arrangements for a surgical 7 consult? 8 MR. KILBANE: objection. 9 You can answer. 10 A Again, you have to see the patient. It 11 depends on how hypotensive the patient is. 12 If the patient is on the floor or 13 transferred to the Intensive Care Unit, you want 14 to make sure the patient is in a safe, monitored 15 environment, where he could be treated should 16 something more significant occur. 17 Once that happens, then you call your 18 surgeon. 19 Q Are aware of the fact that Mi. Brooks 20 arrested? 21 A Now I am.
22 ultrasound might help in bleeding, other than if	
23 it shows up a large amount of blood and clotting	22 Q Do you have an opinion as to why he 23 arrested?
24 in the peritoneal cavity.	24 A I haven't gone through the
2.5 Q How long is it reasonable for someone	25 entire chart in detail, so I really cannot tell
Page 6	
<ul> <li>1 exactly why.</li> <li>2 Q Do you have an opinion as you sit here</li> <li>3 right now as to whether or not his cardiac arrest</li> <li>4 was preventable and avoidable?</li> <li>5 A Again, I would have to really go</li> <li>6 through the chart. I don't know the details of</li> <li>7 what transpired.</li> <li>8 I would have to review it in</li> <li>9 detail.</li> <li>10 Q And in order to be able to provide that</li> <li>11 opinion, would you have to look at what the</li> <li>12 pressures were? That would be one thing,</li> <li>13 correct?</li> <li>14 A You would have to look at pressures,</li> <li>15 oxygenation, the general status, the morbidity</li> <li>16 conditions, the previous history, has he</li> <li>17 arrested? Is there vascular disease?</li> <li>18 MR. KELLEY: Let's go</li> <li>19 off the record.</li> <li>20</li> <li>21 (A discussion was had off the</li> <li>22 record.)</li> <li>23</li> <li>24 MR. MISHKIND: If you want</li> <li>25 to state that on the record, go</li> </ul>	1ahead.2MR. KELLEY: I don't3remember what he just said about the4things that he would look to, but at5this point we don't have an intention6on calling him as an expert witness as7pertains to the ultimate cause of8death.9If we change our opinion, we10will let you know.11MR. MISHKIND: okay.12BY MR. MISHKIND:13 QWhat I would like you to do is to take a14 look, if you would, at the nursing progress15 records that reflect the vital signs that Mr.16 Brooks had going into the early morning hours of17 June 5th, after midnight.18At what point in time does it appear that19 Mr. Brooks became hypotensive previous?20 AIt says here 2:15.21MR. KLIBANE: Are you22talking about the first time entry next23to 24?24 BY MR. MISHKIND:25 QIf you look to the right of the black
*** No	tes ***

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Page 6 1 thick line, that's 2:45 a.m 2 A Yes. 3 Q on June 5th. The next one is 2:50, et 4 cetera. 5 Let me rephrase the question. 6 Are the vital signs as you look at them after 7 midnight, at 2:45, are those concerning vital 8 signs? 9 A 2:45, they are. 2:50, they are. 2:53, 0 certaintly they are. 1 Q And in a patient who has been less than 2 24 hours before had a PEG tube placement, of what 3 concern would you have looking at those vital 4 signs? 5 A Pulmonary embolus. 6 Myocardial infarction. 7 Bleeding. 8 Less likely sepsis. 9 Q Okay. 0 And if bleeding is a consideration, what 1 else would you need to do to evaluate the 2 patient? 3 A Well, in a patient like this, with these 4 changes, I would like to resuscitate the patient, 5 transfer him to a stable environment, like a	<ul> <li>Page 6</li> <li>1 monitored environment. Get gastrics, lavage, get</li> <li>2 your blood tests, chest X-ray, an EKG to rule-out</li> <li>3 myocardial infarction.</li> <li>4 Q At what time would you want to</li> <li>5 start doing those things according to the vital</li> <li>6 signs?</li> <li>7 A Right away. Obviously you start treating</li> <li>8 the patient. You put them on oxygen, give them</li> <li>9 fluids.</li> <li>10 And then you contact you make</li> <li>11 arrangements to transfer the patient to the</li> <li>12 unit.</li> <li>13 Q To what unit?</li> <li>14 A To an intensive care unit. You do an EKG</li> <li>15 to rule-out myocardial infarction.</li> <li>16 Q If the patient at 2:25 a.m., along with</li> <li>17 those vital signs is also demonstrating decreased</li> <li>18 mental status, all of that is expected in a</li> <li>19 patient that is sick?</li> <li>20 A None of that is specific for one disease</li> <li>21 process.</li> <li>22 Q Okay.</li> <li>23 But in any event, at that time, 2:25,</li> <li>24 2:50, 2:53, in that range, you are saying</li> <li>25 that the patient obviously should be seen,</li> </ul>

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1 correct?	1 A That is correct.
