

1 THE STATE of OHIO,
2 COUNTY of CUYAHOGA.

: SS:

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4 IN THE COURT OF COMMON PLEAS

5 -----

6 ESTATE OF LAWRENCE BROWN, :
7 plaintiff,

8 vs.

: Case No. 346342

9 UNIVERSITY HOSPITALS OF
CLEVELAND, et al.,
10 defendants.

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12
13 Deposition of ERIN FUREY, M.D., a
14 defendant herein, called by the plaintiff for the
15 purpose of cross-examination pursuant to the Ohio
16 Rules of Civil Procedure, taken before Constance
17 Campbell, a Notary Public within and for the State
18 of Ohio, at University Hospitals, 11100 Euclid
19 Avenue, Cleveland, Ohio, on FRIDAY, AUGUST 14TH,
20 1998, commencing at 9:04 a.m. pursuant to agreement
21 of counsel.

1 APPEARANCES:

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26 ALSO PRESENT:

27 Jai Lee, M.D.
28 Tracy McGerth

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(NO EXHIBITS MARKED)

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ERIN FUREY, M.D.

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

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.

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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

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

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

8 A. Yes.

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

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

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

17 A. Yes.

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

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

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

1 A. Of this patient?

2 Q. Yes, of this patient?

3 A. Yes, I have.

4 Q. Have you also reviewed the autopsy results?

5 A. Yes, I have.

6 Q. Have you had an opportunity to review medical
7 records that were generated for other care to this
8 patient before he came to UH?

9 A. No, I haven't.

10 Q. Fair enough.

11 When you say that you see most of
12 the patients in SICU, is it you yourself or is
13 there a group of critical care attendings?

14 A. There is a group of critical care attendings,
15 I'm not sure exactly what you are getting at.

16 Q. Let me ask the question a different way.

17 If I recall your interrogatory
18 answers it's clear you're not an employee of the
19 hospital, correct?

20 A. That's right.

21 Q. You belong to a group of anesthesiologists
22 that is your practice group?

23 A. Yes.

24 Q. That practice group's name is?

25 A. University Anesthesia, Incorporated.

1 Q. Does University Anesthesia, Incorporated
2 provide anesthesia service to the hospital, to the
3 surgical intensive care unit?

4 A. Yes.

5 Q. And I'm asking --

6 A. Yes.

7 Q. Who is Dr. Effron?

8 A. Dr. Effron is a cardiologist in this
9 hospital.

10 Q. He s not part of the critical care attending
11 team?

12 A. He s not part of University
13 Anesthes ologists.

14 Q. Fair enough.

15 Did you consider yourself to be one
16 of Lawrence Brown's attending physicians in this
17 matter?

18 A. Yes, I did.

19 Q. From your review of the records, on what date
20 did you become involved in his care?

21 A. I have to look at the chart.

22 Q. That's fine.

23 A. I believe the 2nd of June, 1997. Yes,
24 June 2, 1997.

25 Q. You know that by referencing which note?

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

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

6 A. That is my initials.

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

9 A. That's right.

10 Q. Is the signature above that a resident?

11 A. My nurse practitioner.

12 Q. Do you always countersign those notes?

13 A. Yes, I do. I try to.

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

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

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

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

25 A. I rotate duties through the surgical

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


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

6 A. That's correct.

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

10 A. Not with certainty.

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

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

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

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

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

25 A. My understanding was that he was a patient

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

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

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

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

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

13 Q. Sure.

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

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

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

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

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

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

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

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

21 A. Not that I'm aware.

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

25 A. I believe.

1 Q. How was the hypernatremia being treated?

2 A. I believe he was getting water for that.

3 Q. Would you have a medical opinion as to
4 whether or not the hypernatremia that existed on
5 June 2nd was a life threatening medical condition
6 from which he could not have recovered?

7 A. I don't believe it was.

8 Q. The renal insufficiency that we're
9 discussing, are you conversant enough with the
10 chart to indicate what the cause of renal
11 compromise was at that time?

12 A. Not with certainty.

13 Q. What were your thoughts about what had
14 caused -- we're discussing abnormality in the
15 creatinine, BUNs, right?

16 A. Yes.

17 Q. Did you have an opinion as to what the cause,
18 possible reasons for that were?

19 A. The best of my recollection I thought it was
20 what we call an acute tubular necrosis or ATM,
21 which can be seen in the postoperative period.

