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

IN THE COURT OF COMMON PLEAS

BESSIE M. BROOKS, INDIVIDUALLY AND AS ADMINISTRATOR OF THE ESTATE OF LEE THOMAS BROOKS,

Plaintiff,

-v-

Case No. 397309

THE CLEVELAND CLINIC FOUNDATION, ET AL.,

Defendants.

DEPOSITION OF AARON BRZEZINSKI, M.D.

Thursday, June 29, 2000

Deposition of AARON BRZEZINSKI, M.D., called for examination by the Plaintiff under the Ohio Rules of Civil Procedure, taken before me, Robert A. Cangemi, a Notary Public in and for the State of Ohio, at The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, commencing at 2:45 p.m., the day and date set forth.

CORSILLO & GRANDILLO
COURT REPORTERS
950 Citizens Building
Cleveland, Ohio 44114
216-523-1700

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APPEARANCES:

On Behalf of the Plaintiff:

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Cleveland, Ohio 44113

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On Behalf of the Defendants:

JAY M. KELLEY, III, ESQUIRE
THOMAS B. KILBANE, ESQUIRE
Reminger & Reminger
Suite 700
The 113 St. Clair Building
Cleveland, Ohio 44113

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AARON BRZEZINSKI, M.D.
called by the Plaintiff for examination under the Ohio Rules of Civil Procedure, after having been first duly sworn, as hereinafter certified, was examined and testified as follows:

- - - - -

EXAMINATION

- - - - -

BY MR. MISHKIND:

Q Would you please state your name for the record?
A Aaron Brzezinski. Would YOU like me to spell it?
Q Yes, please.
A A-a-r-o-n, B-r-z-e-z-i-n-s-k-i.
Q Dr. Brzezinski, my name is Howard Mishkind, I represent the estate of **Mr.** Brooks in connection with the lawsuit that's pending.
I am sure I am not telling you anything that is a mystery to you. I have some questions for you relative to your involvement in the care of Mr. Brooks back in June of 1998, okay?
A Sure.

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Q By Virtue of your accent, I detect that that's not a Northeastern Ohio accent, is that correct?
A That is correct.
Q Where are you from?
A I am originally from Mexico, born and raised in Mexico.
Q Really.
Would you briefly trace for me your educational background?
A Sure. I went to medical school in Mexico.
Q Which school?
A The National University in Mexico.
Then I did an internship and two years of medicine in Mexico.
Then I moved to Canada and I was at the University of Toronto from 1985 through 1992 in various positions.
I did my training in medicine and a fellowship in gastroenterology, which in Canada is called a residency.
Q What?
A A residency. They don't differentiate the fellowship from the residency.

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Q I've got it.
A Then I had a year of training at Masters Institute of Medical Sciences in Toronto, a year of research in inflammatory bowel disease, and clinical research.
And lastly I was working at Sunny Brook Hospital as part of the University of Toronto.
Q When did you first become affiliated with the Cleveland Clinic Foundation?
A November, 1992.
Q Are you a full-time staff member here at the hospital?
A Yes, I am.
Q Since November of 1992?
A That is correct.
Q Have you ever had your deposition taken before, sir?
A Yes, I have.
Q And on how many occasions?
A Three.
Q Your area of specialty is gastroenterology?
A Yes.
Q Do you have an area of subspecialty within

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gastroenterology?
A Inflammatory bowel disease.
Q You performed the percutaneous endoscopic gastrostomy on Mr. Brooks?
A That is correct.
Q That is the same thing as a PEG tube placement?
A Yes.
Q To keep the transcript shorter, I will refer to it as PEG tube.
A Sounds good.
Q Going back to your testifying experience, were you testifying as an expert witness in the other three occasions where your deposition was taken?
A No. They were variable. One of them was in Toronto.
One of them was a building lawsuit. And the third one I am trying to remember.
The third one was as an expert witness.
Q The situation in Toronto, were you a defendant in that matter?
MR. KILBANE: objection.
A I was one of the defendants.

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Q What year approximately would that have been?
A Maybe 1987, 1988. I really can't recall the exact year.
Q Was your involvement as it relates to some gastroenterological issue?
A Yes.
Q Did it have to do with inflammatory bowel disease?
A No.
Q Did it have to do with PEG tube placement?
A No.
Q Tell me what it had to do with. Was it relating to you?
A I was translating for a hispanic patient from English to Spanish, so that she would understand.
And she had a procedure at a different institution, and subsequently the patient and the family decided to sue the University of Toronto, three hospitals, fifty physicians.
It never made it to court, because *the* court felt that there was no merit to it.

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Q The building lawsuit, were you bringing a claim. or was --
a Yes.
Q You had a problem with a builder?
A Major problem.
Q Was that in Canada?
A No, here in Cleveland.
Q Cleveland?
A Yes.
Q Did that matter go to trial?
A It did.
Q You were the plaintiff in that case?
A Yes.
Q And you have served as an expert witness on one occasion?
A That **is** correct.
Q Were you the expert for the physician or the hospital or for the patient?
A For the patient.
Q You gave a deposition?
A Yes.
Q Did you testify at trial?
A It has not arrived to trial, yet.
Q What is the name of the case?

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A. D'Angelo. I don't remember the names of the defendants. There are five defendants.
Q. D'Angelo is the plaintiff?
A. Yes.
Q. Is it a local defendant?
A. Yes.
Q. Would you be able to check the name of the defendant in that case, or perhaps, if you remember the name of the attorney that you are serving as an expert for?
A. Mr. DiCello.
MR. KELLEY: You know what --
BY MR. MISHKIND:
Q. His deposition has been taken?
MR. KELLEY: Let me have 30 seconds to think.
- - - - -
(A discussion was had off the record.)
- - - - -
MR. MISHKIND: Back on the record.
BY MR. MISHKIND:
Q. Have you done any writing?