2 A Should be seen.	$_{2O}$ Like the vicera are not getting enough
3 Q And should be transferred to an intensive	3 oxygen?
4 care unit?	4 MR. MISHKIND: Off the
5 A Well, you start your evaluation and make	5 record one second.
6 arrangements.	6
7 Q What causes severe lactic acidosis,	7 (A discussion was had off the
8 Doctor?	8 record.)
9 A Hypoperfusion.	9
10 Q Is that prolonged, inadequate	110 MR. MISHKWD: Let's go
11 perfusion?	11 back on the record.
12 MR. KILBANE: Objection.	12 BY MR, MISHKIND:
13 A Not necessarily prolonged. It could be	<sup>113</sup> Q There's a Dr. Stanisic referenced
14 acute hypoperfusion.	114 in the CPR data sheet. Do you know who Dr.
15 In general, it produces lactic	115 Stanisic is?
16 acidosis.	116A No.
17 Q Is there a level of hypotension that you	17  Q When there is a complication
18 need to experience to have severe lactic	18 following PEG tube placement that requires a
19 acidosis?	19 laparotomy, is that outside of your area of
20 A No. Really hypoperfusion is caused	20 expertise?
21 usually by high blood pressure, hypotension. It	21 A That is correct.
22 means that the muscles, or that vicera, they	22 Q So, had there been an indication for
23 don't get enough oxygen.	23 surgical consultation earlier than what took
24 Q Hypotension can also cause hypoprofusion,	24 place in this case, you would not have been the
25 as well, correct?	25 individual to have been consulted with as to
**	** Notes ***

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whether a surgeon should be brought in or not,	I age 00	1 pain, responsive, but not fully oriented per	Fage
correct?		2 apparent baseline.	
A That is correct.		3 Do you see that?	
Q According to your review of the records,		4 A Yes.	
and I recognize that you have not looked in			
detail at this, but when was the patient admitted		5 Q Patient initially bolused. NS means 6 what?	
to the Intensive Care Unit?		7 A Normal saline.	
A Probably 4:38. Just browsing through			
this, I think it was 4:38.		8 Q Without response, is that correct? 9 A I don't like to use the S's or C's. I	
Q This is after the patient had arrested,		10 like to write a little bit.	
correct?		4	
A I have to go to the doctors'		11 Q The patient upon my arrival at 12 approximately 3:15 a.m. was continued	
sheet.		13 hypotensive. I am not sure whether that is	
CPR appeared to have started at ten past		14 responsive or not responsive.	
four in the morning.		15 Do you see where I am referring to?	
Q Okay.		16 A We would have to ask.	
Doctor, there's a reference to a senior			
medical resident that saw the patient. This is on June 5th. This is in the clinical sheets and		18 A Right.	
progress notes.		19Q Yes? 20 A Yes.	
The notes that I am referring to, there's			
a narration in here that talks about this		21 Q Now, do you know whether this individual 22 is Dr. Goldman, or are we referring to someone	
particular doctor, saying that at approximately			
2:00 a.m. the patient apparently became		23 else?	
hypotensive initially with chest pain, abdominal		<ul> <li>24 MR. KELLEY I don't</li> <li>25 <i>think</i> that's Goldman. Goldman signed</li> </ul>	
hypotensive initially with cliest pain, abdonnia	*** No	· · · · · · · · · · · · · · · · · · ·	
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different. I will tell you, I think it may be a resident who is now in a University Hospital fellowship, Michelle Lisgaris. MR. MISHKIND: That's one of the doctors that was attached to the interrogatories? MR. KELLEY Yes. MR. MISHKIND: Who has been MR. KELLEY: We are trying to our best indication is that is who it is. MR. MISHKIND: okay. MR. KELLEY: We are trying to get in touch with her to verify whether that's her note. BY MR. MISHKIND: Q Do you have any familiarity with that individual at all?	Page 68	<ol> <li>Is an EGD indicated in a patient</li> <li>that has hypotensive shock that's suspected</li> <li>to be due to hypovolemia from an intra-abdomin</li> <li>bleed?</li> <li>A Probably not. It may not add much</li> <li>6 information.</li> <li>7 Q A patient that is in hypotensive</li> <li>8 shook due to hypovolemia from an intra-abdom</li> <li>9 bleed, that is a medical emergency, is it</li> <li>10 not?</li> <li>11 MR. KILBANE: objection.</li> <li>12 A It is.</li> <li>13 Q And in addition to trying to</li> <li>14 provide fluid to the patient, if the patient</li> <li>15 is not responsible, responding to fluid</li> <li>16 treatment, does that then also become a surgical</li> <li>17 emergency?</li> <li>18 MR. KILBANE: Objection.</li> <li>19 A Number one, you have to be confident that</li> <li>20 that is happening.</li> <li>21 And number two, you have to, to the best</li> <li>22 of your ability, to stabilize and optimize the</li> </ol>	nal

