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

IN THE COURT OF COMMON PLEAS

ESTATE OF LAWRENCE BROWN, :
plaintiff,

vs. : Case No. 346342

UNIVERSITY HOSPITALS OF CLEVELAND, et al.,
defendants.

Deposition of ERIN FUREY, M.D., a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at University Hospitals, 11100 Euclid Avenue, Cleveland, Ohio, on FRIDAY, AUGUST 14TH, 1998, commencing at 9:04 a.m. pursuant to agreement of counsel.

APPEARANCES:

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ALSO PRESENT:
Jai Lee, M.D.
Tracy McGerth

I N D E X

WITNESS: ERIN FUREY, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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

MISS KOLIS: As you know my name is Donna Kolis, I've been retained to represent the Estate of Lawrence Brown.

My purpose today is to ask you hopefully a short number of concise questions that will clarify information contained in the medical chart and other information about recollection that you may have surrounding these events.

If at any time I ask a question that you don't understand, which is likely to happen because I'm an attorney and you are a doctor, you can indicate that you don't understand what I'm asking.

All of your answers need to be verbal, I see you are nodding in agreement, I haven't given you a chance to speak at this point. You do have to answer audibly, without body language indicate what your answer is.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. Having said that, let me ask you this: Have you ever had the opportunity to give a deposition before today?

A. Yes.

Q. Was it in the context of being deposed in another medical/legal case?

A. Yes.

Q. Would that be in reference to the case that you referred to in your interrogatories?

A. I don't know what you are talking about.

Q. Your interrogatories I asked a question whether or not you had ever been sued before for medical negligence, *you* responded affirmatively, there was one other pending case; is that accurate?

A. Yes, that's correct.

Q. Is that the case in which you gave a deposition?

A. No, it's not.

Q. So you've had an opportunity to testify in other people's cases; is that right?

A. Yes.

Q. I guess we will start with the basics. I

received a copy of your CV that was supplied to me by your attorney, Marc Groedel. I would like to go through some of the information so that I can understand what it is you do at UH.

If I understand it you are Boarded both in anesthesiology, correct, and critical care medicine?

A. Yes.

Q. Your primary practice here at the hospital consist of what?

A. It's split fairly evenly between delivery of anesthesia in the operating room and practicing critical care medicine in the surgical intensive care unit.

Q. The practice of critical care medicine in SICU, you are an attending I take it?

A. Yes.

Q. How is it you come to be involved in cases in SICU?

A. I'm responsible for most if not all of the patients in the SICU. I am a consultant for the surgeons who admit their patients to the SICU.

Q. In this particular instance have you had an opportunity before today to review the medical records?

A. Of this patient?
Q. Yes, of this patient?
A. Yes, I have.
Q. Have you also reviewed the autopsy results?
A. Yes, I have.
Q. Have you had an opportunity to review medical records that were generated for other care to this patient before he came to UH?
A. No, I haven't.
Q. Fair enough.

When you say that you see most of the patients in SICU, is it you yourself or is there a group of critical care attendings?
A. There is a group of critical care attendings, I'm not sure exactly what you are getting at.
Q. Let me ask the question a different way.

If I recall your interrogatory answers it's clear you're not an employee of the hospital, correct?
A. That's right.
Q. You belong to a group of anesthesiologists that is your practice group?
A. Yes.
Q. That practice group's name is?
A. University Anesthesia, Incorporated.

Q. Does University Anesthesia, Incorporated provide anesthesia service to the hospital, to the surgical intensive care unit?
A. Yes.
Q. And I'm asking --
A. Yes.
Q. Who is Dr. Effron?
A. Dr. Effron is a cardiologist in this hospital.
Q. He s not part of the critical care attending team?
A. He s not part of University Anesthes ologists.
Q. Fair enough.
Did you consider yourself to be one of Lawrence Brown's attending physicians in this matter?
A. Yes, I did.
Q. From your review of the records, on what date did you become involved in his care?
A. I have to look at the chart.
Q. That's fine.
A. I believe the 2nd of June, 1997. Yes, June 2, 1997.
Q. You know that by referencing which note?

A. The patient note dated 6-2-97, the heading SICU postop day five.

Q. Could I see it? I had difficulty reading the records. Not the handwriting but my copy was a poor one. Is your signature on there?

A. That is my initials.

Q. Now I know if I see this little squiggle that happens to be your initials.

A. That's right.

Q. Is the signature above that a resident?

A. My nurse practitioner.

Q. Do you always countersign those notes?

A. Yes, I do. I try to.

Q. Let me ask you this question: Prior to June 2, who was managing him as a SICU attending?

A. June 2nd as I recall was a Monday, one of my partners, Clifford Popple, was taking care of him on Saturday and Sunday the weekend before, prior to that, the end of May, my partner Jim Rowbottom was taking care of him.

Q. Now I think I can identify whose signatures those are.

How is it you came to care for Mr. Brown on June 2nd?

A. I rotate duties through the surgical

intensive care unit on a monthly basis. The Monday of -- June, 1997 was one of my months when I was on duty.

Q. You began patient care on that Monday, which was June 2nd?

A. That's correct.

Q. Having reviewed the autopsy, can you tell me in your medical opinion what was the cause of death for Mr. Brown?

A. Not with certainty.

Q. With medical probability can you indicate what you believe the cause of death is?

A. Well, I think the best I can determine he died -- he had a pulmonary embolus, he had heart failure.

Q. Generally speaking -- generally speaking is not a good way for an attorney to start a question -- if you are able to, when you took over his care on June 2nd, did you first of all review the notes of his progress in the hospital up to that time?