22 Q. As a result of surgery?

23 A. As a result of peri-operative stress and
24 sustaining all the events he went through.

25 Q. Fair enough.

1 In reviewing the autopsy with that
 2 give you any additional information about the cause
 3 of the renal failure?

4 A Not that I recall

5 Q Do you have an opinion as to whether or not
 6 the person had any underlying kidney disease prior
 7 to surgery?

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

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

12 A At this time I don't recall if he had
 13 underlying renal insufficiency or not
 14 Q Do you have a recollection in looking at the
 15 label as to whether this acute renal compromise was
 16 in its resolving phase by the time he came under
 17 your care?

18 A. I believe we felt it was getting better
 19 because the numbers were improving?

20 A I believe that is the case yeah

21 Q In getting to the first one with them in
 22 reverse order the respiratory failure with you
 23 have an opinion based upon the notes that you with
 24 respiratory as to what was causing the respiratory
 25 failure in this patient?

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

5 Q. Let's try to deal with those.

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

10 A. In this patient?

11 Q. Yes.

12 A. Say it again.

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

16 A. I would agree with that.

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

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

24 Q. Let's try to narrow that.

25 When you say remote, would you

1 agree with me there is some evidence in the chart
2 that he experienced a pulmonary embolus some time
3 after his surgery, before he came under your care?

4 A. No, I couldn't agree with that.

5 Q. Tell me why not.

6 A. I can't -- I'm unable from the chart to say
7 with certainty that he suffered a pulmonary embolus
8 after surgery, whether it was after surgery, or
9 before surgery.

10 Q. In your mind there is a possibility as part
11 of his MI hospitalization he might have actually
12 had clot in the lung prior to that event?

13 A. Yes.

14 Q. Fair enough.

15 Why would you draw that conclusion?

16 A. Well, from my reading of the autopsy report.

17 Q. That would be because there was some evidence
18 of organized clot that predated the major event of
19 6-4; is that a fair way to state it?

20 A. I believe the autopsy report referred to
21 remote pulmonary embolus.

22 Q. Fair enough. I wanted to see how you saw
23 this.

24 At that time he came under your
25 care, was there already an established diagnosis of

1 PE in the chart?

2 A. Well, there was the strong consideration
3 of PE.

4 Q. Who had strongly considered that possibility
5 as far as your understanding was?

6 A. I believe the first note to that effect was
7 by Dr. Popple.

8 Q. That was 5-29 or 5-31, let's take a look.

9 MR. MOSCARINO: What date are
10 we looking at?

11 MISS KOLIS: We're trying to
12 find it since I didn't make a note on it and I
13 can't read the handwriting, so that didn't help
14 me.

15 Q. This is Dr. Popple's note you recall, 5-31?

16 A. Yes.

17 Q. I'm representing to you that is the first
18 place that I see that consideration. If you want
19 to look if something predates the 5-31 note.

20 A. Not that I'm aware of, although I don't want
21 to say categorically nobody else did.

22 Q. Would you agree with Dr. Popple's assessment
23 on 5-31-97 that the respiratory failure could have
24 been as result of COPD?

25 A. Yes, could have been.

1

Q What laboratory data would you expect to see if the respiratory failure was a result of COPD?

2

A There is no laboratory data that would definitively say that his respiratory failure was from COPD alone.

5

Q Is there something that could suggest it?

6

A Something that could suggest that his respiratory failure was solely due to COPD?

8

Q. Yes.

9

A. No.

10

Q. In the SICU do you call in pulmonology to deal with respiratory failure?

12

A Not routinely

13

Q. Why is that?

14

A Because it's one of my areas of expertise

15

Q Fair answer I was curious

16

Would you agree with me there is no

17

pulmonology consult in this?

18

A For this patient

19

Q Yes

20

A Not that I'm aware of

21

Q You state for the record I don't want to

22

misinterpret what you are saying are you

23

indicating to me based upon your practice and

24

experience you feel capable of dealing with

25

1 respiratory failure without a pulmonary consult?

2 A. Peri-operative respiratory failure yes.

3 Q. Have you published in that area?

4 A. No.

5 Q. Just asking. I didn't recall that from your
6 CV. Anything in press on that issue?

7 A. No.

8 Q. Would you agree with me that prior to the
9 morning of 6-4, that the Heparinization attempted
10 on this patient was nontherapeutic?

