

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

2 - - - - -
3 IN THE COURT OF COMMON PLEAS
4 - - - - -

5 BESSIE M. BROOKS,)
6 INDIVIDUALLY AND AS)
7 ADMINISTRATOR OF THE)
8 ESTATE OF LEE THOMAS BROOKS,)

9 Plaintiff,)

10 -v-)

Case No. 397309

11 THE CLEVELAND CLINIC)
12 FOUNDATION, ET AL.,)
13)
14 Defendants. - - - - -)

15 DEPOSITION OF AARON BRZEZINSKI, M.D.

16 Thursday, June 29, 2000

17 - - - - -

18 Deposition of AARON BRZEZINSKI, M.D., called for
19 examination by the Plaintiff under the Ohio Rules
20 of Civil Procedure, taken before me, Robert A.
21 Cangemi, a Notary Public in and for the State of
22 Ohio, at The Cleveland Clinic Foundation, 9500
23 Euclid Avenue, Cleveland, Ohio, commencing at
24 2:45 p.m., the day and date set forth.
25

26 - - - - -
27 CORSILLO & GRANDILLO
28 COURT REPORTERS
29 950 Citizens Building
30 Cleveland, Ohio 44114
31 216-523-1700
32 - - - - -

Computer-Aided Transcription By
Corsillo & Grandillo Court Reporters

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15 APPEARANCES:

16
 17
 18 On Behalf of the Plaintiff:

19
 20 HOWARD D. MISHKIND, ESQUIRE
 21 Becker & Mishkind
 22 Skylight Office Tower
 23 Suite 660
 24 Cleveland, Ohio 44113
 25

1 On Behalf of the Defendants:

2
 3 JAY M. KELLEY, III, ESQUIRE
 4 THOMAS B. KILBANE, ESQUIRE
 5 Reminger & Reminger
 6 Suite 700
 7 The 113 St. Clair Building
 8 Cleveland, Ohio 44113
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*** Notes ***

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

6 -----
 7 EXAMINATION
 8 -----

9 BY MR. MISHKIND:

10 Q Would you please state your name for the
 11 record?

12 A Aaron Brzezinski. Would you like me to
 13 spell it?

14 Q Yes, please.

15 A A-a-r-o-n, B-r-z-e-z-i-n-s-k-i.

16 Q Dr. Brzezinski, my name is Howard

17 Mishkind, I represent the estate of

18 Mr. Brooks in connection with the lawsuit that's
 19 pending.

20 I am sure I am not telling you anything
 21 that is a mystery to you. I have some questions
 22 for you relative to your involvement in the care
 23 of Mr. Brooks back in June of 1998,
 24 okay?

25 A Sure.

1 Q By Virtue of your accent, I detect that
 2 that's not a Northeastern Ohio accent, is that
 3 correct?

4 A That is correct.

5 Q Where are you from?

6 A I am originally from Mexico, born and
 7 raised in Mexico.

8 Q Really.

9 Would you briefly trace for me your
 10 educational background?

11 A Sure. I went to medical school in
 12 Mexico.

13 Q Which school?

14 A The National University in Mexico.

15 Then I did an internship and two years of
 16 medicine in Mexico.

17 Then I moved to Canada and I was at the
 18 University of Toronto from 1985 through 1992 in
 19 various positions.

20 I did my training in medicine and a
 21 fellowship in gastroenterology, which in Canada
 22 is called a residency.

23 Q What?

24 A A residency. They don't differentiate the
 25 fellowship from the residency.

*** Notes ***

1 Q I've got it.
 2 A Then I had a year of training at Masters
 3 Institute of Medical Sciences in Toronto, a year
 4 of research in inflammatory bowel disease, and
 5 clinical research.
 6 And lastly I was working at Sunny
 7 Brook Hospital as part of the University of
 8 Toronto.
 9 Q When did you first become affiliated with
 10 the Cleveland Clinic Foundation?
 11 A November, 1992.
 12 Q Are you a full-time staff member here at
 13 the hospital?
 14 A Yes, I am.
 15 Q Since November of 1992?
 16 A That is correct.
 17 Q Have you ever had your deposition taken
 18 before, sir?
 19 A Yes, I have.
 20 Q And on how many occasions?
 21 A Three.
 22 Q Your area of specialty is
 23 gastroenterology?
 24 A Yes.
 25 Q Do you have an area of subspecialty within

1 gastroenterology?
 2 A Inflammatory bowel disease.
 3 Q You performed the percutaneous endoscopic
 4 gastrostomy on Mr. Brooks?
 5 A That is correct.
 6 Q That is the same thing as a PEG tube
 7 placement?
 8 A Yes.
 9 Q To keep the transcript shorter, I will
 10 refer to it as PEG tube.
 11 A Sounds good.
 12 Q Going back to your testifying experience,
 13 were you testifying as an expert witness in the
 14 other three occasions where your deposition was
 15 taken?
 16 A No. They were variable. One of them was
 17 in Toronto.
 18 One of them was a building lawsuit. And
 19 the third one I am trying to remember.
 20 The third one was as an expert
 21 witness.
 22 Q The situation in Toronto, were you a
 23 defendant in that matter?
 24 MR. KILBANE: objection.
 25 A I was one of the defendants.

*** Notes ***

1 Q What year approximately would that have
 2 been?
 3 A Maybe 1987, 1988. I really can't recall
 4 the exact year.
 5 Q Was your involvement as it relates to some
 6 gastroenterological issue?
 7 A Yes.
 8 Q Did it have to do with inflammatory bowel
 9 disease?
 10 A No.
 11 Q Did it have to do with PEG tube
 12 placement?
 13 A No.
 14 Q Tell me what it had to do with. Was it
 15 relating to you?
 16 A I was translating for a hispanic patient
 17 from English to Spanish, so that she would
 18 understand.
 19 And she had a procedure at a different
 20 institution, and subsequently the patient and the
 21 family decided to sue the University of Toronto,
 22 three hospitals, fifty physicians.
 23 It never made it to court,
 24 because *the* court felt that there was no merit to
 25 it.