A. I didn't review every note, no.

Q. What was your understanding of the issues surrounding his medical management at that time?

A. My understanding was that he was a patient

who had had a cardiac surgery, who suffered a myocardial infarction prior to the cardiac surgery, he had some hypoxia in the postoperative period.

Q. Would it be fair to characterize that the primary medical problem at the time you took over his care on the morning of the 2nd, assuming you came in in the morning, was respiratory failure?

A. It would be fair to say that was one of his problems.

Q. Would you list for me what you believe his medical problems were on the morning of June 2nd?

A. I'm going to refer to the chart again.

Q. Sure.

A. In addition to respiratory failure he was recovering from some renal failure he had suffered in the postoperative period. He was also being treated for hypernatremia. He was also receiving what we call enteral nutritional supplementation because he was unable to take nutrition by himself.

Q. I would like to go through those four so we have a basis for looking at the medical management.

The enteral nutrition, did you have an opinion at the time that you began to care for

the patient as to why he was unable to take oral nutrition?

A. I can't completely recall but my opinion at the time was that he was debilitated enough so that he wouldn't be able to ingest enough calories on his own to help him to recover from all his medical problems in the postoperative period.

Q. When you say he was debilitated enough he couldn't take in appropriate calories, can you explain to me what medical mechanism you are describing that prevented him from having oral nutrition?

A. He was weak. I don't know specifically why but he wasn't -- I don't know how to put it -- all together enough or recovered enough from the stress of his surgery and postoperative course to pick up a knife and fork, get in enough calories.

Q. There was no anatomical defect that occurred as a result of surgery that prevented him from swallowing?

A. Not that I'm aware.

Q. Really just a constellation of his lethargy and his own reserves from trying to recover from the surgery that created that?

A. I believe.

Q. How was the hypernatremia being treated?
A. I believe he was getting water for that.
Q. Would you have a medical opinion as to whether or not the hypernatremia that existed on June 2nd was a life threatening medical condition from which he could not have recovered?
A. I don't believe it was.
Q. The renal insufficiency that we're discussing, are you conversant enough with the chart to indicate what the cause of renal compromise was at that time?
A. Not with certainty.
Q. What were your thoughts about what had caused -- we're discussing abnormality in the creatinine, BUNs, right?
A. Yes.
Q. Did you have an opinion as to what the cause, possible reasons for that were?
A. The best of my recollection I thought it was what we call an acute tubular necrosis or ATM, which can be seen in the postoperative period.
Q. As a result of surgery?
A. As a result *of* peri-operative stress and sustaining all the events he went through.
Q. Fair enough.

In reviewing the autopsy did that gives you any additional information about the cause of the renal failure?

A Not that I recall

Q Do you have an opinion as to whether or not Mr Brown had any underlying kidney disease prior to surgery?

A. I don't recall. I can look through.

Q If you would like to look at it that's fine I'm trying to know what your answers to these questions would be

A At this time I don't recall if he had underlying renal insufficiency or not

Q Do you have a recollection in looking at the labs as to whether this acute renal compromise was in its resolving phase by the time he came under your care?

A. I believe we felt it was getting better

Q because the numbers were improving?

A I believe that is the case yeah

Q In getting to the first one I did them in reverse order the respiratory failure did you have an opinion based on the notes that you did review as to what was causing the respiratory failure in this patient?

A. I believe that it was my opinion that he suffered a pulmonary embolus. That he also had some pulmonary congestion, was suffering from pulmonary infection.

Q. Let's try to deal with those.

You and I, believe it or not, could agree it's not always easy to determine with precision the specific time that the PE occurs: would you agree with that statement?

A. In this patient?

Q. Yes.

A. Say it again.

Q. Would you agree with me that it is not always possible to determine a precise moment that pulmonary embolus occurs in a person's lung?

A. I would agree with that.

Q. To the best of your medical ability, based upon the records as you reviewed them, when did you believe he suffered from his first episode of pulmonary embolus?

A. From what I can determine looking at the records, some time remote from when I came in contact with him.

Q. Let's try to narrow that.

When you say remote, would you

agree with me there is some evidence in the chart that he experienced a pulmonary embolus some time after his surgery, before he came under your care?
A. No, I couldn't agree with that.
Q. Tell me why not.
A. I can't -- I'm unable from the chart to say with certainty that he suffered a pulmonary embolus after surgery, whether it was after surgery, or before surgery.
Q. In your mind there is a possibility as part of his MI hospitalization he might have actually had clot in the lung prior to that event?
A. Yes.
Q. Fair enough.
Why would you draw that conclusion?
A. Well, from my reading of the autopsy report.
Q. That would be because there was some evidence of organized clot that predated the major event of 6-4; is that a fair way to state it?
A. I believe the autopsy report referred to remote pulmonary embolus.
Q. Fair enough. I wanted to see how you saw this.
At that time he came under your care, was there already an established diagnosis of

PE in the chart?
A. Well, there was the strong consideration of PE.
Q. Who had strongly considered that possibility as far as your understanding was?
A. I believe the first note to that effect was by Dr. Popple.
Q. That was 5-29 or 5-31, let's take a look.
MR. MOSCARINO: What date are we looking at?
MISS KOLIS: We're trying to find it since I didn't make a note on it and I can't read the handwriting, so that didn't help me.
Q. This is Dr. Popple's note you recall, 5-31?
A. Yes.
Q. I'm representing to you that is the first place that I see that consideration. If you want to look if something predates the 5-31 note.
A. Not that I'm aware of, although I don't want to say categorically nobody else did.
Q. Would you agree with Dr. Popple's assessment on 5-31-97 that the respiratory failure could have been as result of COPD?
A. Yes, could have been.