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A. Yes, I have.
Q. Published articles --
A. Yes.
Q. -- in various journals and textbooks?
A. That is correct.
Q. Have you published or written any chapters in any textbooks?
A. I have.
Q. Have you written any textbooks or edited any textbooks?
A. No. Chapters, no textbooks.
Q. Do any of the articles or chapters in the textbooks have to do with PEG tube issues?
A. No.
Q. Would it be too much of a problem for you to provide a copy of your curriculum vitae to either of these gentlemen, and they in turn will provide me with a copy?
A. No problem.
Q. Thank you.
You are board certified, I presume?
A. That is correct.
Q. In internal medicine?
A. In internal medicine and gastroenterology,

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in the U.S. and in Canada.
Q. Have any of the chapters that you have written or participated in been included in the Amata's Textbook of Gastroenterology?
A. No.
Q. Which textbook?
A. There's a textbook by Fazio --
Q. Okay.
A. -- and four other physicians. It is a textbook on inflammatory bowel disease. It is in England and the U.S.
A. textbook by Milsom and Michelas.
MR. KILBANE: Can you spell that?
THE WITNESS: M-i-c-h-e-l-a-s, I believe.
A. And Cecil's.
Q. Internal Medicine?
A. Yes.
Q. Okay.
A. The short version of Cecil's Internal Medicine.
Q. Okay.
You wrote a book chapter on inflammatory bowel disease in that?

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A. That is correct.
I can't remember off the top of my head the other ones. There's two or three.
Q. Your curriculum vitae is relatively up-to-date?
A. Within six months, yes.
Q. And it would have most, if not all of the publications within the last six months or so?
A. Not within the last 6 months. Up to about six months ago. It has most of them.
Q. Fair enough.
Myositis, would you define that for me, please?
A. Myositis is inflammation of the muscles.
Q. What is proximal myopathy?
A. It can be used in several ways. Myopathy means a disease of the muscle, which could be inflammatory or non-inflammatory.
Proximal myopathy can be either primary or secondary. If it is primary, you can see it in conditions such as polymyositis or dermatomyositis.
Secondary could be, for example, if you

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have cervical damage or spinal damage.
Medications used, like corticosteroids, could produce myopathy.
Or patients that have Duchenne's muscular dystrophy, all of the muscular dystrophies. One of them is proximal myopathy. Polymyositis would be primary. Polymyositis involves many muscles.
Q How is polymyositis diagnosed?
A History, medical history, physical examination, laboratory tests, and on occasions it requires muscle biopsy.
By the way, I should emphasize this is one of the areas of medicine that is most commonly seen by rheumatologists and internists.
Q And I recognize that you were brought in, as I understand it, due to dysphagic development secondary to polymyositis.
In other words, because of aspiration problems, there was a need for PEG tube placement on this individual, correct?
A I was brought in for the procedure itself.
Q But --
A There was dysphagia.
Q And the dysphagia was a manifestation of

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his myositis, his polymyositis?
A I believe it was.
Q Were you involved in any other aspects of Mr. Brooks' care other than the PEG tube placement?
A No, I wasn't.
Q Have you had a chance to review the record on Mr. Brooks?
A I have briefly reviewed the record in the past hour.
Q And you have probably counsel's copy in front of you, right?
A Yes. That is available to me.
Q You didn't review the actual -- the original records from The Cleveland Clinic chart?
A No, I haven't.
Q Feel free to refer to the records, even though they would tell to you do so. It is not a memory contest.
I want to ask you some questions about the indications for the PEG tube placement.
Then I want to ask you about the risks and complications associated with PEG tube placement.

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A Okay.
Q And then probably a few other questions, okay?
A Okay.
Q In a patient that has developed dysphagia, one of the concerns is continued aspiration, correct?
A That is one of the concerns.
Q What are some of the other concerns?
A Malnutrition.
Weight loss.
Unable to maintain hydration. And all of the consequences of malnutrition.
Q As it relates to the history of polymyositis and the course that a patient follows in terms of morbidity, are you an expert in that particular area?
A No, I am not.
Q So as relates to what the long-term prognosis would have been for Mr. Brooks had he not experienced the hypovolemic complications following the PEG tube placement, are you in a position to say what type of morbidity he would likely have sustained?

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A Is the question, what would have been the prognosis of his polymyositis?
Q You put it better than I did.
A No, I am not an expert in the area.
Q Is that type of a situation, in terms of the prognosis for a patient that has polymyositis, is that either a rheumatological or a neurological diagnosis?
A Usually rheumatologist would look after most of the parents with polymyositis.
Neurologists become involved, as well.
Q That's not your subspecialty?
A No.
Q There was another doctor referenced in the procedure, a Dr. Janis Ong?
A That is correct.
Q Who is Dr. Ong?
A Dr. Ong is a fellow in gastroenterology.
At the time he was doing consult for gastroenterology.
Q Is she still here?
A Yes, he still is.
Q I apologize on the record for referring to Dr. Ong as a female.
He is a male?

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A That is correct.
Q Is Dr. Ong still here at the Clinic?
A For another two days, I believe.
Q And where is Dr. Ong going on July 1st?
A To the NIH.
Q Would that be in Atlanta?
A Maryland.
Q What aspect of the PEG tube placement did Dr. Ong perform, and what aspects did you perform?
If you can tell from the record itself.
A Well, you want only the specific technical aspect of the PEG or the involvement in the PEG?
Q I am not sure. Tell me what specific technical aspect that Dr. Ong performed.
A I can't recall if he did the scope or the skin. There's one person that does the endoscopy.
I can't recall who did which.
Q What I would like you to do for me in a

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brief fashion, because, believe it or not, I have studied a little bit, so I am somewhat familiar with the procedure.
But just in a relatively simple manner, perhaps in a manner that you would explain to a Mr. Brooks, when you are performing the insertion of the PEG tube or about to perform it, how would you explain it in a simple fashion, what the mechanical aspects of the procedure are going to be?
A Okay.
I explain to the patient that we will be giving intravenous medication for sedation, so the patient will be relaxed. And that we will spray the throat, and we usually use a term such as nasty tasting spray -- all of them have agreed so far -- to numb the throat, to prevent the gagging reflex during the procedure.
Q Let me stop you.
Continue.
A So I explain, if I am dealing specifically with the technique of the procedure, I tell the patient we will be giving intravenous medication, spraying the throat.