1 Q The building lawsuit, were you bringing a
 2 claim. or was --
 3 A Yes.
 4 Q You had a problem with a builder?
 5 A Major problem.
 6 Q Was that in Canada?
 7 A No, here in Cleveland.
 8 Q Cleveland?
 9 A Yes.
 10 Q Did that matter go to trial?
 11 A It did.
 12 Q You were the plaintiff in that
 13 case?
 14 A Yes.
 15 Q And you have served as an expert witness
 16 on one occasion?
 17 A That **is** correct.
 18 Q Were you the expert for the physician or
 19 the hospital or for the patient?
 20 A For the patient.
 21 Q You gave a deposition?
 22 A Yes.
 23 Q Did you testify at trial?
 24 A It has not arrived to trial, yet.
 25 Q What is the name of the case?

*** Notes ***

1 A D'Angelo. I don't remember the names of
 2 the defendants. There are five defendants.
 3 Q D'Angelo is the plaintiff?
 4 A Yes.
 5 Q Is it a local defendant?
 6 A Yes.
 7 Q Would you be able to check the name of the
 8 defendant in that case, or perhaps, if you
 9 remember the name of the attorney that you are
 10 serving as an expert for?
 11 A Mr. DiCello.
 12 MR. KELLEY: You know
 13 what --
 14 BY MR. MISHKIND:
 15 Q His deposition has been taken?
 16 MR. KELLEY: Let me have
 17 30 seconds to think.
 18 -----
 19 (A discussion was had off the
 20 record.)
 21 -----
 22 MR. MISHKIND: Back on the
 23 record.
 24 BY MR. MISHKIND:
 25 Q Have you done any writing?

1 A Yes, I have.
 2 Q Published articles --
 3 A Yes.
 4 Q -- in various journals and textbooks?
 5 A That is correct.
 6 Q Have you published or written any chapters
 7 in any textbooks?
 8 A I have.
 9 Q Have you written any textbooks or edited
 10 any textbooks?
 11 A No. Chapters, no textbooks.
 12 Q Do any of the articles or
 13 chapters in the textbooks have to do with PEG
 14 tube issues?
 15 A No.
 16 Q Would it be too much of a problem for you
 17 to provide a copy of your curriculum vitae to
 18 either of these gentlemen, and they in turn will
 19 provide me with a copy?
 20 A No problem.
 21 Q Thank you.
 22 You are board certified, I presume?
 23 A That is correct.
 24 Q In internal medicine?
 25 A In internal medicine and gastroenterology,

*** Notes ***

1 in the U.S. and in Canada.
 2 Q Have any of the chapters that you have
 3 written or participated in been included in the
 4 Amata's Textbook of Gastroenterology?
 5 A No.
 6 Q Which textbook?
 7 A There's a textbook by Fazio --
 8 Q Okay.
 9 A -- and four other physicians. It is a
 10 textbook on inflammatory bowel disease. It is in
 11 England and the U.S.
 12 A textbook by Milsom and Michelas.
 13 MR. KILBANE: Can you
 14 spell that?
 15 THE WITNESS:
 16 M-i-c-h-e-l-a-s, I believe.
 17 A And Cecil's.
 18 Q Internal Medicine?
 19 A Yes.
 20 Q Okay.
 21 A The short version of Cecil's Internal
 22 Medicine.
 23 Q Okay.
 24 You wrote a book chapter on inflammatory
 25 bowel disease in that?

1 A That is correct.
 2 I can't remember off the top of my head
 3 the other ones. There's two or three.
 4 Q Your curriculum vitae is relatively
 5 up-to-date?
 6 A Within six months, yes.
 7 Q And it would have most, if not
 8 all of the publications within the last six
 9 months or so?
 10 A Not within the last 6 months. Up to about
 11 six months ago. It has most of them.
 12 Q Fair enough.
 13 Myositis, would you define that for me,
 14 please?
 15 A Myositis is inflammation of the
 16 muscles.
 17 Q What is proximal myopathy?
 18 A It can be used in several ways. Myopathy
 19 means a disease of the muscle, which could be
 20 inflammatory or non-inflammatory.
 21 Proximal myopathy can be either primary or
 22 secondary. If it is primary, you can see it in
 23 conditions such as polymyositis or
 24 dermatomyositis.
 25 *** Secondary could be, for example, if you

*** Notes ***

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

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

*** Notes ***

1 A Okay.
 2 Q And then probably a few other questions,
 3 okay?
 4 A Okay.
 5 Q In a patient that has developed dysphagia,
 6 one of the concerns is continued aspiration,
 7 correct?
 8 A That is one of the concerns.
 9 Q What are some of the other
 10 concerns?
 11 A Malnutrition.
 12 Weight loss.
 13 Unable to maintain hydration. And all of
 14 the consequences of malnutrition.
 15 Q 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?
 19 A No, I am not.
 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?

1 A Is the question, what would have been the
 2 prognosis of his polymyositis?
 3 Q You put it better than I did.
 4 A No, I am not an expert in the area.
 5 Q Is that type of a situation, in terms of
 6 the prognosis for a patient that has
 7 polymyositis, is that either a rheumatological or
 8 a neurological diagnosis?
 9 A Usually rheumatologist would look after
 10 most of the parents with polymyositis.
 11 Neurologists become involved, as well.
 12 Q That's not your subspecialty?
 13 A No.
 14 Q There was another doctor referenced in the
 15 procedure, a Dr. Janis Ong?
 16 A That is correct.
 17 Q Who is Dr. Ong?
 18 A Dr. Ong is a fellow in gastroenterology.
 19 At the time he was doing consult for
 20 gastroenterology.
 21 Q Is she still here?
 22 A Yes, he still is.
 23 Q I apologize on the record for referring to
 24 Dr. Ong as a female.
 25 He is a male?

*** Notes ***

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 1st?
 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
 22 skin. There's one person that does the
 23 endoscopy.
 24 I can't recall who did which.
 25 Q What I would like you to do for me in a

*** Notes

1 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.

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

*** Notes ***

1 attached to what will actually become the feeding
 2 tube.
 3 And then we pull 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.