Q What laboratory data would you expect to see if the respiratory failure was a result of COPD?
A There is no laboratory data that could definitively say that his respiratory failure was from COPD alone.
Q Is there something that could suggest it?
A Something that could suggest that his respiratory failure was solely due to COPD?
Q. Yes.
A. No.
Q. In the SICU do you call in pulmonology to deal with respiratory failure?
A Not routinely
Q. Why is that?
A Because it's one of my areas of expertise
Q Fair answer I was curious
Would you agree with me there is no pulmonology consult in this?
A For this patient?
Q Yes
A Not that I'm aware of
Q You stated for the record I don't want to misinterpret what you are saying are you indicating to me based upon your practice and experience you feel capable of dealing with

respiratory failure without a pulmonary consult?
A. Peri-operative respiratory failure yes.
Q. Have you published in that area?
A. No.
Q. Just asking. I didn't recall that from your CV. Anything in press on that issue?
A. No.
Q. Would you agree with me that prior to the morning of 6-4, that the Heparinization attempted on this patient was nontherapeutic?
A. No, I wouldn't agree with that.
Q. Tell me why not.
A. Would you repeat the question?
Q. Sure. I might not have asked it very artfully, although I thought I had.

I was asking whether or not you agree with me prior to the morning of 6-4 the Heparinization attempted on this patient did not reach therapeutic levels is probably a better way to say it.

A. I'm going to review the lab values --
Q. That's fine.
A. -- to refresh my memory.

6-3 we have PTT values of 51 and 60, which I would consider therapeutic.

Q. That's the first time that they had reached therapeutic levels?
A. I do not believe -- I believe that that is not the case. I believe they had been therapeutic prior to that.
Q. Before you look for them, let me ask this question: Define for me what you consider to be therapeutic PT and PTT levels?
A. In general about one and a half times normal.
Q. When you say in general, are you relying upon guidelines published in the literature?
A. I can't cite a literature precedence for that.
Q. So you believe that therapeutic levels are one and a half times the normal numbers?
A. Yes. I think also clinical correlation is required, is the patient getting better on the regimen he's on with the particular levels that he has.
Q. Let me ask you this: There is a SICU note dated 6-3-97, it isn't timed. Clearly I believe we will be able to establish a time today. I have it highlighted, you don't have to dig for it.
Whose signature is on the bottom?

A. Kelly Popovich, I initialed it.
Q. Is Kelly Popovich your SICU nurse?
A. Yes.
Q. You initial her note?
A. That's correct.
Q. Do you agree she said she believed the PTT is still subtherapeutic at that time?
A. I agree that is what is written.
Q. You countersigned her note; is that correct?
A. Yes, I did.
Q. Would that then be fair for me to conclude at least at whatever time you signed the note on 6-3 you agreed the PTTs were at a subtherapeutic level?
A. I agree that they were not optimal at that point, so we at that point increased his Heparin shortly thereafter.
Q. When you say they are not optimal, at this point my understanding, which might not be completely accurate, is that when we initiate Heparin there is no such thing as a standard dosage for any human being; do you agree with that statement?
A. Yes.
Q. Everybody's biology will react differently to Heparin, that is why we continue to monitor the PT

and PTTs?

A. Yes.

Q. In any given patient as you said you have to look at the numbers and clinical correlation?

A. Yes.

Q In this patient on the morning of 6-7-97 what could how say the clinical correlation was to the Heparin that was being given and the recovery that was being achieved? You can go back and look I don't know what note you were looking at

A On the morning of 6-3 the PTT that was being referred to in that note was a numerical value of 44, which is slightly less than where we wanted it We wanted it around 50

At that time the clinical correlation was that the patient's oxygenation had improved with that numerical value of 44 so that what we were doing was some fine tuning of his Heparin.

Q Let me as you this so I won't be confused at a later time: Referring back to the note written by your nurse it says O_2 sats what does the M mean; do you know?

A. I think that's what she is saying, O_2 sat on 50 percent VM or venti mask

Q. What was his oxygen saturation?
A. That morning looks like his oxygen saturation was varying between 95 approximately -- 95 or actually had been as high as 99 at 2:00 in the morning, varied between that and 89, 89 to 99.
Q. That was with oxygen, right?
A. Correct.
Q. Do I gather that you were not reassured by this clinical course, therefore there was something else you thought should happen?
A. I don't know how to respond to whether I was reassured. I thought that there were other measures we needed to take.
Q. Let's talk about those.
You thought there were other measures that needed to be taken for what reason?
A. Well, I thought that there was a significant possibility that the patient had had a pulmonary embolism, I thought we needed to investigate whether there was a blood clot that we could determine where it was, that would be number one. If he had a blood clot in his legs.
Q. In fact you initiated a request for that particular examination, a duplex ultrasound, correct?