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Then doing an endoscopy. That involves introducing a tube that has a camera and a light, through the mouth, into the esophagus, into the stomach; examining the stomach to make sure there's no significant lesions in the stomach.
Examining the outlet of the stomach, which is the pylorus, and going to the second portion of the duodenum where the small intestine begins.
If no lesions are identified, then the skin is cleaned with an iodine solution. A site where insertion of the tube will take place is identified, and the area is numbed with a local anesthetic.
And during that process, they may feel like a stinging sensation, like a bee sting. And after that is done, then a small incision is performed, and a trocar is inserted through the skin into the stomach.
A guide wire is advanced through the trocar, and with forceps we put the instrument through the endoscope.
We grab the guide wire and pull the endoscope out. And then that guide wire is

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attached to what will actually become the feeding tube.
And then we gull the guide wire out. We pull it out, and that will pull the PEG tube, the feeding tube will pull and come out through the abdomen.
Then we put in a buffer to keep it in place. After that we apply a local solution, a topical antiseptic, a bandage, and the patient will go to the recovery area, and subsequently to the floor.
Q In this particular case, do you know who made the incision into the abdomen?
A That I can't recall.
Q It might have been you and it might have been Dr. Ong?
A That is correct.
Q Do you use the same general location for the incision everytime that you perform PEG tube placement?
A You try to go at least two or three finger breaths, which is about four to six centimeters below the costal margin, preferably on the left side, and preferably on the line of the rectus muscle.

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But that is just a general area where you start looking for optimal position. In every patient, given anatomical variations and all other conditions, you have to identify an optimal site.
Q You recognize that you are essentially making an incision somewhat blindly into the area, correct?
A The incision is not blindly. The incision of the trocar is.
Q And the hope is that you are not going to, in inserting the trocar, that you are not going to involve any major blood vessels, correct?
A You expect to minimize complications.
Q Now, as far as the potential risks and complications, I believe somewhere in your notes it indicates that the risks and benefits were discussed.
A That is correct.
Q Is that your normal procedure to do that?
A I always discuss the procedure with the patient.
Q And the risks that may take

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place?
A Which in this case was inability to maintain nutrition. I explain the risks of the procedure and the potential benefits or alternatives to the procedure.
Q Do you remember Mr. Brooks at all?
A I do.
Q Tell me what you remember about him.
A He was not very communicative on the day when he came down for the procedure.
He appeared to be an elderly, thin, African American male.
Q When you say he was not very communicative, did he have someone with him at the point in time that you were explaining the risks and benefits and alternatives?
A Not in the room.
Not a member of the family.
Q Even though he was not communicative, was he able to, in your opinion, to appreciate what it was that you were saying to him?
A I remember going and speaking to the family --

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Q Okay.
A -- given that I wasn't sure, and I explained to them the procedure. This had already been explained also at length by Dr. Ong to the family.
Q How do you know that?
A Because when Dr. Ong presented the patient to me, I asked him if he had explained the procedure to the family, because he expressed his concerns about whether Mr. Brooks really was understanding or not.
And he told me again that he spoke with the family.
Q There is no question in your mind that, based upon the history that was provided to you, as well as your experience, that from a standpoint of nutrition, the PEG tube was an appropriate means of providing nutritional support to this gentleman, correct?
MR. KILBANE: objection.
A That is correct.
Q Would you agree there was no clinical contraindication to proceeding with PEG tube placement for this gentleman?
A There was no contraindication. One of the

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concerns I expressed to the family is that there is an increased risk of complications from sedation, and generally in a person like Mr. Brooks.
Q What kind of concerns did you have with regards to Mr. Brooks?
A They are more prone to agitation. Sometimes when they become agitated, you have to use more sedation.
There can be a higher potential for respiratory complications, respiratory depression.
Q This is intraoperatively?
A During the procedure, mostly.
Q That did not take place in this case, correct?
A No.
Q So the concern that you had relative to sedation in this type of patient did not come to fruition, correct?
A Correct.
Q Do you remember talking with the family, also?
A I do.
Q Tell me, was it Mrs. Brooks that you spoke

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to?
A I can't remember who it was from the family. There were two people, and I remember speaking to them before and at the end of the procedure.
Q Can you tell me whether it was a male or a female that you spoke to?
A Female.
Q As to whether it was his wife, you don't know?
A I can't recall.
Q Was it someone of compatible age?
A I cannot recall if it was a wife or a daughter or another member of the family.
Q Are you able to formulate any type of a picture in your mind of that individual?
A The individual, no. I recall very well the moment when I spoke to them.
Q When you spoke to the family?
A Before and after, yes.
Q I am going to ask you to tell me what you told them. Are you able to -- in addition to remembering what you said, are you able to

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describe for me their appearance?
A No, I can't recall the description. I do remember the indication for the procedure.
I did explain to them that there is a potential for risk, that there's a potential for complications, that they range roughly five to ten percent; that some of them are minor, like inflammation, or infection, where the tube goes in.
But that there is also the potential for significant complications, such as respiratory depression, aspiration, bleeding, infection, perforating the bowel, or going through other organs, and that the patient is debilitated; that there is a risk of death, if the complication were to occur, would be much higher.
Q If you were talking with medical students or residents as it relates to the complications or the potential complications associated with PEG tube placement, what would be the best or some of the best sources of reliable information in the medical literature that outlines the relative risks of these various complications occurring?

