THE STATE OF OHIO,)
) SS: CORRIGAN, J.
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

CIVIL BRANCH

DOROTHY BROWN, Administratrix, etc. et al.
Plaintiff,

vs.

Case No. CV-346342

UNIVERSITY HOSPITALS OF CLEVELAND, et al.
Defendant.

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EXCERPT OF PROCEEDINGS
CROSS-EXAMINATION OF ERIN FUREY, M.D.

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Whereupon the following proceedings were had before the Honorable Brian J. Corrigan, and a Jury, in Court Room No. 22-B, The Justice Center, Cleveland, Ohio, on August 28, 2000, upon the pleadings filed heretofore.

APPEARANCES:

Donna J. Taylor-Kolis, Esq.,
on behalf of the Plaintiff;

Reminger & Reminger Co. LPA, by
Marc W. Groedel, Esq. and
Marilena DiSilvio, Esq.,
on behalf of the Defendant.

Suzanne Vadnal, RMR
Official Court Reporter
Cuyahoga County, Ohio

MONDAY AFTERNOON SESSION, AUGUST 28, 2000

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THE COURT: Miss Kolis, call your first witness.

MS. KOLIS: Thank you very much, your Honor. At this time on behalf of the plaintiff, I wish to call Dr. Erin Furey as if on cross-examination.

THE COURT: Okay. Now, ladies and gentlemen, what "as if on cross-examination" means is that you're only going to be hearing part of Dr. Furey's testimony. It's going to be the cross-examination part. Any sort of redirect that might be necessary will be dealt with later in the case. In any event, sometimes the plaintiff has to prove certain things that can only be established by talking to the defendant, and, hence, we allow them to call them as if on cross-examination.

Dr. Furey, you'd raise your right hand, sir.

The PLAINTIFF, to maintain the issues on its part to be maintained, called as a witness ERIN JAMES FUREY, M.D. who, being first duly sworn, was examine and testified as follows:

CROSS-EXAMINATION OF ERIN FUREY, M.D.

BY MS. KOLIS:

Q Thank you very much. Doctor, you're the first person that the jury has gotten to talk to, and I think it would be rude if I didn't ask you to go ahead and introduce yourself to the jury. Would you please do so?

A My name is Erin Furey. I work at University Hospital.

Q All right. Dr. Furey, on a prior occasion I was supplied with a copy of your curriculum vitae. I'd like to have the Court Reporter mark that Exhibit 2, Exhibit 1 being Joint Exhibit, Defendant and Plaintiff, University Hospital records.

(Thereupon Plaintiff's Exhibit 2 was marked for identification.)

Q Doctor, would you -- and I know you'll have an opportunity at another time. I'd like for you to just basically explain to the jury the educational background that led you to your current physician occupation. I guess that's the easy way to say it.

A Okay. Well, first thing that I did after -- or first thing that you do when you become a doctor, after you graduate from medical school, is you go through what's called residency. That's kind of like on-the-job training. You spend three, four, five years, whatever, depending on your specialty, on the job, learning a

particular specialty of medicine. And in my case, I spent four years -- actually I spent one year doing surgery, general surgery, followed by three years of anesthesia training. Anesthesia is putting people to sleep in the operating room, waking them up, monitoring all their vital signs carefully in between.

After I completed my training in surgery and in anesthesia, then I spent an extra year training in critical care medicine. And critical care medicine is taking care of people in the intensive care unit, people who are critically ill. And many anesthesiologists go into critical care medicine because it relates rather closely to anesthesia, to the kind of monitoring and care that we take of patients in the operating room. So after I did the anesthesia, then I did the critical care medicine training.

And then following that, I did more training in heart and lung anesthesia, anesthesia for heart and lung surgery.

So that worked out to be about five years of on-the-job training, what we call residency after medical school. And then after that, I got a job at University Hospital doing anesthesia and critical care medicine.

Q Doctor, I'd like for you to be able to explain this to the jury. After you complete certain specialty

training, as you're indicating your residency, you are then eligible to apply for board certification. Am I stating that correctly?

A Yes.

Q And, Doctor, you are, in fact, boarded in anesthesiology?

A Yes.

Q You obtained that board in October of 1994.

A Yes.

Q Okay. Doctor, you have what is called a special qualification in critical care medicine which you obtained in December of 1995.

A Yes.