A. Correct.
Q. The duplex ultrasound revealed a clot, didn't it?
A. Yes.
Q. Specifically positive clot in the left extremity; is that your recollection?
A. That's my recollection, yes.
Q. That appeared to be fresh clot to you; is that right or wrong?
A. I will read the note.
Q. Okay.
A. Note says the left external iliac vein patent, positive clot from CFE coming from the vein, superficial femoral vein, popliteal vein and also acute thrombus superimposed on chronic changes of older clot, so it would appear there was acute and older clot.
Q. Fair enough.

In response to that, I think that what is in response to that is your note at the bottom, is that an accurate characterization, this is your note at the bottom?
A. That's correct.
Q. Could you read that note into the record for us.

A. High suspicion for PE, SAO_2 better in CICU after thrombolysis. Plan: Anticoagulation. I think he deserves an IVC filter. Angio thrombolysis when CTS feels it's safe to do this.

Q. Let me ask you several questions about that.

First of all, start with the IVC, inferior vena cava filter, some people use different names, that's the technically correct name for it.

Why do you think he deserved an IVC filter?

A. Because he had had poor oxygenation, he had clot in his leg, I was concerned that should more of that clot break loose, that he could be injured by that.

Q. When you say -- let me ask it a different way.

In every single person who you believe has had a PE that you find clot, do you automatically use IVC?

A. No.

Q. In this case would I be fair to assume, you can correct me, that Mr. Brown was at high risk for death from PE because of his poor underlying lung status?

A. I think that's fair to say.
Q. That would have been why you wanted to do an IVC filter?
A. I think that is fair to say.
Q. I also like to see if I learned anything in my research. I want to say a normal person -- I don't think there is one normal person in this room -- in the average medical patient who previously enjoyed good health, you found them in this situation, you wouldn't necessarily be concerned about putting in a filter because their lungs in themselves might be able to deal with the clot: is that a fair characterization of why we don't put a filter in everyone?
A. Go through it again.
Q. Let me ask you the question because you'll give the medical answer: Why don't we put an IVC in every person in this situation, this situation being that there was a previous PE, now the discovery of fresh clot?
A. Because the placement of the filter carries some morbidity with it. We can have an effective treatment of blood clot with Heparinization.
Q. Fair enough.
What was your desired goal in terms

of angiothrombolysis?
A. If he had had a pulmonary embolism, if it was sizeable, if we could safely dissolve that clot, then that would have been my goal.
Q. In your note you indicate that you would favor that when CTS, I assume cardiothoracic surgery feels it's safe to do this?
A. Um-hum.
Q. What are the safety issues you perceived around doing an angio at that time?
A. Angiography, one of the risks from angiography at that point was he had some renal compromise, angiography involves injection of radio opaque dye, exacerbates renal failure. That was the concern about angiography.

Concern about thrombolysis was the agent that we give for that not only dissolves clot that we don't want, it dissolves clot we do want. Namely close around his recent surgery.
Q. Would you be referring to Urokinase?
A. That would be one agent that could be used.
Q. Were you to make the decision, what agents would be used or would this fall into the purview of someone else?
A. The decision of what agent to use I think

would probably be made by the angiographer.
Q. Why didn't you schedule him immediately for an IVC filter?
A. I did schedule him for the IVC filter.
Q. For the following morning?
A. No, for that day.
Q. I think there is some confusion in the notes, let's try to clear that up.
You are telling me you did schedule him for that procedure?
A. Yes.
Q. First of all, who would have done the procedure?
A. One of our radiologists.
Q. An invasive radiologist, is that who would generally do these -- you do have invasive radiologists at UH?
A. Yes.
Q. Is there someone you would specifically request to do it?
A. No, whoever the radiologist on call that day doing them would be the one to do it.
Q. Was the decision to have the placement yours and yours alone, did you have to consult with anyone?

A. I talked to Dr. Lee about it.
Q. To the best of your recollection, describe for me the context between yourself and Dr. Lee regarding the placement of this filter.
A. The context?
Q. Yes.
A. I'm not sure what you mean by context.
Q. Did you call him, did you go see him, what did you discuss?
A. I don't know whether we did it in person or over the phone. I discussed that I was concerned about the patient's oxygenation, I thought that he needed an IVC filter.
Q. So in response, so that I'm clear, I asked you initially if the decision to place the filter was yours and yours alone, is the answer no, you couldn't just order the placement without consulting with the surgeon?
A. No, that's not entirely correct. The management of the patient was a joint effort between myself and Dr. Lee. In ordering tests or procedures of significant import, I always consult with Dr. Lee.
The decision -- so I would do that as a matter of course, in any situation similar to

this where a patient needed an invasive procedure I would discuss it with Dr Lee telling him here is what my concern is here is what I think we ought to do, what do you think

Q So you called him and you told him this is what you believed this patient needed?

A I don't know if it was a phone call I discussed it with him. I don't recall whether it was in person or phone I don't remember how we did it We did discuss it

Q Did he concur with you?

A Yes he did

Q Did he want to do other studies in conjunction with -- did he want to place the filter do other studies to the best of your recollection?

A I don't recall.

Q Why didn't it happen on the 3rd?

A. The reason it didn't happen is that this patient was unable to lie still enough for the procedure to be done safely In my judgment would have required sedation in order to lie still for the procedure

In order to safely administer sedation to the patient you need to have an empty

stomach, he had a full stomach. It was for that reason that I cancelled the procedure for that day, scheduled it for the next morning.

Q. Let's go through what you were thinking.

First of all, you said he wasn't able to lie still. What are you referring to? What I'm trying to say is do you agree with me there are no progress notes written by you or anyone else following your suggestion that he deserved to have a filter, until the next morning when he's in trouble?