11 A. No, I wouldn't agree with that.

12 Q. Tell me why not.

13 A. Would you repeat the question?

14 Q. Sure. I might not have asked it very
15 artfully, although I thought I had.

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

21 A. I'm going to review the lab values --

22 Q. That's fine.

23 A. -- to refresh my memory.

24 6-3 we have PTT values of 51 and
25 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?

1 A. Kelly Popovich, I initialed it.

2 Q. Is Kelly Popovich your SICU nurse?

3 A. Yes.

4 Q. You initial her note?

5 A. That's correct.

6 Q. Do you agree she said she believed the PTT is
7 still subtherapeutic at that time?

8 A. I agree that is what is written.

9 Q. You countersigned her note; is that correct?

10 A. Yes, I did.

11 Q. Would that then be fair for me to conclude at
12 least at whatever time you signed the note on 6-3
13 you agreed the PTTs were at a subtherapeutic level?

14 A. I agree that they were not optimal at that
15 point, so we at that point increased his Heparin
16 shortly thereafter.

17 Q. When you say they are not optimal, at this
18 point my understanding, which might not be
19 completely accurate, is that when we initiate
20 Heparin there is no such thing as a standard dosage
21 for any human being; do you agree with that
22 statement?

23 A. Yes.

24 Q. Everybody's biology will react differently to
25 Heparin, that is why we continue to monitor the PT

1 and PTTs?

2 A. Yes.

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

5 A. Yes.

6 Q In this patient on the morning of 6-3-97
7 what would you say the clinical correlation was to
8 the Heparin that was being given and the recovery
9 that was being achieved? You can go back and look
10 I don't know what notes you were looking at

11 A On the morning of 3-3 the PMT that was being
12 referred to in that note was a numerical value of
13 44, which is slightly less than where we wanted
14 it We wanted it around 50

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

20 Let me ask you this so I don't be confused at
21 a later time: Referring back to the notes written
22 by your nurse it says O₂ sat# what does the M
23 mean; do you know?

24 A. I think that's what she is saying, O₂ sat on
25 50 percent WM or wenti mark

1 Q. What was his oxygen saturation?

2 A. That morning looks like his oxygen saturation
3 was varying between 95 approximately -- 95 or
4 actually had been as high as 99 at 2:00 in the
5 morning, varied between that and 89, 89 to 99.

6 Q. That was with oxygen, right?

7 A. Correct.

8 Q. Do I gather that you were not reassured by
9 this clinical course, therefore there was something
10 else you thought should happen?

11 A. I don't know how to respond to whether I was
12 reassured. I thought that there were other
13 measures we needed to take.

14 Q. Let's talk about those.

15 You thought there were other
16 measures that needed to be taken for what reason?

17 A. Well, I thought that there was a significant
18 possibility that the patient had had a pulmonary
19 embolism, I thought we needed to investigate
20 whether there was a blood clot that we could
21 determine where it was, that would be number one.
22 If he had a blood clot in his legs.

23 Q. In fact you initiated a request for that
24 particular examination, a duplex ultrasound,
25 correct?

1 A. Correct.

2 Q. The duplex ultrasound revealed a clot, didn't

3 it?

4 A. Yes.

5 Q. Specifically positive clot in the left

6 extremity; is that your recollection?

7 A. That's my recollection, yes.

8 Q. That appeared to be fresh clot to you; is

9 that right or wrong?

10 A. I will read the note.

11 Q. Okay.

12 A. Note says the left external iliac vein

13 patent, positive clot from CFE coming from the

14 vein, superficial femoral vein, popliteal vein and

15 also acute thrombus superimposed on chronic changes

16 of older clot, so it would appear there was acute

17 and older clot.

18 Q. Fair enough.

19 In response to that, I think that

20 what is in response to that is your note at the

21 bottom, is that an accurate characterization, this

22 is your note at the bottom?

23 A. That's correct.

24 Q. Could you read that note into the record for

25 us.

1 A. High suspicion for PE, SAO₂ better in CICU
2 after thrombolysis. Plan: Anticoagulation. I
3 think he deserves an IVC filter. Angio
4 thrombolysis when CTS feels it's safe to do this.