1 But that is just a general area where you
 2 start looking for optimal position. In every
 3 patient, given anatomical variations and all
 4 other conditions, you have to identify an optimal
 5 site.
 6 Q You recognize that you are essentially
 7 making an incision somewhat blindly into the
 8 area, correct?
 9 A The incision is not blindly. The incision
 10 of the trocar is.
 11 Q And the hope is that you are
 12 not going to, in inserting the trocar, that you
 13 are not going to involve any major blood vessels,
 14 correct?
 15 A You expect to minimize complications.
 16 Q Now, as far as the potential risks and
 17 complications, I believe somewhere in your notes
 18 it indicates that the risks and benefits were
 19 discussed.
 20 A That is correct.
 21 Q Is that your normal procedure to do
 22 that?
 23 A I always discuss the procedure with the
 24 patient.
 25 Q And the risks that may take

1 place?
 2 A Which in this case was inability to
 3 maintain nutrition. I explain the risks of the
 4 procedure and the potential benefits or
 5 alternatives to the procedure.
 6 Q Do you remember Mr. Brooks at
 7 all?
 8 A I do.
 9 Q Tell me what you remember about
 10 him.
 11 A He was not very communicative on the day
 12 when he came down for the procedure.
 13 He appeared to be an elderly, thin,
 14 African American male.
 15 Q When you say he was not very
 16 communicative, did he have someone with him at
 17 the point in time that you were explaining the
 18 risks and benefits and alternatives?
 19 A Not in the room.
 20 Not a member of the family.
 21 Q Even though he was not communicative, was
 22 he able to, in your opinion, to appreciate what
 23 it was that you were saying to him?
 24 A I remember going and speaking to the
 25 family --

*** Notes ***

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

1 concerns I expressed to the family is that there
 2 is an increased risk of complications from
 3 sedation, and generally in a person like Mr.
 4 Brooks.
 5 Q What kind of concerns did you have with
 6 regards to Mr. Brooks?
 7 A They are more prone to agitation.
 8 Sometimes when they become agitated, you have to
 9 use more sedation.
 10 There can be a higher potential for
 11 respiratory complications, respiratory
 12 depression.
 13 Q This is intraoperatively?
 14 A During the procedure, mostly.
 15 Q That did not take place in this case,
 16 correct?
 17 A No.
 18 Q So the concern that you had relative to
 19 sedation in this type of patient did not come to
 20 fruition, correct?
 21 A Correct.
 22 Q Do you remember talking with the family,
 23 also?
 24 A I do.
 25 Q Tell me, was it Mrs. Brooks that you spoke

*** Notes ***

1 to?
 2 A I can't remember who it was from the
 3 family. There were two people, and I remember
 4 speaking to them before and at the end of the
 5 procedure.
 6 Q Can you tell me whether it was a male or a
 7 female that you spoke to?
 8 A Female.
 9 Q As to whether it was his wife, you don't
 10 know?
 11 A I can't recall.
 12 Q Was it someone of compatible age?
 13 A I cannot recall if it was
 14 a wife or a daughter or another member of the
 15 family.
 16 Q Are you able to formulate
 17 any type of a picture in your mind of that
 18 individual?
 19 A The individual, no. I recall very well
 20 the moment when I spoke to them.
 21 Q When you spoke to the family?
 22 A Before and after, yes.
 23 Q I am going to ask you to tell me what you
 24 told them. Are you able to -- in addition to
 25 remembering what you said, are you able to

*** Notes ***

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

1 MR. KILBANE: Objection.
 2 Your question assumes that there are
 3 reliable texts.
 4 MR. MISHKIND: Of
 5 course.
 6 A What I will do is -- what I
 7 usually do is go retrieve -- I do a literature
 8 search.
 9 Q Okay.
 10 A I read the papers and decide which are
 11 really the better studies. I use those as a
 12 reference for the purpose of teaching.
 13 Q You do teach?
 14 A I do.
 15 Q I assume that you are aware of some good
 16 articles that outline the risks and the
 17 complications that can occur and what are the
 18 symptoms that you should look for in those
 19 complications, correct?
 20 A My area of teaching is mostly inflammatory
 21 bowel disease, diarrhea and acute upper and lower
 22 GI bleed.
 23 That's usually what I teach and lecture
 24 on.
 25 Q Are there any textbooks or chapters in

*** Notes ***

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

1 institution dealing with complications and the
2 frequency of complications following PEG tube
3 placement?
4 A Studies, no.
5 Q Are you aware of any studies or chapters
6 in books that deal with tertiary care facilities
7 and the frequency of complications following PEG
8 tube placement?
9 A I can't, not off the top of my
10 head.
11 Q Is there anything that you consider to be
12 authoritative as relates to how frequently in the
13 medical community various complications, whether
14 they be respiratory, infection, bleeding or the
15 other complications associated with PEG tube
16 placement, how frequently they occur and what
17 steps need to be taken to recognize those
18 Complications?
19 MR. KILBANE: Objection.
20 A Authoritative?
21 Q Yes.
22 A There is no one standard that you can
23 apply to all of the institutions.
24 Q I am not suggesting that there is any one
25 standard.

*** Notes ***

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.
21 Q 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 placement?
2 A Well, I haven't done a literature search
3 presently.
4 Q Do you have any articles in your office
5 that deal with complications following PEG tube
6 placement?
7 A I don't keep -- the records I keep --
8 Q Deal with inflammatory bowel
9 disease?
10 A Yes.
11 Q How long did the PEG tube placement from
12 start to finish take?
13 A Usually that takes, from the
14 time that you start giving sedation, until you
15 are done, it usually takes between 20 and 45
16 minutes.
17 Q Can you tell from the record in this case
18 how long it took?
19 A The medication was given at ten past
20 nine. We usually wait about five minutes before
21 we start, five, ten minutes.
22 So we started between 9:15 and 9:20.
23 We probably finished at ten to ten, around
24 9:50.
25 Q I am looking at the same document that you