A. Yes, I agree with that.

Q. Fair enough. Obviously then I can't know what is going on if there is nothing in writing. I'm asking you to detail for me as best you can what physical condition you are describing about him not being able to lay still?

MR. GROEDEL: Objection to your reference there is nothing in writing. I think the admission and discharge summary does cover that part of his explanation. With that said, you may go ahead and answer.

A. The procedure involves the patient laying on a hard table down in the radiology suite. Involves insertion of a cannula into the person's groin, a

large cannula, a large IV, then insertion of the device, this filter through the cannula into a major blood vessel, the largest vein in the body.

So if a patient is wiggling around, that makes it dangerous to perform the procedure. It was my judgment that this patient wouldn't be able to lie still enough for the procedure to safely be performed unless we sedated the patient.

Q. I heard what you said, I appreciate your answer.

What about this patient made you believe that he couldn't lie still enough for this procedure?

A. Well, as I recall, the best of my recollection, he was wiggling around quite a bit in bed, rather uncomfortable and unable to be calmed down enough by the nurses -- he was wiggling around enough in bed.

It wasn't causing him any harm wiggling around in bed, but I didn't think that we would be able to talk to him, say please lie still for the half an hour, forty minutes, hour, whatever it takes to lie down for this procedure. I don't think he would respond adequately to verbal requests to lie still. I thought he would need

some sedation to tolerate the procedure.
Q. Is there any information in the nurses' notes or any of these progress notes that Mr. Brown was experiencing episodes of agitation?
A. I don't recall offhand. If you would like I'll go through.
Q. You can look, I'm asking you to show me some place in the chart it indicates he's thrashing or rolling about in bed.
MR. GROEDEL: First of all, that's not what he said, thrashing or rolling about in bed.
Secondly, he's not going to sit here, review every single nurse's note from the admission to answer that question.
Q. It's your recollection that he was moving about in bed?
A. Yes. Not in a way that was deleterious to him in bed, but that might well have been on an angiography table when he was getting a percutaneous procedure.
Q. Had he been, from your point of view, capable of laying on the angiography table and following instructions for a half an hour or so, what kind of sedation would have been needed to place this

filter?
A. Then he probably wouldn't have needed any sedation.
Q. What kind of sedation do you believe, or your medical opinion would have been required to put him in a position to lay still for a half an hour to 45 minutes on that table?
A. Well, first of all, I'm not sure half an hour to 45 minutes, might have been longer than that. As to the question what kind of sedation, I think he needed intravenous medication to have him be a little more sedated.
Q. Let's clarify two things. I only said a half an hour to 45 minutes because that's what I thought you said.
A. Right. I threw that out as an example, I'm not an authority in terms of how long he would have had to lay on the table.
Q. You don't know how long the procedure takes?
A. That's correct, I do not know.
Q. I gather from the second answer that you just gave to what would have been necessary, you are not discussing general anesthesia, are you?
A. No. I do not think he needed general anesthesia, although he may have required sedation

at a level approaching g'eneral anesthesia.
Q. What would have been your suggestion as to what kind of sedation he would have needed?
A. Intravenous medication.
Q. What are you referring to?
A. There are a number of different medications that we can use. You want me to detail them?
Q. Sure, talking about an I.V. administration of Demerol or something to calm him, sedate him, something in that regard?
A. Benzodiazepin, Diprivan which is one of the sedative agents we use.
Q. Are you including in your answer the suggestion he needed a paralytic of any sort?
A. No.
Q. So you are just talking sedation drugs, Demerol, other things in that family or group?
A. I'm talking about drugs that would sedate the patient. There are a number of different drugs that would sedate the patient.
Q. If I understand this, was it your decision that he was not in a position to undergo this procedure?
A. It was my decision it was not safe to sedate him for this procedure, yes.

Q. Did anyone participate in making that decision with you?
A. I discussed it with Dr. Lee.
Q. Was he, to your recollection, in agreement with that decision?
A. Yes, he was as far as I recall.
Q. You believe the risk was caused by the fact he did not have an empty stomach?
A. Yes.
Q. You were concerned about aspiration I gather?
A. Yes.
Q. As an anesthesiologist, do you know if there is any way to protect the airway against aspiration under these kinds of circumstances?
A. Yes, i do.
Q. What would that be?
A. in an emergency we do something called a rapid sequence induction, when we insert an endotracheal tube into the patient's trachea with administration of -- we give them a general anesthetic, we put them deeply asleep, we administer muscle relaxers, paralytics, put an endotracheal tube in.
Q. Short of that, are you aware of a method that you could have used that day to empty the contents

of his stomach?
A. There is a method to empty the contents of the stomach, not completely, not reliably to prevent against aspiration.
Q. What method had you had in mind if that crossed your mind to do that?
A. There is no method to reliably empty the stomach against aspiration. The standard of care is the patient has to wait, let the stomach empty on its own,
Q. You believe that is the standard of care?
A. That is the standard of care.
Q. This situation, did you undergo a risk/benefit analysis in your decision to delay placement of the filter?
A. Yes.
Q. How did you analyze for protecting against the risk if he would throw more clots into his lungs?
A. The way I looked at it was that he had improved, his oxygenation had improved on Heparin therapy, both postoperatively and pre-operatively. When he had very poor oxygenation he was started on Heparin.
So on two occasions his oxygenation

had improved significantly with the administration of Heparin. I thought that it would be safer to -- given he had been -- his oxygenation had improved, rather than risk aspiration, to wait overnight, bring him down for the procedure with an empty stomach when we could safely sedate him.