Q And you obtained that by virtue of the specialty training that you received at University Hospital/Case Western Reserve's program, correct?

A Yes.

Q Would you acknowledge for the jury that critical care medicine is multidisciplinary and that a number of physicians with different boards are qualified to be critical care physicians?

A Yes. What that means is that you can start your training in what they call internal medicine, or in surgery, or in anesthesia, and still get trained to be a critical care doctor.

Q And each and every person who is trained in critical care medicine must essentially follow the precepts for that kind of medicine. In other words, it doesn't matter if you're a pulmonologist or anesthesiologist. If you get your certificate in critical care medicine, there is an assumption that we all are working under the same set of medicine; is that right?

A In general. But things usually -- people who go into pulmonology usually handle a little different set of patients than people who go into critical care medicine out of anesthesiology like I do.

Q In fact, Doctor, at University Hospital there is an AMA -- an American Medical Association accredited program in critical care with the anesthesiology surrounding it, correct?

A That's right.

Q That's the specialty board there. And for a program to have an AMA certification, it's above and beyond, in other words, not just any hospital can get an AMA certified program, correct?

A That's right.

Q It is rigorous credentialing.

A Yes.

Q Okay. Having said that, are you currently involved, Doctor, in teaching in that program?

A In teaching in the critical care program?
Q Yes.
A Yes, I am.
Q Okay. And if I understand this correctly -- but you may, of course, correct my numbers -- at present there are three residents in that program?
A No. At the present time there's only one resident in that program.
Q Okay. Then I did misspeak. My last checking through the AMA of the certification was for three. To what degree are you involved in training those residents in critical care medicine?
A Well, at this point in my career, my training of them consists of giving them lectures.
Q Okay. Do they round with you as an attending?
A Well, they do. I should explain that for about the last six months, I have taken a leave of absence from the intensive care unit because of health reasons, so that I'm not actually working there now. I was working there for the first five years. When I did work there, they did round with me, yes.
Q I do stand corrected. I did not know that you were no longer in the critical care department. As was alluded to, am I clear in my understanding that on June 2nd, 1997, you would do an every other month rotation through

critical care?

A Yes.

Q All right. And the month that you were off, you were performing anesthesia in an operating room.

A That's right.

Q Doctor, you would agree with me that you are not board certified in pulmonology.

A That's right.

Q Would you agree with me, Doctor, that when a critical care physician encounters a patient who has an underlying lung and/or other circulatory problem dealing with the lungs, that they can, of course, always call in a pulmonologist?

A In our hospital, you can, yes.

Q Okay, at your hospital. And that's something that was available to you as an option in June of 1997. Had you considered the need to call in a pulmonologist, there was no prohibition against doing so.

A No.

Q Okay. Doctor, have you published any publications in the area of critical care?

A I believe there is one on the list there.

Q And that is a 1998 publication and that's your one and only publication, Safety and Efficacy of Early Extubation in the Elderly?

A Yes.

Q Thank you very much for sharing your background with us.

Doctor, on June 2nd, 1997, you considered yourself to be one of Lawrence Brown's attending physicians. Would I be stating that correctly?

A Yes.

Q And from your recollection, or I see that you have the medical records there, on June 5th, 1997, Mr. Brown was approximately five days postop his graft; is that correct?

A No. He died on June 4th.

Q I'm asking you on June 2nd when he came under your care, was he not five days postop?

A Yes.

Q Okay. Between May 28th and the date of June 2nd, Mr. Brown had undergone a single graft bypass and at all times was managed by your then partners, Dr. Popple or Dr. Rowbottom; is that a fair statement?

A Yes.

Q Could you please explain to the jury how your group worked at that time in 1997?

A We are a group of critical care doctors and we take care of all the patients in the intensive care unit, particularly during the day when the surgeon is in the

operating room. A surgeon -- for instance, a heart surgeon will operate on a patient and then that patient goes from the operating room to the intensive care unit. And our area of specialty is a little different from the surgeon's. We take care of problems in the intensive care unit, like lung problems and kidney problems and heart problems, breathing problems. And during the day predominantly and somewhat at night, we're there all the time watching over the patient, and working along with the surgeon to manage those problems.

Q Okay. And so, therefore, personally, Mr. Brown, who came in on May 24th, would be managed by one or a number of partners in your group but not necessarily consistently the same SICU doctor, correct?