*** Notes ***

1 are. This is the Ambulatory Clinic Procedure
2 Record?
3 A Yes.
4 Q How is it that you are looking
5 at the same thing that I am looking at and you
6 are able to say the procedure ended at about
7 9:50?
8 A You asked me to *guess*.
9 Q I didn't ask you to *guess*. I asked you,
10 when did the procedure start, and when did it end
11 in this particular case?
12 A I can tell roughly. I cannot tell
13 exactly. Do you see the initials of the
14 nurse.
15 Q I see the initials of nurses going all the
16 way up to 10:40.
17 A The first ones are DO, DO, DO, DO. That
18 last one is DO.
19 Then they change. So the last
20 ~~three~~ is a recovery area nurse. The first one is
21 the nurse that is with me all of the time in the
22 room.
23 Q Do you know who DO is?
24 A No.
25 Q The next one appears to be RM, is that

1 reasonable?
 2 A Possibly.
 3 Q Are you able to recall whose initials
 4 those might belong to?
 5 A Actually, yes.
 6 Nurses signature and initials. It is DC,
 7 Diane Cency, C-e-n-c-y.
 8 Q Okay.
 9 A And RM, Rosalyn McKeon, M-c-K-e-o-n.
 10 Q There is another one also, a Deborah
 11 Osborne, or something?
 12 A Osborne.
 13 Q Osborne?
 14 A Yes.
 15 Q Would Deborah have been the
 16 nurse that would have been assisting during the
 17 procedure?
 18 A No.
 19 Q Deborah Osborne?
 20 A Could be. Could have been.
 21 Q Do you remember any of these women?
 22 A Yes.
 23 Q Are they still working in this
 24 department?
 25 A Yes.

1 Q All three of them?
 2 A Yes.
 3 Q Did this procedure on Mr. Brooks take
 4 longer than what is considered to be customary
 5 for this type of procedure?
 6 A No.
 7 Q It was within the standard deviation, if
 8 you will?
 9 A That is correct.
 10 Q Did the procedure to your knowledge go
 11 uneventful?
 12 A Yes.
 13 Q No complications that you were aware of
 14 during the procedure?
 15 A That is correct.
 16 Q Or immediately at the end of the
 17 procedure?
 18 A That is correct.
 19 Q You told me that you remember Mr. Brooks,
 20 and you remember having a conversation before and
 21 after with family members, correct?
 22 A That is correct.
 23 Q Do you remember actually performing the
 24 PEG tube placement on Mr. Brooks?
 25 A I do remember.

*** Notes

1 Q But you just don't remember whether you
 2 were the one that did --
 3 A Scope or skin.
 4 Q -- did the scope or skin?
 5 A That is correct.
 6 Q How many PEG tube placements do you do on
 7 average on any given day?
 8 A It is probably fair to say in a given week
 9 --
 10 Q Okay.
 11 A -- or month.
 12 It varies from rotation to rotation,
 13 depending on what rotation I am doing. Maybe
 14 three to five a month.
 15 Q The conversation that you had with the
 16 family before the procedure started --
 17 A Yes.
 18 Q -- would it have been sometime early that
 19 morning?
 20 A Yes.
 21 Q Do you have any recollection of what was
 22 said by any of the family members to you or any
 23 questions that were asked of you when you talked
 24 to them?
 25 A No.

1 Q Dr. Ong, have you talked with him at all
 2 about this case?
 3 A No, I haven't.
 4 Q Does he know that your deposition is being
 5 taken?
 6 A No.
 7 Q How many family members do you remember
 8 being present?
 9 A I believe there were two. Two people I
 10 spoke to.
 11 Q The conversation that you
 12 had, would it have been in some type of a waiting
 13 area?
 14 A Yes. it was. Not in the room. It was
 15 outside.
 16 Q Is there a procedure room that you use for
 17 these?
 18 A No. We have two endoscopy
 19 units. They have many different rooms in the
 20 same area.
 21 Q Is it essentially an examining room that
 22 the endoscopic procedure is done in, or is
 23 it --
 24 a No, it is an endoscopy room.
 25 Q Like an operating room?

*** Notes ***

1 A No, just for endoscopies, undifferentiated
2 endoscopies.
3 You can do upper endoscopies and lower PEG
4 tube placements, sigmoidoscopies.
5 Q The conversation that you had with the
6 family would have been outside of that area,
7 correct?
8 A That is correct.
9 Q Do you remember anything in particular
10 about the substance of the conversation with the
11 family beforehand?
12 A I recall that I asked if they had any
13 questions. I went over the risks.
14 Upon finishing the procedure, I indicated
15 that everything during the procedure went fine
16 and that he was stable.
17 Q What was their reaction?
18 A They were relieved that it was
19 over.
20 Q Do you remember anything that they said to
21 you afterwards?
22 A No.
23 Q Did Dr. Ong come out with you at that
24 time?
25 A I don't believe so. I don't

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

*** Notes ***

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

1 Q Okay.
2 And what about the trocar?
3 A It is the standard trocar that comes with
4 the kit.
5 Q So there's a standard PEG tube kit that
6 you use?
7 A That is correct.
8 Q You never met Mr. Brooks
9 or the family before June 4th, 1998, did
10 you?
11 A No.
12 No, I didn't.
13 Q After you left the endoscopy suite, after
14 telling the family the good news, everything went
15 fine, et cetera, he is doing fine, did you have
16 any further involvement with the family after
17 that?
18 A No, I did not.
19 Q I want to talk a little bit about the
20 potential risks and complications. You told me
21 about respiratory problems --
22 A Yes.
23 Q -- correct?
24 A That is correct.
25 Q You told me about infection?