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<ul> <li>1 surgery, if in fact they are not responding to</li> <li>2 fluids and their blood pressure is continuing to</li> <li>3 drop?</li> <li>4 A There are a lot of additional medications</li> <li>5 that can be used, pressors.</li> <li>6 Adequate ventilation.</li> <li>7 A high concentration of oxygen.</li> <li>8 You have to do all of those things,</li> <li>9 EKG to make sure they are not having a</li> <li>10 myocardial infarction as the cause of their</li> <li>11 hypotension.</li> <li>12 Q Should a surgical consultation be</li> <li>13 obtained?</li> <li>14 MR. KILBANE: Objection.</li> <li>15 A You have to obtain it at some point,</li> <li>16 yes.</li> <li>17 Q To determine whether or not it is</li> <li>18 appropriate and prudent to take the patient for a</li> <li>19 laparotomy to explore the source of the bleed,</li> <li>20 correct?</li> <li>21 A I believe that you should obtain a</li> <li>22 surgical consultation to get input from a</li> <li>23 surgical team, if your suspicion is very high</li> <li>24 that that's what is going on.</li> <li>25 It doesn't mean that you are going to do</li> </ul>	Page TO	<ul> <li>1 all of the others, and it doesn't mean that you</li> <li>2 don't do all of the other things.</li> <li>3 Q I am not suggesting that you don't. A</li> <li>4 surgical consultation, that would be on the list</li> <li>5 of things that is being administered as you are</li> <li>6 trying to get the patient stabilized with</li> <li>7 fluids</li> <li>8 MR. KILBANE: Objection.</li> <li>9 BY MR. MISHKIND:</li> <li>10 Q correct?</li> <li>11 A If you do it within a period of</li> <li>12 time.</li> <li>13 Q I mean, we are not talking six, seven</li> <li>14 hours, are we, after the patient developed</li> <li>15 hypotension?</li> <li>16 A It depends on how long it took for the</li> <li>17 patient to be stable, and to have some of the</li> <li>18 results back.</li> <li>19 If a patient has an acute MI or a</li> <li>20 pulmonary embolism, tachycardia, you</li> <li>21 don't want to treat the primary</li> <li>24 problem.</li> <li>25 Q*** Do you have an opinion in this case as to</li> </ul>	Page
15 It doesn't mean that you are going to do	***		
1 whether or not there was a delay in taking the	Page 72	2	Page
<ol> <li>whether or not there was a delay in taking the</li> <li>patient for surgical intervention to discovery</li> <li>the source of the bleed?</li> <li>A I don't know. I would have to go in</li> <li>5 detail through the entire record</li> </ol>	Page 72	<ul> <li>1 case?</li> <li>2 A No.</li> <li>3 Q So you don't know why it is that Mr.</li> <li>4 Brooks died, do you?</li> </ul>	Page
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	<b>fulti-Page<sup>™</sup></b> ge 74	Page 7
And you may have talked with		I age 1
2 Grundfest, you are just not certain that you	2	
3 did?	3	
<b>A</b> I doubt that. Around that time I did. I	4	
5 really can't recall if I ever spoke with her	5	
6 about it.	6	
7 MR. MISHKIND: Doctor, I	7	
8 don't think that I have any further	8	
questions for you at this time.	9	
I am going to reserve the right, depending uponiust because	10 11	
<ul><li>right, depending uponjust because</li><li>of the nature of these depositions,</li></ul>	11	
depending upon what is learned as	12	
relates to some of these other	14	
5 depositions, possibly to revisit Dr.	15	
5 Brzezinski.	16	
7 I doubt very much that I will	17	
8 need to.	18	
MR. KELLEY: We will	19	
address it if it comes up, if it is	20	
appropriate.	21	
2 He will read.	22	
(Denocition concluded)	23	
4 (Deposition concluded.)	24 25	
***	* 123 *** Notes	
Dec		<b>D</b> <sub>1</sub> + +
1 The State of Ohio, )	1	Page
	1 2 IN WITNESS WHEREOF, I have hereunto set my	-
1 The State of Ohio, ) 2 County of Cuyahoga. ) SS: CERTIFICATE 3 )	1 2 IN WITNESS WHEREOF, I have hereunto set my 3 hand and affixed my seal of office at Cleveland,	-
1 The State of Ohio, ) 2 County of Cuyahoga. ) SS: CERTIFICATE 3 ) 4	1 2 IN WITNESS WHEREOF, I have hereunto set my 3 hand and affixed my seal of office at Cleveland, 4 Ohio on this 2nd day of July, 2000.	-
1 The State of Ohio, ) 2 County of Cuyahoga. ) SS: CERTIFICATE 3 ) 4 5 I, Robert A. Cangemi, a Notary Public within	1 2 IN WITNESS WHEREOF, I have hereunto set my 3 hand and affixed my seal of office at Cleveland, 4 Ohio on this 2nd day of July, 2000. 5	-
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