A Well, we would take a month at a time. So, for instance, my month on duty was the month of June, and I start at the beginning of June and work Monday through Friday taking care of the patients, and then one or two weekends. And then those weekends that I don't, I'm not on duty, one of my partners would round for me.

Q Okay. But my question was this. In a person in Mr. Brown's circumstances who came in in the middle of -- I don't want to call it a shift change but a cycle change, he comes in on May 24th, you come on on June 22nd, so obviously he doesn't have continuity of care from one

singular SICU doctor, correct, because you changed and went into rotation?

A Well, he came in on -- when he came in on May 24th, he was not in our intensive care unit. He came to our intensive care unit, I believe it was on May 28th, after he had had his operation, five days after he'd been in the hospital. Prior to that he'd been in an entirely different intensive care unit with different doctors.

After his operation on May 28th, then he came to our intensive care unit and that's the unit in which my partners and I take care of the patients.

Q And again but that's what I meant. And I did misspeak the date. In other words, your patient -- it isn't that you're assigned a patient. You follow them from admission to discharge in your unit. A doctor will change based upon month rotations; is that right?

A That's right. We take a month at a time.

Q Fair enough. Doctor, I guess to get right to the heart of some things for the jury. Doctor, to a reasonable degree of medical probability is it a fair statement that you believe that the best that you can determine was that Mr. Brown died due to pulmonary embolus and heart failure?

A Yes.

Q That is what you testified to in a prior occasion,

correct?

A Yes.

Q Doctor, I don't usually do this, but I'm going to ask you a question that I don't know the answer to. What do you believe was the cause of Mr. Brown's heart failure?

A Well, I think it was a number of different things. I think that the pulmonary embolus that he had had before he came into the hospital was a big part of it. I also think that his heart attack that he had suffered before he came into the hospital was a big part of it. And I also think that his lung problems contributed to it, as well as his kidney failure.

Q I'm sorry, I was writing. You said you also felt that his lung problems --

A And his kidney failure.

Q Okay. When you say his lung problems, specifically what about his lung problems do you believe caused his heart failure?

A Well, I don't think I said his lung problems caused his heart failure. I think that it all kind of worked together. But as far as his lung problems went, he basically had weak lungs to begin with from years of smoking, and that weakness kind of predisposed or made him vulnerable to other kinds of lung problems. When he had his heart attack, in addition to his underlying lung

weakness, he had an additional problem of water on the lungs, what we call congestive heart failure. The heart attack caused water on the lungs and produced congestive heart failure.

Then in addition to that, several days after his operation he developed pneumonia, which is another lung problem and that's an infection in the lungs. So all of these conditions weakened him and weakened his condition.

Q Doctor, I appreciate the fact that you've, you know, patiently given me that answer, but I'm still not clear. I asked you what you thought the cause of the heart failure was and I want to walk away with a clear understanding today. Are you saying -- first of all, you've said pulmonary embolus. In what way did the pulmonary embolus cause his heart failure?

A Well, as was explained when you and Mr. Groedel in the beginning of the case talked, when there is a blood clot in the vessel, in the blood vessel that comes out of the heart, the heart has to squeeze extra hard, and that's what he had in the blood vessel. He had a big clot in the blood vessel coming out of the heart and the heart had to work overtime to pump, and that would, after a while, with the size of the blood clot that he had, cause his heart to just give out.

Q Doctor, do you have a copy of the autopsy?

A I have one here.
Q Sure. If could you refer to it because I want to ask you a couple of questions so that the jury can understand what your thinking might be on these issues.
A Okay.
Q At the time of autopsy, would you agree with me that Dr. Vande Pol reported that the blockages in the left and main trunks -- I call them trunks -- of the main pulmonary artery were 80 percent and 90 percent?
A Well, the one I'm looking at here says right and left greater than 80 percent.
Q Okay. Are you looking at the gross anatomic or the microscopic?
A I'm looking at final clinical and anatomic diagnosis on Page 2. Right and left main pulmonary arteries greater than 80 percent occlusion.
Q Doctor, do you have an opinion to a reasonable degree of medical probability as to whether or not it is possible for anyone to be alive with that kind of blockage in the left and right branches?
A Well, I do. I think it's very difficult for someone to live with that kind of blockage.
Q Okay. So if someone is contending that that 80 to 90 percent blockage would have been in my client's lungs for a week or more, does that medically make sense to you

that that is possible that someone could have been alive if that clot was sitting there for a week or more?