*** Notes ***

1 A Correct.
 2 Q You told me about bleeding?
 3 A Correct.
 4 Q Are there others?
 5 A Well, there are others. I don't
 6 know that I can recall absolutely all of
 7 them.
 8 There can be inflammation at the site of
 9 the injection.
 10 There can be respiratory arrest or cardiac
 11 arrest. There could be infection at the incision
 12 site.
 13 There could be peritonitis. If you go
 14 through an organ, you can create a fistula
 15 between one organ and another, such as the
 16 stomach.
 17 There's always a potential that it is a
 18 failed PEG, that you cannot place the PEG
 19 successfully, the risk of bleeding --
 20 Q We talked about --
 21 A -- death.
 22 Q Okay.
 23 A And the risk of aspiration, once you
 24 started using the PEG tube.
 25 Q But as to the procedure

1 itself, the insertion, have we pretty
 2 much covered the recognized risks and
 3 complications?
 4 A Those are probably the main ones, the
 5 important ones.
 6 Q Okay.
 7 A That deals With the endoscopy itself.
 8 There's the risk of esophageal tears, perforation
 9 of the esophagus, perforation of the stomach with
 10 the tube, with the scope.
 11 Q All of these potential risks and
 12 complications, do you explain them to the
 13 patient, and if the patient doesn't
 14 appear to be coherent, to a responsible family
 15 member?
 16 A I tell them about the risk of bleeding,
 17 perforation, infection, cardiac arrest,
 18 respiratory arrest, side effects from
 19 medications.
 20 Q Would you say that PEG tube placement is a
 21 relatively simple procedure with few severe
 22 complications?
 23 MR. KILBANE: objection.
 24 A It depends on who does it. I would say,
 25 yes, if it is done by a gastroenterologist that

*** Notes ***

1 is trained. I don't minimize the difficulty of
 2 the PEG tube placement.
 3 I think we should take everyone seriously,
 4 and we do. The potential for significant
 5 complications, is low, but it exists.
 6 Q Tell me about your experience.
 7 How many patients have you had where they
 8 have developed serious bleeding complications
 9 following PEG tube placement?
 10 MR. KILBANE: Objection.
 11 A Well, Mr. Brooks is the only patient that
 12 I know of that has had a complication from the
 13 procedure.
 14 Q Okay.
 15 A I don't know of a complication following
 16 the procedure.
 17 Q At the time that you did Mi-. Brooks' PEG
 18 tube placement -- you had been at the Clinic from
 19 1992 to 1998, correct?
 20 A That is correct.
 21 Q So six years at this institution?
 22 A Yes.
 23 Q Doing three to five, per month?
 24 A Yes. I would have to look
 25 specifically at the numbers, but that is probably

1 an average.
 2 Q Do you keep your own score card, your own
 3 records?
 4 A No.
 5 Q If we took three to five, you
 6 are doing somewhere in the range of 48 to 50 a
 7 year?
 8 A That is correct.
 9 Q And was this pretty much what you were
 10 doing from 1992 up through 1998?
 11 A I believe so.
 12 Q And has it been basically about the same
 13 number since?
 14 A Sometimes it is more. Sometimes it is
 15 less. It depends on whether some of my
 16 colleagues that do PEGs are on vacation or not,
 17 or what type what of rotation I am
 18 doing.
 19 Q From 1992 to the current date, Mr. Brooks
 20 is the only experience that you have had of a
 21 serious bleeding complication?
 22 MR. KILBANE: objection.
 23 BY MR. MISHKIND:
 24 Q Correct?
 25 A *** Of a serious complication.

*** Notes

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

1 mucosal site, there is usually going to be blood
2 return.
3 If that is the case, then there is
4 some things that you can do, depending on the
5 severity of the bleed, what you can do or what
6 you do.
7 Q Are there various clotting factors that
8 you can use to try to enhance the healing process
9 if it is from the gastric mucosa that the bleed
10 is coming from?
11 A I don't know what you mean exactly by
12 clotting factors.
13 Usually clotting factor replacement is
14 effective when there is a clotting factor
15 deficiency.
16 A person that has normal clotting factors,
17 you cannot make him clot better by giving him
18 more.
19 Q Is it fair to say that -- did I cut you
20 off?
21 A No.
22 Q Is it fair to say that when you lavage the
23 site, that if you do not get any return, that
24 that is a fairly good indication that if there is
25 a serious bleed going on, it is not coming from

*** Notes ***

1 the stomach?
2 A It is fair to say that it is
3 very unlikely that there is significant bleeding
4 in the mucosal site or from inside, from inside
5 the stomach.
6 Q Is it also fair to say that the
7 standard of care in treating someone in a
8 postendoscopic -- I am sorry -- post PEG tube
9 placement, where there is concern that the
10 patient has experienced a bleed, that one of the
11 first steps in order to meet the standard of care
12 is to determine whether or not the bleeding is
13 coming from the stomach or whether it is coming
14 from the abdominal area?
15 MR. KILBANE: objection.
16 If you can answer based on those facts,
17 go ahead, Doctor.
18 A The question is, if the patient is
19 bleeding, you have to determine where they are
20 bleeding from.
21 Q Is that the standard of care to do
22 that?
23 A If you know that the patient is
24 bleeding, you like to know where they are
25 bleeding from, yes.

1 Q Or if you have reason to suspect, based
2 upon a drop in hemoglobin and a hypotensive state
3 in the patient, and the patient has a drop in
4 hemoglobin and hypotension that is evidently
5 caused by a bleed, the standard of care is
6 determine whether it is intra-abdominal or coming
7 from the stomach?
8 MR. KILBANE: objection.
9 A A drop in hemoglobin or hypotension or
10 both together?
11 Q Either.
12 If you have a drop in hemoglobin following
13 a PEG tube placement, what does that indicate to
14 you?
15 A It depends on how significant the drop is,
16 an over what period of time.
17 Q If there's a drop from say 13.3 down to
18 about nine following the procedure in less than a
19 24-hour period, are you concerned, or should you
20 be concerned?
21 A It depends. You have to examine the
22 patient and see what's been happening with the
23 patient in that 24-hours.
24 Q If you add in that patient
25 with a drop in hemoglobin that there is a drop in

*** Notes ***

1 blood pressure as well, is that reason to be
 2 concerned?
 3 MR. KILBANE: objection.
 4 A I think that is reason
 5 to see the patient, examine the patient, consider
 6 all of the possibilities that can led to the
 7 picture.
 8 Q And one of the things that has to be high
 9 up on the differential is the possibility of
 10 bleeding?
 11 A Bleeding is one of the possibilities to
 12 consider.
 13 Q Would that be high up in the
 14 differential? Should that be high up in the
 15 differential?
 16 MR. KILBANE: objection.
 17 A It is high.
 18 Q What other factors should be in the
 19 differential with that scenario that I
 20 described?
 21 A Well, if a patient has been receiving a
 22 very large amount of fluids, you can artificially
 23 drop the hemoglobin because you are diluting the
 24 blood.
 25 If the person has hypotension, and the