5 Q. Let me ask you several questions about that.

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

10 Why do you think he deserved an IVC
11 filter?

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

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

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

21 A. No.

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

1 A. I think that's fair to say.

2 Q. That would have been why you wanted to do an
3 IVC filter?

4 A. I think that is fair to say.

5 Q. I also like to see if I learned anything in
6 my research. I want to say a normal person -- I
7 don't think there is one normal person in this
8 room -- in the average medical patient who
9 previously enjoyed good health, you found them in
10 this situation, you wouldn't necessarily be
11 concerned about putting in a filter because their
12 lungs in themselves might be able to deal with the
13 clot: is that a fair characterization of why we
14 don't put a filter in everyone?

15 A. Go through it again.

16 Q. Let me ask you the question because you'll
17 give the medical answer: Why don't we put an IVC
18 in every person in this situation, this situation
19 being that there was a previous PE, now the
20 discovery of fresh clot?

21 A. Because the placement of the filter carries
22 some morbidity with it. We can have an effective
23 treatment of blood clot with Heparinization.

24 Q. Fair enough.

25 What was your desired goal in terms

1 of angiothrombolysis?

2 A. If he had had a pulmonary embolism, if it was
3 sizeable, if we could safely dissolve that clot,
4 then that would have been my goal.

5 Q. In your note you indicate that you would
6 favor that when CTS, I assume cardiothoracic
7 surgery feels it's safe to do this?

8 A. Um-hum.

9 Q. What are the safety issues you perceived
10 around doing an angio at that time?

11 A. Angiography, one of the risks from
12 angiography at that point was he had some renal
13 compromise, angiography involves injection of radio
14 opaque dye, exacerbates renal failure. That was
15 the concern about angiography.

16 Concern about thrombolysis was the
17 agent that we give for that not only dissolves clot
18 that we don't want, it dissolves clot we do want.
19 Namely close around his recent surgery.

20 Q. Would you be referring to Urokinase?

21 A. That would be one agent that could be used.

22 Q. Were you to make the decision, what agents
23 would be used or would this fall into the purview
24 of someone else?

25 A. The decision of what agent to use I think

1 would probably be made by the angiographer.

2 Q. Why didn't you schedule him immediately for
3 an IVC filter?

4 A. I did schedule him for the IVC filter.

5 Q. For the following morning?

6 A. No, for that day.

7 Q. I think there is some confusion in the notes,
8 let's try to clear that up.

9 You are telling me you did schedule
10 him for that procedure?

11 A. Yes.

12 Q. First of all, who would have done the
13 procedure?

14 A. One of our radiologists.

15 Q. An invasive radiologist, is that who would
16 generally do these -- you do have invasive
17 radiologists at UH?

18 A. Yes.

19 Q. Is there someone you would specifically
20 request to do it?

21 A. No, whoever the radiologist on call that day
22 doing them would be the one to do it.

23 Q. Was the decision to have the placement yours
24 and yours alone, did you have to consult with
25 anyone?

1 A. I talked to Dr. Lee about it.

2 Q. To the best of your recollection, describe
3 for me the context between yourself and Dr. Lee
4 regarding the placement of this filter.

5 A. The context?

6 Q. Yes.

7 A. I'm not sure what you mean by context.

8 Q. Did you call him, did you go see him, what
9 did you discuss?

10 A. I don't know whether we did it in person or
11 over the phone. I discussed that I was concerned
12 about the patient's oxygenation, I thought that he
13 needed an IVC filter.

14 Q. So in response, so that I'm clear, I asked
15 you initially if the decision to place the filter
16 was yours and yours alone, is the answer no, you
17 couldn't just order the placement without
18 consulting with the surgeon?

19 A. No, that's not entirely correct. The
20 management of the patient was a joint effort
21 between myself and Dr. Lee. In ordering tests or
22 procedures of significant import, I always consult
23 with Dr. Lee.

24 The decision -- so I would do that
25 as a matter of course, in any situation similar to

1 this where a patient never would an invasive procedure
 2 I would discuss it with Dr Lee telling him here
 3 is what my concern is here is what I think we
 4 ought to do, what do you think

5 Q So you called him and you told him this is
 6 what you believe this patient needs?

7 A I don't know is it was a phone call I
 8 discussed it with him. I don't recall whether it
 9 was in person or phone I don't remember how we
 10 did it we did discuss it

11 Q Did he concur with you?

12 A Yes he did

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

17 A I don't recall.

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

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

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

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

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

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

12 A. Yes, I agree with that.

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

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

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

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

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

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

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

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

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

1 some sedation to tolerate the procedure.

2 Q. Is there any information in the nurses' notes
3 or any of these progress notes that Mr. Brown was
4 experiencing episodes of agitation?