A It's possible, yes.

Q To what degree would it even be possible?

A I'm sorry, I don't quite understand.

Q Sure. When you're saying it's possible, Doctor, given those findings and what we know about his underlying COPD from autopsy, how possible is it that he could have been alive if that clot had actually been sitting in there for a week or longer?

A Well, you know, I think the possibility is not great, but if you look at what he was doing and the situation he was in, he was lying in bed receiving -- and he wasn't moving around at all, and he was receiving medicines to support his heart and to help his kidneys, and breathing treatments, so I think under those circumstances we were able to keep him alive in spite of the odds.

Q Would you -- let me withdraw that question.

Can you tell the jury what a patent foramen ovoli is?

A There are four chambers in the heart, two -- there's a left side and a right side. And each side has two different -- has two chambers. There's upper chambers and lower chambers. And the tissue in between the two upper

chambers is very thin, and when you're a baby or when you're in the uterus, that thin tissue has a little hole in it. In some people, a certain percentage of the population, that hole never covers over or just covers over in a very thin manner so that it could be opened up.

Q Okay.

A That's a patent foramen ovoli.

Q And do you know approximately what percentage of the population has this defect? Do you have enough training through critical care to know this aspect of cardiology?

A If it's what we call a problem patent foramen ovoli, meaning that little tissue could give way, it's usually estimated about 25 percent of the population has that condition.

Q Okay. And in this particular instance, if someone testifies that the heart failure, if there was heart failure, that occurred in Mr. Brown was due to a right to left shunt, would you agree with that?

A I'm sorry, can you repeat that?

Q Sure. First of all, I think we need to explain this better to the jury. You've already told them about this defect which should close. It's a necessary thing but it should close at birth. But in about 25 percent of the population it does not; is that correct?

A Not really. It does close but it's not real solidly

closed.

Q It's not a perfect closure I guess is an easier way to describe it.

A Um-hum.

Q In a person with high pulmonary artery pressures -- first of all, would you establish for the jury that you probably never saw a normal pulmonary artery pressure in Mr. Brown during his confinement, did you?

A Not that I recall.

Q Okay. And they were high enough, were they not, Doctor, that they would have placed a lot of stress on the right atrium?

A Yes.

Q Okay. And that would have caused potentially what problem with the patent foramina ovoli?

A Well, the problem is is that you can get transfer of material from the right side to the left side of the heart.

Q Okay. Just to make sure -- and I'm really sorry. I should have brought this up here. Now I get to walk around the courtroom, but I'll keep on speaking loudly. When you're saying transfer of material, I had discussed with the jury as you know, you were sitting here, in opening statement, the normal functioning of the heart. And that normal functioning, once again, Doctor, of

course, is right atrium to right ventricle, up through the pulmonary artery and around.

What you're indicating to the jury, are you not, is that if there is a problem with the patent foramina ovoli that the blood will go directly across right to left and skip the pulmonary artery?

A It can.

Q Okay. Do you have any evidence whatsoever that there was shunting that was occurring from right to left in this patient?

A No, I don't. And when they did an echocardiogram on his admission, there was no evidence of that.

Q Doctor, a little more than the echocardiogram, doesn't the cardiac catheterization report that was generated by the hospital indicate that at the time of that examination on May 27, 1997 there were no shunts detected?

A I can look it up.

Q Tell you what. I'm going to hand this to you so you don't have to dig through the record.

A Right, that's what it says.

Q Okay. And you would have no reason to not believe this report of the cardiology department of the hospital; is that a fair statement?

A Yes.

Q And if someone was to create a supposition that there was a right to left shunt, that would have developed after he was in the hospital, wouldn't it?

A Well, what that report says is that they didn't see any right to left shunt at the time they were doing the procedure. Whether he had one before or after, you couldn't really say.

Q Well, Doctor, let's try to be precise here. At the time of the cardiac catheterization, a defect which they can check for is right to left shunting. Are we in agreement with that?

A Yes.

Q Okay. And that cardiac catheterization report finds absolutely no shunting on that day.

A Yes, I agree with that.

Q In other words, when they did it the pathophysiology was that he was still pumping blood correctly from his right atrium to his right ventricle. Would you agree with that statement?

A Yes.