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MR. KILBANE: Objection. Your question assumes that there are reliable texts.
MR. MISHKIND: Of course.
A What I will do is -- what I usually do is go retrieve -- I do a literature search.
Q Okay.
A I read the papers and decide which are really the better studies. I use those as a reference for the purpose of teaching.
Q You do teach?
A I do.
Q I assume that you are aware of some good articles that outline the risks and the complications that can occur and what are the symptoms that you should look for in those complications, correct?
A My area of teaching is mostly inflammatory bowel disease, diarrhea and acute upper and lower GI bleed.
That's usually what I teach and lecture on.
Q Are there any textbooks or chapters in

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textbooks or journals or articles, that you are aware of, that you consider in your opinion to be reliable sources of information as it relates to the complications that are acknowledged in the medical literature associated with PEG tube placement?
MR. KILBANE: objection.
A I cannot quote a single one. You have to read in between the lines in all of these papers or book chapters, because you cannot generalize what happens from one institution to the next.
You cannot generalize what happens in a tertiary care center to what happens in a community center.
You can have a series of one hundred patients, and the complications from a small town, where they do one PEG once a week, is not going to be the same as if you read a series of one hundred patients in a major tertiary care center.
Q Let's talk about the Cleveland Clinic. This is a major tertiary care center?
A That is correct.
Q Are you aware of any studies done at this

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institution dealing with comulications and the frequency of complications following PEG tube placement?
A Studies, no.
Q Are you aware of any studies or chapters in books that deal with tertiary care facilities and the frequency of complications following PEG tube placement?
A I can't, not off the top of my head.
Q Is there anything that you consider to be authoritative as relates to how frequently in the medical community various complications, whether they be respiratory, infection, bleeding or the other complications associated with PEG tube placement, how frequently they occur and what steps need to be taken to recognize those Complications?
MR. KILBANE: Objection.
A Authoritative?
Q Yes.
A There is no one standard that you can apply to all of the institutions.
Q I am not suggesting that there is any one standard.

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There is one or more sources that you would suggest to someone that wants to look for reasonably, reliable scientific information, that you should look here, or look here, or you should look here?
MR. KILBANE: Objection.
A I would recommend that they do a literature search, Medline.
Q You are not able to tell me any particular journal or book chapters that you consider to be some of the better sources for this information?
MR. KILBANE: Objection.
A Again, no.
Q Okay.
That's fine. If your answer is no, that's all I want to know.
A You have to read each one of them and take from each one of them what is applicable.
Q Have you done any research in preparation for this deposition, or within the last six or eight months, as it relates to the issues of complications that are acknowledged in the medical literature to occur following PEG tube

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placement?
A Well, I haven't done a literature search presently.
Q Do you have any articles in your office that deal with complications following PEG tube placement?
A I don't keep -- the records I keep --
Q Deal with inflammatory bowel disease?
A Yes.
Q How long did the PEG tube placement from start to finish take?
A Usually that takes, from the time that you start giving sedation, until you are done, it usually takes between 20 and 45 minutes.
Q Can you tell from the record in this case how long it took?
A The medication was given at ten past nine. We usually wait about five minutes before we start, five, ten minutes.
So we started between 9:15 and 9:20.
We probably finished at ten to ten, around 9:50.
Q I am looking at the same document that you

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are. This is the Ambulatory Clinic Procedure Record?
A Yes.
Q How is it that you are looking at the same thing that I am looking at and you are able to say the procedure ended at about 9:50?
A You asked me to *guess.*
Q I didn't ask you to *guess.* I asked you, when did the procedure start, and when did it end in this particular case?
A I can tell roughly. I cannot tell exactly. Do you see the initials of the nurse.
Q I see the initials of nurses going all the way up to 10:40.
A The first ones are DO, DO, DO, DO. That last one is DO.
Then they change. So the last three is a recovery area nurse. The first one is the nurse that is with me all of the time in the room.
Q Do you know who DO is?
A No.
Q The next one appears to be RM, is that

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reasonable?
A Possibly.
Q Are you able to recall whose initials those might belong to?
A Actually, yes.
Nurses signature and initials. It is DC, Diane Cency, C-e-n-c-y.
Q Okay.
A And RM, Rosalyn McKeon, M-c-K-e-o-n.
Q There is another one also, a Deborah Osborne, or something?
A Osborne.
Q Osborne?
A Yes.
Q Would Deborah have been the nurse that would have been assisting during the procedure?
A No.
Q Deborah Osborne?
A Could be. Could have been.
Q Do you remember any of these women?
A Yes.
Q Are they still working in this department?
A Yes.

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Q All three of them?
A Yes.
Q Did this procedure on Mr. Brooks take longer than what is considered to be customary for this type of procedure?
A No.
Q It was within the standard deviation, if you will?
A That is correct.
Q Did the procedure to your knowledge go uneventful?
A Yes.
Q No complications that you were aware of during the procedure?
A That is correct.
Q Or immediately at the end of the procedure?
A That is correct.
Q You told me that you remember Mr. Brooks, and you remember having a conversation before and after with family members, correct?
A That is correct.
Q Do you remember actually performing the PEG tube placement on Mr. Brooks?
A I do remember.

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Q But you just don't remember whether you were the one that did --
A Scope or skin.
Q -- did the scope or skin?
A That is correct.
Q How many PEG tube placements do you do on average on any given day?
A It is probably fair to say in a given week --
Q Okay.
A -- or month.
It varies from rotation to rotation, depending on what rotation I am doing. Maybe three to five a month.
Q The conversation that you had with the family before the procedure started --
A Yes.
Q -- would it have been sometime early that morning?
A Yes.
Q Do you have any recollection of what was said by any of the family members to you or any questions that were asked of you when you talked to them?
A No.

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Q Dr. Ong, have you talked with him at all about this case?
A No, I haven't.
Q Does he know that your deposition is being taken?
A No.
Q How many family members do you remember being present?
A I believe there were two. Two people I spoke to.
Q The conversation that you had, would it have been in some type of a waiting area?
A Yes. it was. Not in the room. It was outside.
Q Is there a procedure room that you use for these?
A No. We have two endoscopy units. They have many different rooms in the same area.
Q Is it essentially an examining room that the endoscopic procedure is done in, or is it --
A No, it is an endoscopy room.
Q Like an operating room?