5 A. I don't recall offhand. If you would like
6 I'll go through.

7 Q. You can look, I'm asking you to show me some
8 place in the chart it indicates he's thrashing or
9 rolling about in bed.

10 MR. GROEDEL: First of all,
11 that's not what he said, thrashing or rolling about
12 in bed.

13 Secondly, he's not going to sit
14 here, review every single nurse's note from the
15 admission to answer that question.

16 Q. It's your recollection that he was moving
17 about in bed?

18 A. Yes. Not in a way that was deleterious to
19 him in bed, but that might well have been on an
20 angiography table when he was getting a
21 percutaneous procedure.

22 Q. Had he been, from your point of view, capable
23 of laying on the angiography table and following
24 instructions for a half an hour or so, what kind of
25 sedation would have been needed to place this

1 filter?

2 A. Then he probably wouldn't have needed any
3 sedation.

4 Q. What kind of sedation do you believe, or your
5 medical opinion would have been required to put him
6 in a position to lay still for a half an hour to
7 45 minutes on that table?

8 A. Well, first of all, I'm not sure half an hour
9 to 45 minutes, might have been longer than that.
10 As to the question what kind of sedation, I think
11 he needed intravenous medication to have him be a
12 little more sedated.

13 Q. Let's clarify two things. I only said a half
14 an hour to 45 minutes because that's what I thought
15 you said.

16 A. Right. I threw that out as an example, I'm
17 not an authority in terms of how long he would have
18 had to lay on the table.

19 Q. You don't know how long the procedure takes?

20 A. That's correct, I do not know.

21 Q. I gather from the second answer that you just
22 gave to what would have been necessary, you are not
23 discussing general anesthesia, are you?

24 A. No. I do not think he needed general
25 anesthesia, although he may have required sedation

1 at a level approaching g'eneral anesthesia.

2 Q. What would have been your suggestion as to
3 what kind of sedation he would have needed?

4 A. Intravenous medication.

5 Q. What are you referring to?

6 A. There are a number of different medications
7 that we can use. You want me to detail them?

8 Q. Sure, talking about an I.V. administration of
9 Demerol or something to calm him, sedate him,
10 something in that regard?

11 A. Benzodiazepin, Diprivan which is one of the
12 sedative agents we use.

13 Q. Are you including in your answer the
14 suggestion he needed a paralytic of any sort?

15 A. No.

16 Q. So you are just talking sedation drugs,
17 Demerol, other things in that family or group?

18 A. I'm talking about drugs that would sedate the
19 patient. There are a number of different drugs
20 that would sedate the patient.

21 Q. If I understand this, was it your decision
22 that he was not in a position to undergo this
23 procedure?

24 A. It was my decision it was not safe to sedate
25 him for this procedure, yes.

1 Q. Did anyone participate in making that
2 decision with you?

3 A. I discussed it with Dr. Lee.

4 Q. Was he, to your recollection, in agreement
5 with that decision?

6 A. Yes, he was as far as I recall.

7 Q. You believe the risk was caused by the fact
8 he did not have an empty stomach?

9 A. Yes.

10 Q. You were concerned about aspiration I gather?

11 A. Yes.

12 Q. As an anesthesiologist, do you know if there
13 is any way to protect the airway against aspiration
14 under these kinds of circumstances?

15 A. Yes, i do.

16 Q. What would that be?

17 A. in an emergency we do something called a
18 rapid sequence induction, when we insert an
19 endotracheal tube into the patient's trachea with
20 administration of -- we give them a general
21 anesthetic, we put them deeply asleep, we
22 administer muscle relaxers, paralytics, put an
23 endotracheal tube in.

24 Q. Short of that, are you aware of a method that
25 you could have used that day to empty the contents

1 of his stomach?

2 A. There is a method to empty the contents of
3 the stomach, not completely, not reliably to
4 prevent against aspiration.

5 Q. What method had you had in mind if that
6 crossed your mind to do that?

7 A. There is no method to reliably empty the
8 stomach against aspiration. The standard of care
9 is the patient has to wait, let the stomach empty
10 on its own,

11 Q. You believe that is the standard of care?

12 A. That is the standard of care.

13 Q. This situation, did you undergo a
14 risk/benefit analysis in your decision to delay
15 placement of the filter?

16 A. Yes.

17 Q. How did you analyze for protecting against
18 the risk if he would throw more clots into his
19 lungs?

20 A. The way I looked at it was that he had
21 improved, his oxygenation had improved on Heparin
22 therapy, both postoperatively and pre-operatively.
23 When he had very poor oxygenation he was started on
24 Heparin.