Q Okay. Fair enough. Doctor, I would like to talk to you about the care and treatment that you gave to Mr. Brown beginning on the 2nd. You have the medical notes, I'm assuming?

A Um-hum.

Q Okay. First of all, Doctor, it wasn't until June 3rd that you believe that there was a significant possibility that there was a pulmonary embolus and that you should investigate for the blood clot; is that a correct statement?

A No, that's not correct.

Q Okay. Why don't you clarify the statement for me then?

A Well, you asked me two different questions, or I heard two different questions.

Q All right.

A One was, it wasn't until June 3rd that I believe he had a significant possibility of a pulmonary embolus. And I would disagree with that. And it wasn't until June 3rd that I felt the need to investigate that. I personally ordered the test on June 3rd. But prior to that I was satisfied with the plan of tests that the surgeons had come up with and my partners had come up with prior to that.

Q Doctor, do you dispute that on June 1st, contained within that medical chart are recommendations by both your service and cardiothoracic surgery to rule out pulmonary embolus?

A No, I don't dispute it. I'd have to review it specifically to remember it but --

Q Well, I'd like for you to look in the medical records.

A Okay.

Q Just so that I'm not misstating. I'm asking you -- I'm making a representation that there is a June 1st note after two days of prophylactic Heparin therapy that these two medical groups wanted a pulmonary embolus to be ruled out.

A Sounds right. Dr. Popple writes -- he's my partner -- writes, "Rule out PE," and Dr. Azoury, who is Dr. Lee's assistant, writes, "Consider pulmonary angiogram."

Q Doctor, on June 2nd is it a fair statement that you did not perform any tests to rule out pulmonary embolus?

A Yes.

Q Is it also not a fair statement, Doctor, that it was possible to do it on June 2nd; that there were no medical contraindications?

A That's right.

Q Doctor, and you just didn't do it on that day; is that a fair statement?

A That's right.

Q Okay. And is it also clear -- let me withdraw that because I think you've answered that.

Doctor, the reason that you decided to look for blood clot on June 3rd is that you were concerned that Mr.

Brown had poor oxygenation and you were concerned that if there were additional clot that would break loose from a location in his leg he would be injured?

A Well, the reason I decided to look for the blood clot on June 3rd was that they hadn't done it on June 2nd. Hadn't been done prior to that.

Q Well, you didn't do it on June 2nd; is that correct?

A That's right.

Q And you completely had the power and authority and medical ability to do so, correct?

A That's right.

Q But the reason you were looking for it on June 3rd was because you knew that if it was there it would present a risk of injury to the patient should clot dislodge; is that a fair statement?

A Yes.

Q All right. Now, at approximately 9:30 in the morning on that day, and we're talking about June 3rd, according to the nurse's records, you evaluated the patient and made a decision to have the ultrasound done, and do I have the time frame correctly for you?

A On that Tuesday morning of June 3rd, I ordered the ultrasound to be done.

Q Okay. And to be certain, because I'm trying to make a time line for the jury that will make some sense, the

nurse's notes says 9:00 Dr. Furey and team at bedside. Discussion with patient. Dr. Furey -- doesn't say. If it says that you were there at 9:00, that's the point that you would have ordered the Doppler, is that --

A Probably.

Q Okay. And the results, Doctor, were reported to you at approximately eleven o'clock and those were preliminary results?

A Yes.

Q Okay. In actuality -- and I just wanted to time it because the time to me is important -- the nurse's notes say 10:30, Dr. Furey notified of positive Doppler. Does that seem accurate to you?

A Yes, if that's what it says.

Q Doctor, the Doppler results as you recall them, the impressions were there were areas of acute and subacute thrombus in the left lower extremity in the proximal as well as the distal. Do you recall that?

A Yes.

Q Okay. So that meant there was old and new clot. Am I stating that accurately?

A Yes.

Q Okay. And because of that finding, you determined that a filter was needed.

A I thought that one was needed, yes.

Q Okay. Doctor, isn't the insertion of an IVC filter, a Greenfield filter, the standard of care in the treatment of a patient who is at high risk for reembolization?

A Say that again, please.

Q Sure. I can read it or the Court Reporter can read it, but I guess I can say it again.

A If that's all right.

Q Doctor, in fact, isn't it the standard of care to insert an IVC filter in a patient who is at high risk for embolization who has poor pulmonary status?