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A No, just for endoscopies, undifferentiated endoscopies.
You can do upper endoscopies and lower PEG tube placements, sigmoidoscopies.
Q The conversation that you had with the family would have been outside of that area, correct?
A That is correct.
Q Do you remember anything in particular about the substance of the conversation with the family beforehand?
A I recall that I asked if they had any questions. I went over the risks.
Upon finishing the procedure, I indicated that everything during the procedure went fine and that he was stable.
Q What was their reaction?
A They were relieved that it was over.
Q Do you remember anything that they said to you afterwards?
A No.
Q Did Dr. Ong come out with you at that time?
A I don't believe so. I don't

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recall.
Q Do you know how many PEG tube placements you had scheduled on that day?
A I don't remember.
Q If a blood vessel is nicked or hit at the time of insertion through the skin, is that something that you would normally appreciate at the time that it occurs?
A We do take every possible measure to try to detect it early on. We anesthetize as we are putting the needle in.
We want to see the needle entering into the stomach. This is a thin needle, a relatively short needle. And that would confirm that it is in a good position, that you don't have to go through a lot of tissue, or you are likely to go through other organs with that syringe.
After we put the anesthetic on, we pull out by making suction. So if you are already in the skin and you get a bloody return, you know that you are in a blood vessel.
Q Okay.
A If you are already in the skin and you get air, you can suspect that you went through a different organ, such as the colon.

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So that is during anesthetizing the local area. Then when we insert the trocar. We also insert the trocar and do suction for the same reason, if you are going through a blood vessel, the syringe would fill up with blood, until going into the stomach. That's when you get air.
Q Even though you take precautions, checking to see whether you have air or any bodily fluids coming out, that doesn't guarantee that there hasn't been an incidental blood vessel, whether it is superficial, or a larger vessel that was nicked during the procedure, correct?
A That is correct.
Q Sometimes you can experience bleeding as a result of the PEG tube placement that you do not appreciate at the time, even though you pulled back on the syringe, or you checked to see, it doesn't materialize until a later point, correct?
A That is correct.
Q What gauge needle do you use? Is there a standard gauge that you use for this type of procedure?
A I use a 23 gauge.

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Q Okay.
And what about the trocar?
A It is the standard trocar that comes with the kit.
Q So there's a standard PEG tube kit that you use?
A That is correct.
Q You never met Mr. Brooks or the family before June 4th, 1998, did you?
A No.
No, I didn't.
Q After you left the endoscopoy suite, after telling the family the good news, everything went fine, et cetera, he is doing fine, did you have any further involvement with the family after that?
A No, I did not.
Q I want to talk a little bit about the potential risks and complications. You told me about respiratory problems --
A Yes.
Q -- correct?
A That is correct.
Q You told me about infection?

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A Correct.
Q You told me about bleeding?
A Correct.
Q Are there others?
A Well, there are others. I don't know that I can recall absolutely all of them.
There can be inflammation at the site of the injection.
There can be respiratory arrest or cardiac arrest. There could be infection at the incision site.
There could be peritonitis. If you go through an organ, you can create a fistula between one organ and another, such as the stomach.
There's always a potential that it is a failed PEG, that you cannot place the PEG successfully, the risk of bleeding --
Q We talked about --
A -- death.
Q Okay.
A And the risk of aspiration, once you started using the PEG tube.
Q But as to the procedure

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itself, the insertion, have we pretty much covered the recognized risks and complications?
A Those are probably the main ones, the important ones.
Q Okay.
A That deals With the endoscopy itself. There's the risk of esophageal tears, perforation of the esophagus, perforation of the stomach with the tube, with the scope.
Q All of these potential risks and complications, do you explain them to the patient, and if the patient doesn't appear to be coherent, to a responsible family member?
A I tell them about the risk of bleeding, perforation, infection, cardiac arrest, respiratory arrest, side effects from medications.
Q Would you say that PEG tube placement is a relatively simple procedure with few severe complications?
MR. KILBANE: objection.
A It depends on who does it. I would say, yes, if it is done by a gastroenterologist that

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is trained. I don't minimize the difficulty of the PEG tube placement.
I think we should take everyone seriously, and we do. The potential for significant complications, is low, but it exists.
Q Tell me about your experience.
How many patients have you had where they have developed serious bleeding complications following PEG tube placement?
MR. KILBANE: Objection.
A Well, Mr. Brooks is the only patient that I know of that has had a complication from the procedure.
Q Okay.
A I don't know of a complication following the procedure.
Q At the time that you did Mi-. Brooks' PEG tube placement -- you had been at the Clinic from 1992 to 1998, correct?
A That is correct.
Q So six years at this institution?
A Yes.
Q Doing three to five, per month?
A Yes. I would have to look specifically at the numbers, but that is probably

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an average.
Q Do you keep your own score card, your own records?
A No.
Q If we took three to five, you are doing somewhere in the range of 48 to 50 a year?
A That is correct.
Q And was this pretty much what you were doing from 1992 up through 1998?
A I believe so.
Q And has it been basically about the same number since?
A Sometimes it is more. Sometimes it is less. It depends on whether some of my colleagues that do PEGs are on vacation or not, or what type what of rotation I am doing.
Q From 1992 to the current date, Mr. Brooks is the only experience that you have had of a serious bleeding complication?
MR. KILBANE: objection.
BY MR. MISHKIND:
Q Correct?
A Of a serious complication.

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Q And would that then carry back to your experiences back in Canada, as well?
A That is correct.
Q Would you agree that when complications do take place, close attention to the signs and the symptoms associated with the complications will minimize unsatisfactory outcomes?
MR. KILBANE: objection.
A As a general statement, treating complications, yes, it improves outcomes.
Q Okay.
Do you have an explanation in Mr. Brooks' case as to why he had a serious complication?
A I do not.
Q If the bleeding is from the gastric mucosa of the stomach as opposed to intra-abdominally, are there certain standard techniques that you can use to try to treat the bleed?
A If a patient is bleeding, first we would like to know -- number one, you have to confirm that the patient is bleeding, and you do a lavage or an aspiration and see if there is blood returned.
If the patient is bleeding from the

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mucosal site, there is usually going to be blood return.
If that is the case, then there is some things that you can do, depending on the severity of the bleed, what you can do or what you do.
Q Are there various clotting factors that you can use to try to enhance the healing process if it is from the gastric mucosa that the bleed is coming from?
A I don't know what you mean exactly by clotting factors.
Usually clotting factor replacement is effective when there is a clotting factor deficiency.
A person that has normal clotting factors, you cannot make him clot better by giving him more.
Q Is it fair to say that -- did I cut you off?
A No.
Q Is it fair to say that when you lavage the site, that if you do not get any return, that that is a fairly good indication that if there is a serious bleed going on, it is not coming from

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the stomach?
A It is fair to say that it is very unlikely that there is significant bleeding in the mucosal site or from inside, from inside the stomach.
Q Is it also fair to say that the standard of care in treating someone in a postendoscopic -- I am sorry -- post PEG tube placement, where there is concern that the patient has experienced a bleed, that one of the first steps in order to meet the standard of care is to determine whether or not the bleeding is coming from the stomach or whether it is coming from the abdominal area?
MR. KILBANE: objection.
If you can answer based on those facts, go ahead, Doctor.
A The question is, if the patient is bleeding, you have to determine where they are bleeding from.
Q Is that the standard of care to do that?
A If you know that the patient is bleeding, you like to know where they are bleeding from, yes.