25 So on two occasions his oxygenation

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

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

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

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

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

14 A. Yes.

15 Q. Why did you think it was too risky?

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

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

1 placement of the endotracheal tube

2 This is just probably because I can't write
3 talk and think at the same time, once again what
4 did you feel the risk of separating him was?

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

7 Q I wanted to be sure that is what I thought
8 you understood the risk was

9 You didn't consider this an
10 emergency situation?

11 A. Correct.

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

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

21 Q. Let me see if I can sort this out in my own
22 mind since I don't have a lot of handwritten notes
23 by you

24 Now indicating in your testimony
25 after learning the results of the poplar after

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

3 A. That's correct.

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

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

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

20 A. Correct.

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

24 THE WITNESS: Yes, I did.

25 -----

(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.

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

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

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

11 MR. GROEDEL: 10:30 a.m.

12 Q. 10:30 a.m.

13 A. Okay.

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

16 Can you make out what the 1414 note
17 says?

18 A. A line placed at bedside by CRN.

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

21 A. Urn-hum.

22 Q. Skipping down to 1621 it says angio
23 cancelled?

24 A. Yes.

25 Q. Patient not n.p.o.

1 A Correct

2 Q To your knowledge was there an angio
3 procedure on that day?

4 A What do you mean by angio? I didn't write
5 the note but that would have been the filter
6 placement it's done in the angiography suite

7 Q Where was not -- someone didn't follow
8 through on your earlier suggestion of angiography
9 being done?

10 A. Correct.

11 Q. If you've looked through this chart you
12 didn't see angio was ordered that day?

13 A Correct the angiography I'm referring to
14 would have been pulmonary angiography the
15 placement of the filter is done in the angiography
16 suite and I'm not totally familiar with the
17 procedure. It may have involved some installation
18 of a little bit of dye, I don't know. That
19 probably doesn't clarify.

20 Q All I want to say since there were other
21 things that weren't clear from the charting, there
22 was not an order for pulmonary angiography on that
23 day?

24 A. As far as I know.

25 Q. You didn't participate in the decision to

1 orwer that on that way?

2 A I did not.

3 Q When Mr. Brown came under your care, did you
4 have information available to you about the
5 condition of his lungs? That's a very general
6 question.

7 A. Yes.

8 Q. What information did you have?

9 A I had the information that he had been a
10 heavy smoker that he had COPD that he had had
11 problems with oxygenation pre-operatively and
12 postoperatively

13 Q. Harkening back to the note you wrote on the
14 3rd you thought he needed a filter because I'm
15 recalling this correctly poor oxygenation
16 correct?

17 A I thought that he needed a filter because of
18 the risk to him from a pulmonary embolism.

19 Q Where is not a good way to ask it so I'll do
20 it the best I can: What did you feel the risk to
21 him was for pulmonary embolism?

22 A I thought that it could certainly compromise
23 his health or kill him.

24 Q. Was that risk greater than the risk of
25 sedating him to undergo filter placement?

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

3 MISS KOLIS: Yes.

4 MR. GROEDEL: Go ahead.

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

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

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

14 MR. GROEDEL Regular for
15 who?

16 A. No.

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

19 A. No.

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

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

25 Q. Would you have indicated any changes of

1 circumstance in the oxygenation that you would
 2 have wanted them to call you at home personally and
 3 tell you about?

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

9 Q Fair enough.

10 I'll ask this question so

11 Mr. Moscarino can just type this morning: In your
 12 review of the chart do you have any criticisms of
 13 the conduct of nurses or residents following what
 14 normally would be your department from the
 15 hospital on the evening of the 3rd to the morning
 16 of the 4th?

17 A. Not that I can recall at this time.

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

21 A. Popple.

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

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

1 that day?

2 A. I agree there was reason to be concerned
3 about that.

4 Q. They in fact initiated Heparin therapy on
5 that day?

6 A. Yes.

7 Q. Can you discern any reason that a duplex
8 ultrasound of the extremities could not have been
9 performed prior to the 3rd of June?