A Well, I wouldn't say it was the standard of care. Standard of care implies that you've got to do it. I would say, though, that in the kind of patient that you mentioned, like Mr. Brown, who is at high risk for problems with his lungs, that it's highly -- it should be considered and it's an important thing to consider about putting a filter in.

Q Dr. Furey, are we mincing words when you say it's not the standard of care but it should be considered?

A Well, we might be a little bit. I think that -- to me, standard of care means it's like black and white. It's like if you're going for an operation, nothing to eat or drink after midnight. That's standard of care. You don't deviate from that unless it's an emergency.

Standard of care in a situation where you're putting

in a device like this is not as cut and dry, so maybe we are mincing words and I don't intend to.

Q I think I need to explore that with you at some length, Doctor. First of all, has someone told you what the definition of standard of care is?

A Not recently, no.

Q Okay. Well, when you indicated in your answer that we might be mincing words because you might not be interpreting standard of care, let me define it for you this way. What the reasonably prudent physician would do. A positive, affirmative thing that they would do under like or similar circumstances. And so my question to you is that not anybody else on the planet, Lawrence Brown, in the condition that he was on the morning of June 3rd, once you found out those positive Doppler findings, a filter was the recommendation.

A That was my recommendation, yes.

Q Okay. Doctor, if another physician who participates in critical care were to have seen those Doppler findings with fresh and acute clot and not ordered a filter, would you not believe that that person had deviated from the standard of care?

A Not necessarily.

Q When you were in training, Doctor, I'm assuming that you, like all the other residents in the critical care

department at University Hospital, were given a handbook of some sort to rely upon; is that a fair statement?

A Um-hum.

Q And can you please tell me which handbook you were given?

A No. I got a lot of books.

Q Well, wasn't the standard textbook, first of all, for CWRU during the period that you were in that program Kirby, Taylor & Civetta?

A No. We did not have a standard textbook.

Q You didn't have one.

A That's a well-acknowledged textbook.

Q In fact, it's an authoritative textbook on the subject; is it not?

A Sure.

Q Is it not a fact that many of the AMA certified programs in critical care dispense to their residents and fellows the Handbook of Critical Care by Kirby, Taylor & Civetta?

A Probably. I don't know the answer to that.

Q When was the last time you looked at Kirby, Taylor & Civetta and determined what the indications were for the placement of Greenfield filter?

A Probably sometime within the last several years but I can't tell you specifically.

Q And if it says that -- well, first of all, what are the indications for a person to receive a filter?

A Well, if somebody considered giving someone a filter, if you can't give them any blood thinner, and the reason for that would be if somebody has a bleeding problem and you can't give them Heparin, then you have to consider giving them a Greenfield filter or a filter in their blood vessel.

Another indication for giving someone a filter would be if you've given somebody Heparin already but they have continued to have blood clots to their lungs, that would be another reason for giving somebody a filter.

And a third reason for giving someone a filter and the reason I thought Mr. Brown needed one was that even if you are giving somebody Heparin, a blood thinner, if the risk of a blood clot to them is really serious so that they couldn't recover from it, then you should consider giving someone a filter, too.

So those are the three big -- the big three.

Q In fact, those are medical indications. Those would be listed as the reason to put in a Greenfield filter.

A That's right.

Q All right. Doctor, would you agree with me that based upon the findings at least of your physical examination, and other clinical parameters on the morning

of June 3rd, 1997, that Mr. Brown was at high risk for death should an additional embolus occur because of his poor underlying lung status?

A Yes, I would.

Q Okay. And, Doctor, you agree with me that although Mr. Brown was being Heparinized, Heparin could not dissolve clot that was located in his groin already.

A Yes, I would agree with that.

Q That would either have to dissolve on its own as the process of time, correct?

A Yes.

Q And that's why you were concerned, because you knew on that date and that time and place that that clot could release into his lungs.

A Yes, I was concerned about that.

Q On June 2nd, 1997, Dr. Furey, would you say that it is a fair statement that you had enough clinical data available to you from the notes and records made by everyone else on your service, as well as other physicians caring for him, to recognize that Mr. Brown wasn't simply suffering from postoperative respiratory failure?

A Well, that's -- simply suffering from postoperative respiratory failure. It's not simple.

Q Doctor, I'm sorry. Go ahead.