1 patient has been lying in the hospital for some
 2 period of time, you have to think of
 3 pulmonary embolism.
 4 Septic complications can give you a very
 5 similar picture.
 6 Q Okay.
 7 A Myocardial infarction can give you a
 8 similar picture.
 9 MR. MISHKWD: Do you need
 10 to get that?
 11 THE WITNESS: Yes.
 12 - - - - -
 13 (Recess taken.)
 14 - - - - -
 15 BY MR. MISHKIND:
 16 Q What is the first thing that
 17 you think of as a gastroenterologist in a patient
 18 who has had a PEG tube placed that becomes
 19 hypotensive?
 20 A Within what time frame?
 21 Q Within 24 hours or less.
 22 A If it is within 24 hours, you have to
 23 think of sepsis, pulmonary embolism, MI, and
 24 bleeding.
 25 Q All of those things being medical

*** Notes ***

1 emergencies, correct?
 2 A Correct.
 3 Q Would you agree that if the cause of the
 4 hypotension is bleeding, and it is not just
 5 superficial bleeding, it usually cannot be
 6 corrected endoscopically?
 7 A If the bleeding is not within the stomach
 8 wall at the PEG site, and you cannot see it, you
 9 cannot correct it edoscopically.
 10 Q So a laparotomy is necessary to correct
 11 it, if it is not superficial and if it is not
 12 within the stomach, is that correct?
 13 MR. KILBANE: objection.
 14 A It is one of the possibilities, one of the
 15 means of looking at the problem.
 16 Q How can you resolve the problem if it is a
 17 serious bleed that's taking place as opposed to a
 18 superficial bleed?
 19 A It depends on how you define serious and
 20 how much the patient is bleeding.
 21 Sometimes an angio with embolization could
 22 be helpful.
 23 Q There is reference to a Dr. Goldman.
 24 A Okay.
 25 Q Do you know Dr. Goldman?

1 A I may have seen him. I cannot place
 2 exactly who he is.
 3 Q The records indicate that
 4 at approximately 2:25 a.m. on June 5th Dr.
 5 Goldman was paged.
 6 A 2:25 a.m.?
 7 Q Do you see the note, patient was
 8 complaining of pain?
 9 A Yes.
 10 Q Holding his chest, anxious, short of
 11 breath?
 12 A Yes.
 13 Q I think that says, taking clothes
 14 off?
 15 A Yes.
 16 Q And then later on it says, Dr. Goldman
 17 paged. Dr. Goldman in room?
 18 A Yes.
 19 Q Is Dr. Goldman a gastroenterologist?
 20 A Not to my knowledge.
 21 Q Do you have any knowledge as to what
 22 service Dr. Goldman was on?
 23 A On the primary team taking care of the
 24 patient.
 25 Q What do you mean by primary

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1 team?
 2 A That the patient was not under
 3 gastroenterology. He was under internal
 4 medicine, the White team, which is one of the
 5 internal medicine teams.
 6 Q The White team?
 7 A I can confirm that in a moment. That
 8 should be in the medical note.
 9 Q Okay.
 10 A The patient had been admitted under the
 11 White team. That would be the primary team
 12 taking care of the patient.
 13 Q Okay.
 14 When a bleed is suspected following a PEG
 15 tube placement, is there a procedure here at the
 16 Cleveland Clinic as to who the nurses are to
 17 contact?
 18 A When a patient has a complication
 19 of whatever sort, the contact people are the
 20 people that are taking care primarily of the
 21 patient.
 22 Q Are there situations where you give orders
 23 to the nurses or others that are caring for the
 24 patient after PEG tube placement, that if a
 25 complication occurs, that you or someone in your

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

*** Notes ***

1 hospital?
 2 A It is administrative.
 3 Q Did you have to do anything in response to
 4 that expiration notification?
 5 A No.
 6 Q Did you keep the expiration
 7 notification?
 8 A No.
 9 Q Were you asked to give any type of a
 10 statement to any committee at the hospital as it
 11 relates to the circumstances surrounding Mr.
 12 Brooks' death?
 13 MR. KILBANE: objection.
 14 A No.
 15 Q Did you ever talk with
 16 Dr. Grundfest about what she discovered at the
 17 time that she went in and operated on Mr. Brooks
 18 on June 5th?
 19 A I can't recall.
 20 Q You might have?
 21 A Not within the time that it happened. No,
 22 I really can't recall it.
 23 Q Grundfest is still here at the
 24 hospital?
 25 A Yes.

1 Q Her name is hyphenated now?
 2 A Broniatowski.
 3 Q We will leave it at Grundfest for right
 4 now.
 5 She's the one that did the overseeing of
 6 the --
 7 A I believe that she was a surgeon. If you
 8 want, I can check the record.
 9 Grundfest did the surgery.
 10 Q Have you ever talked, to your knowledge,
 11 to any of the physicians that were involved in
 12 any aspect of Mr. Brooks' care after he was
 13 transferred out of the endoscopy suite on June
 14 4th?
 15 A Not to my recollection, no.
 16 Q Doctor, once it is determined that there
 17 is a high likelihood that there is a bleed
 18 following a PEG tube placement, and it is
 19 determined that the bleed most likely is not
 20 coming from the stomach itself, because the
 21 lavage is clear, would you agree that the
 22 standard of care requires that a stat CT scan be
 23 performed to ascertain the source or the location
 24 of the bleed?
 25 MR. KILBANE: objection.