10 A. Say that again.

11 Q. You ordered an ultrasound of the extremities
12 on the 3rd?

13 A. Urn-hum.

14 Q. We will work it backwards.

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

17 A. I can't tell you that, no.

18 Q. Using that as a springboard, we agreed on
19 May 31st the diagnosis of PE was entertained, in
20 fact Heparin therapy was initiated in the face of
21 that probable diagnosis I guess is what I ll call
22 it.

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

1 before you actually did it on June 3rd?

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

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

9 A. No, there is not.

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

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

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

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

1 A. No, I don't agree with that.

2 Q. When do you think it becomes effective?

3 A. Heparin has some beneficial effect as soon as
4 you start giving it. It's not 100 percent
5 effective, reliable 100 percent, no.

6 Q. Aside from the issue -- let's put it this
7 way: I agree with you it's not 100 percent
8 effective. In the first 24 hours you are trying to
9 raise it to therapeutic levels, correct?

10 A. Um-hum.

11 Q. Looking back in the chart, would you say in
12 the first 24 to 48 hours there is an effective
13 therapeutic coverage from the Heparin?

14 A. You are saying a couple different things. As
15 soon as Heparin started being given, even if it
16 isn't at the level we're shooting for, it has
17 beneficial effects.

18 Q. What beneficial effects does it have?

19 A. It's an anticoagulant. It prevents
20 accumulation of clot. So even if the blood level
21 of it is less than our target rate, it still has
22 beneficial effects.

23 Q. What clot do you think it's effecting in the
24 early stages?

25 A. Heparin has the effect to prevent

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

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

5 A. Yes.

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

9 -----

10 (Recess had.)

11 -----

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

16 MR. MALONE: No.

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

20 -----

21 CROSS-EXAMINATION

22 BY MR. MOSCARINO:

23 Q. Plaintiff's counsel asked if you had any
24 criticism of the hospital staff after you left that
25 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?

4 A. Not now.

5 Q. It appears to me based on my review of the
6 suit papers, what I've been told by counsel, that
7 the issue in this case or one of the key issues is
8 going to be the decision to not perform this filter
9 placement on the day that you initially ordered it,
10 okay.

11 A. Okay.

12 Q. That decision I take it from your deposition
13 testimony was yours, not that of a resident or
14 nurse?

15 A. That's correct.

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

18 MR. MALONE: No questions by
19 Dr. Lee.

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

23 -----

24 (Deposition concluded; signature not waived.)

25 -----

ERRATA SHEETNOTATIONPAGE / LINE

University Anesthesiologists, Inc.

7/25

... ATN

13/20

... Venting mask

22/25

... safer to wait (?)

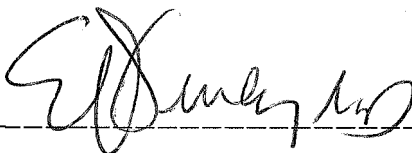
38/2

CRNA

42/18

I have read the foregoing

transcript and the same is true and accurate.



ERIN FUREY, M.D.

PAGE / LINE

This image shows a blank sheet of handwriting practice paper. It features two vertical columns of horizontal lines designed for letter formation. The left column consists of ten sets of three lines each: a solid top line, a dashed middle line, and a solid bottom line. The right column also consists of ten sets of two lines each: a solid top line and a solid bottom line. This layout provides a guide for letter height and placement while leaving space for practice writing.

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

.....

ERIN FUREY, M.D.

1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

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

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

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

21 
22 -----

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

Look-See Concordance Report

UNIQUE WORDS: **971**
 TOTAL OCCURRENCES: **2,539**
 NOISE WORDS: **385**
 TOTAL WORDS IN FILE: **8,579**

SINGLE FILE CONCORDANCE

CASE SENSITIVE

PHRASE WORD LIST(S):

NOISE WORD LIST(S): **NOISE.NOI**

COVER PAGES = 4

INCLUDES ONLY TEXT OF:

QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE
 THRESHOLD: 50

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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:	de self	Locale:	Cleveland Clinic
Type of Document(s):	Deposition/Trial testimony, CV		

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Instructor in Anesthesiology, 1994-95
Attending Anesthesiologist, Cardiothoracic Anesthesiology Group
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Boulder Computer Resource Center
Boulder, CO
Education Coordinator, 1982

Jefferson County District Attorney's Office
Adams County Westminster Shelter Care
Denver, CO
Counselor for Juvenile Delinquents, 1977-80

McDonough 15 Elementary School
New Orleans, LA
Music Teacher, 1974-75

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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,