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Q Or if you have reason to suspect, based upon a drop in hemoglobin and a hypotensive state in the patient, and the patient has a drop in hemoglobin and hypotension that is evidently caused by a bleed, the standard of care is determine whether it is intra-abdominal or coming from the stomach?
MR. KILBANE: objection.
A A drop in hemoglobin or hypotension or both together?
Q Either.
If you have a drop in hemoglobin following a PEG tube placement, what does that indicate to you?
A It depends on how significant the drop is, an over what period of time.
Q If there's a drop from say 13.3 down to about nine following the procedure in less than a 24-hour period, are you concerned, or should you be concerned?
A It depends. You have to examine the patient and see what's been happening with the patient in that 24-hours.
Q If you add in that patient with a drop in hemoglobin that there is a drop in

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blood pressure as well, is that reason to be concerned?
MR. KILBANE: objection.
A I think that is reason to see the patient, examine the patient, consider all of the possibilities that can led to the picture.
Q And one of the things that has to be high up on the differential is the possibility of bleeding?
A Bleeding is one of the possibilities to consider.
Q Would that be high up in the differential? Should that be high up in the differential?
MR. KILBANE: objection.
A It is high.
Q What other factors should be in the differential with that scenario that I described?
A Well, if a patient has been receiving a very large amount of fluids, you can artifically drop the hemoglobin because you are diluting the blood.
If the person has hypotension, and the

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patient has been lying in the hospital for some period of time, you have to think of pulmonary embolism.
Septic complications can give you a very similar picture.
Q Okay.
A Myocardial infarction can give you a similar picture.
MR. MISHKWD: Do you need to get that?
THE WITNESS: Yes.
- - - - -
(Recess taken.)
- - - - -
BY MR. MISHKIND:
Q What is the first thing that you think of as a gastroenterologist in a patient who has had a PEG tube placed that becomes hypotensive?
A Within what time frame?
Q Within 24 hours or less.
A If it is within 24 hours, you have to think of sepsis, pulmonary embolism, MI, and bleeding.
Q All of those things being medical

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emergencies, correct?
A Correct.
Q Would you agree that if the cause of the hypotension is bleeding, and it is not just superficial bleeding, it usually cannot be corrected endoscopically?
A If the bleeding is not within the stomach wall at the PEG site, and you cannot see it, you cannot correct it edoscopically.
Q So a laparotomy is necessary to correct it, if it is not superficial and if it is not within the stomach, is that correct?
MR. KILBANE: objection.
A It is one of the possibilities, one of the means of looking at the problem.
Q How can you resolve the problem if it is a serious bleed that's taking place as opposed to a superficial bleed?
A It depends on how you define serious and how much the patient is bleeding.
Sometimes an angio with embolization could be helpful.
Q There is reference to a Dr. Goldman.
A Okay.
Q Do you know Dr. Goldman?

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A I may have seen him. I cannot place exactly who he is.
Q The records indicate that at approximately 2:25 a.m. on June 5th Dr. Goldman was paged.
A 2;25 a.m.?
Q Do you see the note, patient was complaining of pain?
A Yes.
Q Holding his chest, anxious, short of breath?
A Yes.
Q I think that says, taking clothes off?
A Yes.
Q And then later on it says, Dr. Goldman paged. Dr. Goldman in room?
A Yes.
Q Is Dr. Goldman a gastroenterologist?
A Not to my knowledge.
Q Do you have any knowledge as to what service Dr. Goldman was on?
A On the primary team taking care of the patient.
Q What do you mean by primary

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team?
A That the patient was not under gastroenterology. He was under internal medicine, the White team, which is one of the internal medicine teams.
Q The White team?
A I can confirm that in a moment. That should be in the medical note.
Q Okay.
A The patient had been admitted under the White team. That would be the primary team taking care of the patient.
Q Okay.
When a bleed is suspected following a PEG tube placement, is there a procedure here at the Cleveland Clinic as to who the nurses are to contact?
A When a patient has a complication of whatever sort, the contact people are the people that are taking care primarily of the patient.
Q Are there situations where you give orders to the nurses or others that are caring for the patient after PEG tube placement, that if a complication occurs, that you or someone in your

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department should be paged or contacted?
A No. No. The understanding is that the team taking care of the patient are the people that are contacted.
They make the decisions.
Q As to what type of further diagnostic studies or further consultation, if any, is necessary?
A That is correct.
Q When did you learn about Mr. Brooks' death?
A I cannot tell you exactly the date, but I received notification of the mention of his death. That is when I learned, certainly not when it happened.
Q You received a --?
A Expiration notification.
Q What does that mean?
A That he had expired. When a patient expires, they notify physicians that have been in contact with them, within a certain period of time, of the expiration.
I don't know what the rules are, so you do not go unnoticed.
Q Is this something that is issued by the

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hospital?
A It is administrative.
Q Did you have to do anything in response to that expiration notification?
A No.
Q Did you keep the expiration notification?
A No.
Q Were you asked to give any type of a statement to any committee at the hospital as it relates to the circumstances surrounding Mr. Brooks' death?
MR. KILBANE: objection.
A No.
Q Did you ever talk with Dr. Grundfest about what she discovered at the time that she went in and operated on Mi-. Brooks on June 5th?
A I can't recall.
Q You might have?
A Not within the time that it happened. No, I really can't recall it.
Q Grundfest is still here at the hospital?
A Yes.