*** Notes ***

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
 22 ultrasound might help in bleeding, other than if
 23 it shows up a large amount of blood and clotting
 24 in the peritoneal cavity.
 25 Q How long is it reasonable for someone

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 Q Do you have an opinion as to why he
 23 arrested?
 24 A I haven't gone through the
 25 entire chart in detail, so I really cannot tell

*** Notes ***

1 exactly why.
 2 Q Do you have an opinion as you sit here
 3 right now as to whether or not his cardiac arrest
 4 was preventable and avoidable?
 5 A Again, I would have to really go
 6 through the chart. I don't know the details of
 7 what transpired.
 8 I would have to review it in
 9 detail.
 10 Q And in order to be able to provide that
 11 opinion, would you have to look at what the
 12 pressures were? That would be one thing,
 13 correct?
 14 A You would have to look at pressures,
 15 oxygenation, the general status, the morbidity
 16 conditions, the previous history, has he
 17 arrested? Is there vascular disease?
 18 MR. KELLEY: Let's go
 19 off the record.
 20 - - - - -
 21 (A discussion was had off the
 22 record.)
 23 - - - - -
 24 MR. MISHKIND: If you want
 25 to state that on the record, go

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

*** Notes ***

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,
 10 certainly they are.
 11 Q And in a patient who has been -- less than
 12 24 hours before had a PEG tube placement, of what
 13 concern would you have looking at those vital
 14 signs?
 15 A Pulmonary embolus.
 16 Myocardial infarction.
 17 Bleeding.
 18 Less likely sepsis.
 19 Q Okay.
 20 And if bleeding is a consideration, what
 21 else would you need to do to evaluate the
 22 patient?
 23 A Well, in a patient like this, with these
 24 changes, I would like to resuscitate the patient,
 25 transfer him to a stable environment, like a

1 monitored environment. Get gastrics, lavage, get
 2 your blood tests, chest X-ray, an EKG to rule-out
 3 myocardial infarction.
 4 Q At what time would you want to
 5 start doing those things according to the vital
 6 signs?
 7 A Right away. Obviously you start treating
 8 the patient. You put them on oxygen, give them
 9 fluids.
 10 And then you contact -- you make
 11 arrangements to transfer the patient to the
 12 unit.
 13 Q To what unit?
 14 A To an intensive care unit. You do an EKG
 15 to rule-out myocardial infarction.
 16 Q If the patient at 2:25 a.m., along with
 17 those vital signs is also demonstrating decreased
 18 mental status, all of that is expected in a
 19 patient that is sick?
 20 A None of that is specific for one disease
 21 process.
 22 Q Okay.
 23 But in any event, at that time, 2:25,
 24 2:50, 2:53, in that range, you are saying
 25 that the patient obviously should be seen,

*** Notes ***

1 correct?
 2 A Should be seen.
 3 Q And should be transferred to an intensive
 4 care unit?
 5 A Well, you start your evaluation and make
 6 arrangements.
 7 Q What causes severe lactic acidosis,
 8 Doctor?
 9 A Hypoperfusion.
 10 Q Is that prolonged, inadequate
 11 perfusion?
 12 MR. KILBANE: Objection.
 13 A Not necessarily prolonged. It could be
 14 acute hypoperfusion.
 15 In general, it produces lactic
 16 acidosis.
 17 Q Is there a level of hypotension that you
 18 need to experience to have severe lactic
 19 acidosis?
 20 A No. Really hypoperfusion is caused
 21 usually by high blood pressure, hypotension. It
 22 means that the muscles, or that viscera, they
 23 don't get enough oxygen.
 24 Q Hypotension can also cause hypoperfusion,
 25 as well, correct?

1 A That is correct.
 2 Q Like the viscera are not getting enough
 3 oxygen?
 4 MR. MISHKIND: Off the
 5 record one second.
 6 - - - - -
 7 (A discussion was had off the
 8 record.)
 9 - - - - -
 10 MR. MISHKIND: Let's go
 11 back on the record.
 12 BY MR. MISHKIND:
 13 Q There's a Dr. Stanic referenced
 14 in the CPR data sheet. Do you know who Dr.
 15 Stanic is?
 16 A No.
 17 Q When there is a complication
 18 following PEG tube placement that requires a
 19 laparotomy, is that outside of your area of
 20 expertise?
 21 A That is correct.
 22 Q So, had there been an indication for
 23 surgical consultation earlier than what took
 24 place in this case, you would not have been the
 25 individual to have been consulted with as to

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1 whether a surgeon should be brought in or not,
 2 correct?
 3 A That is correct.
 4 Q According to your review of the records,
 5 and I recognize that you have not looked in
 6 detail at this, but when was the patient admitted
 7 to the Intensive Care Unit?
 8 A Probably 4:38. Just browsing through
 9 this, I think it was 4:38.
 10 Q This is after the patient had arrested,
 11 correct?
 12 A I have to go to the doctors'
 13 sheet.
 14 CPR appeared to have started at ten past
 15 four in the morning.
 16 Q Okay.
 17 Doctor, there's a reference to a senior
 18 medical resident that saw the patient. This is
 19 on June 5th. This is in the clinical sheets and
 20 progress notes.
 21 The notes that I am referring to, there's
 22 a narration in here that talks about this
 23 particular doctor, saying that at approximately
 24 2:00 a.m. the patient apparently became
 25 hypotensive initially with chest pain, abdominal

1 pain, responsive, but not fully oriented per
 2 apparent baseline.
 3 Do you see that?
 4 A Yes.
 5 Q Patient initially bolused. NS means
 6 what?
 7 A Normal saline.
 8 Q Without response, is that correct?
 9 A I don't like to use the S's or C's. I
 10 like to write a little bit.
 11 Q The patient upon my arrival at
 12 approximately 3:15 a.m. was continued
 13 hypotensive. I am not sure whether that is
 14 responsive or not responsive.
 15 Do you see where I am referring to?
 16 A We would have to ask.
 17 Q That individual?
 18 A Right.
 19 Q Yes?
 20 A Yes.
 21 Q Now, do you know whether this individual
 22 is Dr. Goldman, or are we referring to someone
 23 else?
 24 MR. KELLEY I don't
 25 think that's Goldman. Goldman signed

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1 some other note, and the writing is
 2 different.
 3 I will tell you, I think it may
 4 be a resident who is now in a
 5 University Hospital fellowship,
 6 Michelle Lisgaris.
 7 MR. MISHKIND: That's one
 8 of the doctors that was attached to the
 9 interrogatories?
 10 MR. KELLEY Yes.
 11 MR. MISHKIND: Who has been
 12 --
 13 MR. KELLEY: We are
 14 trying to -- our best indication is
 15 that is who it is.
 16 MR. MISHKIND: okay.
 17 MR. KELLEY: We are
 18 trying to get in touch with her to
 19 verify whether that's her note.
 20 BY MR. MISHKIND:
 21 Q Do you have any familiarity with that
 22 individual at all?
 23 A No, not really.
 24 Q Okay. I am not going to ask you any
 25 further questions on that, then.