Q. Did you feel you could not place an endotracheal tube safely to prevent aspiration to place the filter?

A. No, I didn't feel I couldn't do that.

Q. I'm sorry. I talk in double negatives.

Are you saying that you considered doing it, but decided it was too risky?

A. Yes.

Q. Why did you think it was too risky?

A. Endotracheal tubes, we routinely place endotracheal tubes in the manner I described by rapid sequence induction when people have full stomachs and need operations or procedures on an emergent basis. In that case, in that instance we accept the risk of aspiration that is concurrent with placement of the endotracheal tube because of the greater risk of whatever the emergency is.

In this case I felt this procedure was not an emergency, did not justify the risk of

placement of the endotracheal tube

Q This is just probably because I can t write talk and think at the same time, once again what did you feel the risk of separating him was?

A The risk of separating him was he could aspirate since he had food in his stomach

Q I want to be sure that is what I thought you understood the risk was

You didn't consider this an emergency situation?

A. Correct.

Q. Dr Lee I take it concurred with you in that thinking based on your recollection of the conversation?

A. I don't know that I spoke the words this isn't an emergency I believe I told him it was my opinion that it would be better to wait until the next morning. The patient was doing okay, stable on the Heparin regimen we had him on better wait until the next morning.

Q. Let me see if I can sort this out in my own mind since I don t have a lot of handwritten notes by you

You indicated in your testimony after learning the results of the doppler after

writing your note, you did in fact order for this procedure to take place?

A. That's correct.

Q. When you ordered that this procedure needed to take place, didn't you already have this information we just discussed about him moving around in bed, you knew he had food in his stomach, though not regular food but tube nutrition, didn't you know all that information at that time?

A. Well, it was all kind of happening at the same time. We got the results back from the ultrasound, saw he had clot in his leg, I thought that he needed a filter, then realized that -- made the arrangements for the filter to be placed, then realized that he had a full stomach, thought about it, thought it would be safer to wait until the next morning.

Q. You made a decision and changed your mind, that is the easy way to describe it?

A. Correct.

MR. GROEDEL: Wait a minute. Did you finish your answer? I want to mention something to you as long as you are done.

THE WITNESS: Yes, I did.

(Discussion had off the record.)

A. As part of the decision making process, I called downstairs to the radiologist, spoke to him, said how still does this patient need to lie for the procedure. I've got a patient I don't think will be able to lay very still, how still -- I didn't have that information -- how still does he need to lie for the procedure. Was told the patient needs to lie still for the procedure.

Then I looked at how can I insure that this patient can lie still so he can safely have the procedure, he needs sedation for that. From that, got to what are my options after that.

Q. Drew a different conclusion based on additional medical information you received from radiology?

A. I suspected he would need to lie still for the procedure, I was concerned about it. Called the radiologist, found out yes, he has to lie still for the procedure.

Then I thought can I safely sedate this patient for the procedure for which he needs to lie still, made a decision no, at this time I can't safely sedate him for the procedure.

Q. Couple of questions. I don't know if you've gone through the nurses' notes very carefully, they are very difficult to read, I will parenthetically add that.

This is a note, I will represent clearly this note is from 6-3, I highlighted this is 10:30.

MISS KOLIS: Marc, you can look at the time I suppose, Dr. Furey notified of doppler findings.

MR. GROEDEL: 10:30 a.m.

Q. 10:30 a.m.

A. Okay.

Q. I think that is fair enough at least for both of our abilities to read it.

Can you make out what the 1414 note says?

A. A line placed at bedside by CRN.

Q. At 1425 it looks like doppler ultrasound of graft site, Dr. Lee at bedside, correct?

A. Urn-hum.

Q. Skipping down to 1621 it says angio cancelled?

A. Yes.

Q. Patient not n.p.o.

A Correct
Q To your knowledge was there an angio scheduled on that day?
A What do you mean by angio? I didn't write the note out that would have been the filter placement it's done in the angiography suite
Q There was not -- someone didn't follow through on your earlier suggestion of angiography being done?
A. Correct.
Q. If you've looked through this chart you didn't see angio was ordered that day?
A Correct The angiography I'm referring to would have been pulmonary angiography The placement of the filter is done in the angiography suite and I m not totally familiar with the procedure It may have involved some installation of a little bit of dye, I don't know. That probably doesn't clarify.
Q All I want to be sure since there were other things that weren't clear from the charting, there was not an order for pulmonary an iography on that day?
A. As far as I know.
Q. You didn't participate in the decision to

order that on that day?
A I did not.
Q When Mr. Brown came under your care, did you have information available to you about the condition of his lungs? What's a very general question.
A. Yes.
Q. What information did you have?
A I had the information that he had been a heavy smoker that he had COPD that he had had problems with oxygenation pre-operatively and postoperatively
Q. Harkening back to the note you wrote on the 3rd you thought he needed a filter because if I'm recalling this correctly poor oxygenation correct?
A I thought that he needed a filter because of the risk to him from a pulmo ary embolism.
Q There is not a good way to ask it so I'll do it the best I can: What did you feel the risk to him was for pulmonary embolism?
A I thought that it could certainly compromise his health or kill him.
Q. Was that risk greater than the risk of sedating him to undergo filter placement?

MR. GROEDEL: At what point in time, as of the time he's making his decision?