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Q Her name is hypenated now?
A Broniatowski.
Q We will leave it at Grunfest for right now.
She's the one that did the overseeing of the --
A I believe that she was a surgeon. If you want, I can check the record.
Grundfest did the surgery.
Q Have you ever talked, to your knowledge, to any of the physicians that were involved in any aspect of Mr. Brooks' care after he was transferred out of the endoscopy suite on June 4th?
A Not to my recollection, no.
Q Doctor, once it is determined that there is a high likelihood that there is a bleed following a PEG tube placement, and it is determined that the bleed most likely is not coming from the stomach itself, because the lavage is clear, would you agree that the standard of care requires that a stat CT scan be performed to ascertain the source or the location of the bleed?
MR. KILBANE: objection.
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A No, I don't believe so. Usually first you have to stabilize the patient.
You have to assess the patient, stabilize the patient, make sure that they have circulation, adequate volume, breathing. And then you make a determination as to what is the best next step.
And the best next step is not necessarily a CAT scan. There may be reasons not to do a CAT scan.
Q Well, if you are having difficulty stabilizing the patient even with fluids being administered, but the patient is remaining hypotensive, are there reasons not to proceed with further diagnostic studies?
A Well, you have to proceed with diagnostic tests, with particular studies. You have to choose your diagnostic study.
Q You might not do a CAT scan, you might do an ultrasound?
A Ultrasound? I don't know how an ultrasound might help in bleeding, other than if it shows up a large amount of blood and clotting in the peritoneal cavity.
Q How long is it reasonable for someone

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managing a patient that has a bleed following PEG tube placement that is hypotensive, where fluids are being administered, and the patient remains hypotensive; how long is it reasonable to monitor that patient without doing diagnostic studies or without making arrangements for a surgical consult?
MR. KILBANE: objection.
You can answer.
A Again, you have to see the patient. It depends on how hypotensive the patient is.
If the patient is on the floor or transferred to the Intensive Care Unit, you want to make sure the patient is in a safe, monitored environment, where he could be treated should something more significant occur.
Once that happens, then you call your surgeon.
Q Are aware of the fact that Mi. Brooks arrested?
A Now I am.
Q Do you have an opinion as to why he arrested?
A I haven't gone through the entire chart in detail, so I really cannot tell

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exactly why.
Q Do you have an opinion as you sit here right now as to whether or not his cardiac arrest was preventable and avoidable?
A Again, I would have to really go through the chart. I don't know the details of what transpired.
I would have to review it in detail.
Q And in order to be able to provide that opinion, would you have to look at what the pressures were? That would be one thing, correct?
A You would have to look at pressures, oxygenation, the general status, the morbidity conditions, the previous history, has he arrested? Is there vascular disease?
MR. KELLEY: Let's go off the record.
- - - - -
(A discussion was had off the record.)
- - - - -
MR. MISHKIND: If you want to state that on the record, go

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ahead.
MR. KELLEY: I don't remember what he just said about the things that he would look to, but at this point we don't have an intention on calling him as an expert witness as pertains to the ultimate cause of death.
If we change our opinion, we will let you know.
MR. MISHKIND: okay.
BY MR. MISHKIND:
Q What I would like you to do is to take a look, if you would, at the nursing progress records that reflect the vital signs that Mr. Brooks had going into the early morning hours of June 5th, after midnight.
At what point in time does it appear that Mr. Brooks became hypotensive previous?
A It says here 2:15.
MR. KLIBANE: Are you talking about the first time entry next to 24?
BY MR. MISHKIND:
Q If you look to the right of the black

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thick line, that's 2:45 a.m. --
A Yes.
Q -- on June 5th. The next one is 2:50, et cetera.
Let me rephrase the question. Are the vital signs as you look at them after midnight, at 2:45, are those concerning vital signs?
A 2:45, they are. 2:50, they are. 2:53, certainly they are.
Q And in a patient who has been -- less than 24 hours before had a PEG tube placement, of what concern would you have looking at those vital signs?
A Pulmonary embolus.
Myocardial infarction.
Bleeding.
Less likely sepsis.
Q Okay.
And if bleeding is a consideration, what else would you need to do to evaluate the patient?
A Well, in a patient like this, with these changes, I would like to resuscitate the patient, transfer him to a stable environment, like a

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monitored environment. Get gastrics, lavage, get your blood tests, chest X-ray, an EKG to rule-out myocardial infarction.
Q At what time would you want to start doing those things according to the vital signs?
A Right away. Obviously you start treating the patient. You put them on oxygen, give them fluids.
And then you contact -- you make arrangements to transfer the patient to the unit.
Q To what unit?
A To an intensive care unit. You do an EKG to rule-out myocardial infarction.
Q If the patient at 2:25 a.m., along with those vital signs is also demonstrating decreased mental status, all of that is expected in a patient that is sick?
A None of that is specific for one disease process.
Q Okay.
But in any event, at that time, 2:25, 2:50, 2:53, in that range, you are saying that the patient obviously should be seen,

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correct?
A Should be seen.
Q And should be transferred to an intensive care unit?
A Well, you start your evaluation and make arrangements.
Q What causes severe lactic acidosis, Doctor?
A Hypoperfusion.
Q Is that prolonged, inadequate perfusion?
MR. KILBANE: Objection.
A Not necessarily prolonged. It could be acute hypoperfusion.
In general, it produces lactic acidosis.
Q Is there a level of hypotension that you need to experience to have severe lactic acidosis?
A No. Really hypoperfusion is caused usually by high blood pressure, hypotension. It means that the muscles, or that vicera, they don't get enough oxygen.
Q Hypotension can also cause hypoprofusion, as well, correct?