1 Is an EGD indicated in a patient
 2 that has hypotensive shock that's suspected
 3 to be due to hypovolemia from an intra-abdominal
 4 bleed?
 5 A Probably not. It may not add much
 6 information.
 7 Q A patient that is in hypotensive
 8 shock due to hypovolemia from an intra-abdominal
 9 bleed, that is a medical emergency, is it
 10 not?
 11 MR. KILBANE: objection.
 12 A It is.
 13 Q And in addition to trying to
 14 provide fluid to the patient, if the patient
 15 is not responsive, responding to fluid
 16 treatment, does that then also become a surgical
 17 emergency?
 18 MR. KILBANE: Objection.
 19 A Number one, you have to be confident that
 20 that is what is happening.
 21 And number two, you have to, to the best
 22 of your ability, to stabilize and optimize the
 23 patient's condition to undergo surgery.
 24 Q And how do you go about stabilizing a
 25 patient to optimize their situation for

*** Notes ***

1 surgery, if in fact they are not responding to
2 fluids and their blood pressure is continuing to
3 drop?

4 A There are a lot of additional medications
5 that can be used, pressors.

6 Adequate ventilation.

7 A high concentration of oxygen.

8 You have to do all of those things,

9 EKG to make sure they are not having a

10 myocardial infarction as the cause of their

11 hypotension.

12 Q Should a surgical consultation be
13 obtained?

14 MR. KILBANE: Objection.

15 A You have to obtain it at some point,
16 yes.

17 Q To determine whether or not it is
18 appropriate and prudent to take the patient for a
19 laparotomy to explore the source of the bleed,
20 correct?

21 A I believe that you should obtain a
22 surgical consultation to get input from a
23 surgical team, if your suspicion is very high
24 that that's what is going on.

25 It doesn't mean that you are going to do

1 all of the others, and it doesn't mean that you
2 don't do all of the other things.

3 Q I am not suggesting that you don't. A
4 surgical consultation, that would be on the list
5 of things that is being administered as you are
6 trying to get the patient stabilized with
7 fluids --

8 MR. KILBANE: Objection.

9 BY MR. MISHKIND:

10 Q -- correct?

11 A If you do it within a period of
12 time.

13 Q I mean, we are not talking six, seven
14 hours, are we, after the patient developed
15 hypotension?

16 A It depends on how long it took for the
17 patient to be stable, and to have some of the
18 results back.

19 If a patient has an acute MI or a
20 pulmonary embolism, tachycardia, you
21 don't want to take that patient to the operating
22 room.

23 You want to treat the primary
24 problem.

25 Q Do you have an opinion in this case as to

*** Notes

1 whether or not there was a delay in taking the
2 patient for surgical intervention to discovery
3 the source of the bleed?

4 A I don't know. I would have to go in
5 detail through the entire record.

6 Even then, I mean, it is difficult to
7 know, unless you see the patient. But I don't
8 know all of the details of what happened
9 afterwards to give an opinion.

10 Q Would that again be outside of your area
11 of expertise as relates to the surgical
12 intervention or the timing of that surgical
13 intervention?

14 A I believe so. I think this is more in
15 line with ICU, surgery.

16 MR. KILBANE: Off the
17 record.

18 - - - - -

19 (A discussion was had off the
20 record.)

21 - - - - -

22 MR. MISHKIND: Back on the
23 record.

24 BY MR. MISHKIND:

25 Q Did you ever see the autopsy in this

1 case?

2 A No.

3 Q So you don't know why it is that Mr.
4 Brooks died, do you?

5 A No.

6 Q And you don't have any opinion as you are
7 sitting here right now as to whether exploratory
8 surgery should have and could have taken place
9 sooner than it did?

10 A That is correct.

11 Q But you would acknowledge that once
12 postoperative hypovolemia is recognized following
13 PEG tube placement, a surgical consult should be
14 obtained in a timely manner?

15 MR. KILBANE: objection.

16 BY MR. MISHKIND:

17 Q Correct?

18 A In you recognize hypovolemia, yes.

19 Q As far as any of the nurses that were
20 involved in the care of the patient, in the MICU,
21 either prior to or after his arrest, or prior to
22 or after the surgery to resolve the
23 intra-abdominal bleed, did you ever talk with any
24 of those people?

25 A No.

*** Notes ***

1 Q And you may have talked with
2 Grundfest, you are just not certain that you
3 did?

4 A I doubt that. Around that time I did. I
5 really can't recall if I ever spoke with her
6 about it.

7 MR. MISHKIND: Doctor, I
8 don't think that I have any further
9 questions for you at this time.

10 I am going to reserve the
11 right, depending upon --just because
12 of the nature of these depositions,
13 depending upon what is learned as
14 relates to some of these other
15 depositions, possibly to revisit Dr.
16 Brzezinski.

17 I doubt very much that I will
18 need to.

19 MR. KELLEY: We will
20 address it if it comes up, if it is
21 appropriate.

22 He will read.

23 -----
24 (Deposition concluded.)
25 -----

*** Notes

1 The State of Ohio,)
2 County of Cuyahoga.) SS: CERTIFICATE
3)
4)

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

17
18 I do further certify that this deposition
19 was taken at the time and place in the foregoing
20 caption specified and was completed without
21 adjournment.

22 I do further certify that I am not a
23 relative, counsel or attorney of either party or
24 otherwise interested in the event of this aciton.
25

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.

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

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