MISS KOLIS: Yes.

MR. GROEDEL: Go ahead.

A. At that point I thought that the risk of sedating him was greater based on the fact that his oxygenation had improved with Heparin therapy on two occasions pre-operatively and postoperatively.

Q. Did you ask the nursing staff -- did you, if you know -- let me start over.

Do you leave the hospital at a regular time? I know the answer is no, we will give it a shot.

MR. GROEDEL Regular for who?

A. No.

Q. Is there a way for you to know what time you left the hospital on June 3rd?

A. No.

Q. Would you, under these circumstances, have left instructions for the nurses to carefully monitor decreases in his oxygenation that evening?

A. I wouldn't have needed to because they do so routinely.

Q. Would you have indicated any changes of

circumstances in the oxygenation that you would have wanted them to call you at home personally and tell you about?

A I wouldn't have -- I m on call 24 hours a day If there is a major problem with a patient nurses or the physicians can always call me know that they can so that instruction isn't given it's understood.

Q Fair enough.

I·ll ask this question so Mr Moscarino can just type this morning: In your review of the chart do you have any criticisms of the conduct of nurses or residents following what presumably would be your departure from the hospital on the evening of the 3rd to the morning of the 4th?

A. Not that I can recall at this time.

Q Let me ask you another question We looked very early on in this morning's deposition at a note from your partner Dr Cobble is it?

A. Popple.

Q It looks like a C or K so I was thinking that in my mind, back on the 31st of May

Do you agree with me there was sufficient evidence to suggest a diagnosis of PE on

that day?
A. I agree there was reason to be concerned about that.
Q. They in fact initiated Heparin therapy on that day?
A. Yes.
Q. Can you discern any reason that a duplex ultrasound of the extremities could not have been performed prior to the 3rd of June?
A. Say that again.
Q. You ordered an ultrasound of the extremities on the 3rd?
A. Urn-hum.
Q. We will work it backwards.

Can you tell me why you didn't order one on the 2nd?

A. I can't tell you that, no.
Q. Using that as a springboard, we agreed on May 31st the diagnosis of PE was entertained, in fact Heparin therapy was initiated in the face of that probable diagnosis I guess is what I 11 call it.

Is there a medical reason you can determine in this chart that the ultrasound of the legs could not have occurred between May 31st, but

before you actually did it on June 3rd?

MR. GROEDEL: Objection. I think you are asking the doctor to read other people's minds. Go ahead.

Q. I'm not asking you to read anyone s mind. Is there any medical contraindication you ee in this chart that would have prevented that examination from occurring sooner?

A. No, there is not.

Q. Do you have an opinion whether or not it should have occurred sooner?

A. I don't -- well, the critical intervention was at the first suspicion of pulmonary embolism is the administration of Heparin therapy. That is the critical piece when the pulmonary embolism is suspected.

The detection of blood clot or looking for a blood clot can postdate that. The critical piece is administration of Heparin.

Q. Assuming that I agree with initially that is the critical intervention, do you agree with me or am I misunderstanding to a reasonable degree of medical certainty we know that Heparin doesn't give us any insurance against throwing another embolism for at least 24 to 48 hours?

A. No, I don't agree with that.
Q. When do you think it becomes effective?
A. Heparin has some beneficial effect as soon as you start giving it. It's not 100 percent effective, reliable 100 percent, no.
Q. Aside from the issue -- let's put it this way: I agree with you it's not 100 percent effective. In the first 24 hours you are trying to raise it to therapeutic levels, correct?
A. Um-hum.
Q. Looking back in the chart, would you say in the first 24 to 48 hours there is an effective therapeutic coverage from the Heparin?
A. You are saying a couple different things. As soon as Heparin started being given, even if it isn't at the level we're shooting for, it has beneficial effects.
Q. What beneficial effects does it have?
A. It's an anticoagulant. It prevents accumulation of clot. So even if the blood level of it is less than our target rate, it still has beneficial effects.
Q. What clot do you think it's effecting in the early stages?
A. Heparin has the effect to prevent

accumulation of more clot, doesn't dissolve old clot.

Q. That's of course something you knew in June of 1997, correct?

A. Yes.

MISS KOLIS: I'm going to step out in the hallway for two seconds with Tracy, we will be back.

(Recess had.)

MISS KOLIS: In keeping with my representation, this deposition is concluded. I don't have any further questions. Someone else might.

MR. MALONE: No.

MR. MOSCARINO: Doctor, I introduced myself to you, I represent the hospital.

CROSS-EXAMINATION

BY MR. MOSCARINO:

Q. Plaintiff's counsel asked if you had any criticism of the hospital staff after you left that evening, you said you did not, correct?

A. Yes.
Q. Do you have any criticism of the resident staff or nursing staff in the care of this patient?
A. Not now.
Q. It appears to me based on my review of the suit papers, what I've been told by counsel, that the issue in this case or one of the key issues is going to be the decision to not perform this filter placement on the day that you initially ordered it, okay.
A. Okay.
Q. That decision I take it from your deposition testimony was yours, not that of a resident or nurse?
A. That's correct.

MR. MOSCARINO: That's all I have. Thanks.

MR. MALONE: No questions by Dr. Lee.

MISS KOLIS: I assume the Doctor would like to read. I will waive the seven day reading requirement of course.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE
University Anesthesiologists, Inc.	7/25
. . . ATN	13/20
. . . Venting mask	22/25
. . . safe to wait (?)	38/2
CRNA	42/18

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

ERIN FUREY, M.D.