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A That is correct.
Q Like the vicera are not getting enough oxygen?
MR. MISHKIND: Off the record one second.
- - - - -
(A discussion was had off the record.)
- - - - -
MR. MISHKWD: Let's go back on the record.
BY MR. MISHKIND:
Q There's a Dr. Stanisic referenced in the CPR data sheet. Do you know who Dr. Stanisic is?
A No.
Q When there is a complication following PEG tube placement that requires a laparotomy, is that outside of your area of expertise?
A That is correct.
Q So, had there been an indication for surgical consultation earlier than what took place in this case, you would not have been the individual to have been consulted with as to

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whether a surgeon should be brought in or not, correct?
A That is correct.
Q According to your review of the records, and I recognize that you have not looked in detail at this, but when was the patient admitted to the Intensive Care Unit?
A Probably 4:38. Just browsing through this, I think it was 4:38.
Q This is after the patient had arrested, correct?
A I have to go to the doctors' sheet.
CPR appeared to have started at ten past four in the morning.
Q Okay.
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 progress notes.
The notes that I am referring to, there's a narration in here that talks about this particular doctor, saying that at approximately 2:00 a.m. the patient apparently became hypotensive initially with chest pain, abdominal

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pain, responsive, but not fully oriented per apparent baseline.
Do you see that?
A Yes.
Q Patient initially bolused. NS means what?
A Normal saline.
Q Without response, is that correct?
A I don't like to use the S's or C's. I like to write a little bit.
Q The patient upon my arrival at approximately 3:15 a.m. was continued hypotensive. I am not sure whether that is responsive or not responsive.
Do you see where I am referring to?
A We would have to ask.
Q That individual?
A Right.
Q Yes?
A Yes.
Q Now, do you know whether this individual is Dr. Goldman, or are we refemng to someone else?
MR. KELLEY I don't *think* that's Goldman. Goldman signed

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some other note, and the writing is 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?
A No, not really.
Q Okay. I am not going to ask you any further questions on that, then.

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Is an EGD indicated in a patient that has hypotensive shock that's suspected to be due to hypovolemia from an intra-abdominal bleed?
A Probably not. It may not add much information.
Q A patient that is in hypotensive shook due to hypovolemia from an intra-abdominal bleed, that is a medical emergency, is it not?
MR. KILBANE: objection.
A It is.
Q And in addition to trying to provide fluid to the patient, if the patient is not responsible, responding to fluid treatment, does that then also become a surgical emergency?
MR. KILBANE: Objection.
A Number one, you have to be confident that that is what is happening.
And number two, you have to, to the best of your ability, to stabilize and optimize the patient's condition to undergo surgery.
Q And how do you go about stabilizing a patient to optimize their situation for

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surgery, if in fact they are not responding to fluids and their blood pressure is continuing to drop?
A There are a lot of additional medications that can be used, pressors.
Adequate ventilation.
A high concentration of oxygen.
You have to do all of those things, EKG to make sure they are not having a myocardial infarction as the cause of their hypotension.
Q Should a surgical consultation be obtained?
MR. KILBANE: Objection.
A You have to obtain it at some point, yes.
Q To determine whether or not it is appropriate and prudent to take the patient for a laparotomy to explore the source of the bleed, correct?
A I believe that you should obtain a surgical consultation to get input from a surgical team, if your suspicion is very high that that's what is going on.
It doesn't mean that you are going to do

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all of the others, and it doesn't mean that you don't do all of the other things.
Q I am not suggesting that you don't. A surgical consultation, that would be on the list of things that is being administered as you are trying to get the patient stabilized with fluids --
MR. KILBANE: Objection.
BY MR. MISHKIND:
Q -- correct?
A If you do it within a period of time.
Q I mean, we are not talking six, seven hours, are we, after the patient developed hypotension?
A It depends on how long it took for the patient to be stable, and to have some of the results back.
If a patient has an acute MI or a pulmonary embolism, tachycardia, you don't want to take that patient to the operating room.
You want to treat the primary problem.
Q Do you have an opinion in this case as to

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whether or not there was a delay in taking the patient for surgical intervention to discovery the source of the bleed?
A I don't know. I would have to go in detail through the entire record.
Even then, I mean, it is difficult to know, unless you see the patient. But I don't know all of the details of what happened afterwards to give an opinion.
Q Would that again be outside of your area of expertise as relates to the surgical intervention or the timing of that surgical intervention?
A I believe so. I think this is more in line with ICU, surgery.
MR. KILBANE: Off the record.
- - - - -
(A discussion was had off the record.)
- - - - -
MR. MISHKIND: Back on the record.
BY MR. MISHKIND:
Q Did you ever see the autopsy in this

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case?
A No.
Q So you don't know why it is that Mr. Brooks died, do you?
A No.
Q And you don't have any opinion as you are sitting here right now as to whether exploratory surgery should have and could have taken place sooner than it did?
A That is correct.
Q But you would acknowledge that once postoperative hypovolemia is recognized following PEG tube placement, a surgical consult should be obtained in a timely manner?
MR. KILBANE: objection.
BY MR. MISHKIND:
Q Correct?
A In you recognize hypovolemia, yes.
Q As far as any of the nurses that were involved in the care of the patient, in the MICU, either prior to or after his arrest, or prior to or after the surgery to resolve the intra-abdominal bleed, did you ever talk with any of those people?
A No.

*** Notes ***

Q And you may have talked with Grundfest, you are just not certain that you did?
A I doubt that. Around that time I did. I really can't recall if I ever spoke with her about it.
MR. MISHKIND: Doctor, I don't think that I have any further questions for you at this time.
I am going to reserve the right, depending upon --just because of the nature of these depositions, depending upon what is learned as relates to some of these other depositions, possibly to revisit Dr. Brzezinski.
I doubt very much that I will need to.
MR. KELLEY: We will address it if it comes up, if it is appropriate.
He will read.
- - - - -
(Deposition concluded.)
- - - - -

*** Notes ***

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

I, Robert A. Cangemi, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named AARON BRZEZINSKI, M.D., was by me first duly sworn to testify the truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him/her was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a computer, and the foregoing is a true and correct transcript of the testimony so given by him/her as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.
I do further certify that I am not a relative, counsel or attorney of either party or otherwise interested in the event of this aciton.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio on this 2nd day of July, 2000.

_____
Robert **A.** Cangemi, Notary Public
in and for the State of Ohio.
My Commission expires 3-5-02.

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