ERRATA SHEET

NOTATION	PAGE/LINE

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

.....

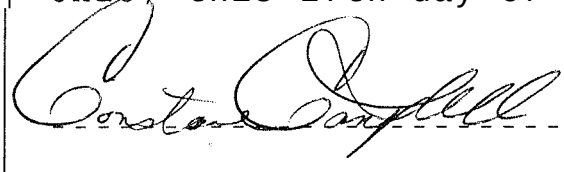
ERIN FUREY, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, ERIN FUREY, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 27th day of August, 1998.



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

Look-See Concordance Report

UNIQUE WORDS: **971**
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* * DATES * *

5-31-97 [1]
17:23
6-2-97 [1]
9:1
6-3-97 [2]
20:22; 22:6
June [1]
47:9
June, 1997 [2]
8:23; 10:2
June 2 [1]
9:15
June 2,1997 [1]
8:24
June 2nd [6]
9:16, 24; 10:5, 19; 11:11; 13:5
June 3rd [2]
45:18; 48:1
June of 1997 [1]
50:3
May [2]
9:19; 46:23
May 31st [2]
47:19, 25

* * 1 * *

100 [3]
49:4, 5, 7
10:30 [3]
42:7, 11, 12
1414 [1]
42:16
1425 [1]
42:19
1621 [1]
42:22
1997 [4]
8:23, 24; 10:2; 50:4

* * 2 * *

2 [2]
8:24; 9:15
24 [4]
46:4; 48:25; 49:8, 12
2:00 [1]
23:4
2nd [9]
8:23; 9:16, 24; 10:5, 19; 11:6, 11; 13:5; 47:16

* * 3 * *

31st [3]
46:23; 47:19, 25
3rd [7]
30:18; 44:14; 45:18; 46:15; 47:9, 12; 48:1

* * 4 * *

44 [2]
22:13, 17
45 [3]
34:7, 9, 14
48 [2]
48:25; 49:12
4th [1]
46:16

* * 5 * *

5-29 [1]
17:8
5-31 [3]
17:8, 15, 19
5-31-97 [1]
17:23
50 [2]
22:14, 25
51 [1]
19:24

* * 6 * *

6-2-97 [1]
9:1
6-3 [4]
19:24; 21:12; 22:11; 42:6
6-3-97 [2]
20:22; 22:6
6-4 [3]
16:19; 19:9, 17
60 [1]
19:25

* * 8 * *

89 [2]
23:5

* * 9 * *

95 [2]
23:3
99 [2]
23:4, 5

* * A * *

a.m. [2]
42:11, 12
abilities [1]
42:15
ability [1]
15:17
able [9]
10:18; 12:5; 20:23; 26:12; 31:6, 17; 32:7, 21; 41:7
abnormality [1]
13:14
accept [1]
38:21
accumulation [2]
49:20; 50:1
accurate [3]
5:17; 21:19; 24:21
achieved [1]
22:9
acute [4]
13:20; 14:15; 24:15, 16
add [1]
42:4
addition [1]
11:14
additional [2]
14:2; 41:16
adequately [1]
32:24
administer [2]
30:24; 36:22
administration [5]
35:8; 36:20; 38:1; 48:14, 19
admission [2]
31:20; 33:15
admit [1]
6:22
affirmatively [1]
5:16
agent [3]
27:17, 21, 25
agents [2]
27:22; 35:12
agitation [1]
33:4
agree [23]
15:7, 9, 13, 16; 16:1, 4; 17:22; 18:17; 19:8, 11, 17; 21:6, 8, 14, 21; 31:7, 12; 46:24; 47:2; 48:20, 21; 49:1, 7
agreed [2]
21:13; 47:18
agreement [1]
36:4
airway [1]
36:13
alone [3]
18:5; 28:24; 29:16
analysis [1]
37:14
analyze [1]
37:17
anatomical [1]
12:18
Anesthesia [2]
7:25; 8:1
anesthesia [5]
6:12; 8:2; 34:23, 25; 35:1
anesthesiologist [1]
36:12
Anesthesiologists [1]
8:13

* * B * *

13:15

* * C * *

* * D * *

*** * E * ***

*** * F * ***

* * J * *

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Case Name:	Estate of Lawrence Brown vs. University Hospitals, et al.		
Court:	Cuyahoga County CCP	Type of Case:	Medical Malpractice / wrongful death
Judge:	Brian Corrigan	Disposition:	defense verdict
Injuries:	death from pulmonary embolus		
Deponent:	Erin J. Furey, MD	Specialty:	Anesthesiology / Critical care
On behalf of:	~~ck~~ self	Locale:	Cleveland Clinic
Type of Document(s):	Deposition/Trial testimony, CV		

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Boulder Computer Resource Center
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Education Coordinator, 1982

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Denver, CO
Counselor for Juvenile Delinquents, 1977-80

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Music Teacher, 1974-75

Erin James Furey, M.D.
Curriculum Vitae

Societies

American Society of Anesthesiologists

Society of Critical Care medicine

Ohio society of Anesthesiologists

American College of Chest Physicians

Publications

Lee JH, Graber RG, Popple CG, Furey EJ, Lyons TC, Murrell HK, Geha AS: Safety and Efficacy of Early Extubation of Elderly Coronary Artery Bypass Surgery Patients. Journal of Cardiothoracic and Vascular Anesthesia. To be published August 1998,