A Especially in Mr. Brown's case. His respiratory

failure wasn't simple. There's four or five different things that were contributing to it. We talked about his underlying lung disease, his pneumonia, the water on his lungs from his heart failure, and at that time the concern that we had that he could have had a pulmonary embolus. At that time we didn't know it.

Q Okay. I'm sorry, and it is my fault for infusing words that are unnecessary in the question. The question that I wanted the answer to was that it was clear by the time that you saw this patient on June 2nd that the cause of his respiratory distress was not postoperative respiratory distress alone. That there was an underlying lung condition.

A I'm having trouble with that question.

Q Did you know he had COPD?

A Yes.

Q Okay. Did you know that the services thought that there were pulmonary embolus?

A Yes.

Q Could you, Doctor, on June 2nd have called in a pulmonologist to assist you in a treatment plan for this patient?

A I could have.

Q And you did not.

A No.

Q Okay. Do you, Doctor, know what the risk of aspiration is for a person of Mr. Brown's age at that time?

A Yes. The risk for someone of Mr. Brown's age and in his condition is -- there is a high risk of death from aspiration.

Q Let's separate out the question. The first question I want the answer to is do you know what the percentage probability is, as is documented in any medical textbook, as to what the real risk is that this person would have actually aspirated?

A You mean just lying in bed there --

Q No.

A -- with the risk of him aspirating?

Q No. If you had had to take this patient for sedation, given there were contents in his stomach, what was the actual percentage risk that he would have actually regurgitated or aspirated that material?

A It was high enough that I wouldn't want to do it.

Q I'm asking you, Doctor, if you're aware of the percentages.

A You mean -- do you want me to put a percentage on it?

Q Well, yes, certainly you may put a percentage on it.

A What was the risk that he would have aspirated?

Q That he would have aspirated. That's the first question.

A I can't give you a number. The problem is is that even if the risk is, you know, five or ten percent, if it's going to be fatal to him to aspirate, then that risk is too high. There is no number that I'm aware of for someone who is critically ill that can tell you, yes, the risk of aspirating is five percent, ten percent. It just doesn't exist.

Q You believe that it does not exist. Is that what your testimony is?

A Yes.

Q Okay. Doctor, in determining not to place this filter, what you're testifying to and what we heard in opening statement was that you were engaging in a risk benefit analysis, correct?

A At that time, on the afternoon of -- or in the morning, early afternoon of June 3rd.

Q All right. Let me ask this question. I heard in opening statement and I have just heard you say that if he had, in fact, aspirated, that he would die.

A Well, I probably should back off from that a little bit. No, you can't say for sure. No doctor can say for sure when anybody's going to live or die. I think only God can say that. But to the best that I can determine,

given my training, if Mr. Brown had vomited and some of that vomit had gone down into his lungs, that would have been it for him.

Q Doctor, I just heard you say based on your training, you're talking about your training as an anesthesiologist and as a critical care doctor.

A Yes.

Q Do you acknowledge that customarily if a person suffers from an aspiration -- well, first let me back that up. Sorry. I'm ahead of myself.

If he would have aspirated, when we were talking -- and we keep using that word and I don't even know if the jury knows -- we're talking about bringing up whatever contents are in his stomach, correct, and it going into his lungs?

A Yeah, vomiting and instead of it coming out of his mouth, he can't cough it up, so instead of the stomach material coming out of his mouth like would normally happen for a healthy person, it goes back down into his lungs and causes a bad reaction in his lungs.

Q That reaction is called aspiration pneumonia; is that --

A Yes.

Q I don't think we've actually used that word with the jury but I want it to be clear. What we're talking about

is an aspiration pneumonia. Doctor, clinically, pulmonology usually treats -- pulmonology and infectious disease customarily treat aspiration pneumonias; do they not?

A That's not true.

Q Not in your facility?

A Well, aspiration pneumonia can happen to patients who have been to the operating room and are now in an intensive care unit. In that case I take care of them because they are surgical patients. Or aspiration pneumonia can happen to somebody who has never been to the operating room, and just gets sick and aspirates, and in that case in our hospital they go to a different intensive care unit, and that's where the pulmonologist take care of them.

Q Doctor, did you, upon learning of the results, and I'm trying to once again get back with time. The chart again says that at 10:30 you were notified of the results of the Doppler. Was it at that precise moment in time that you made the decision that he should have an IVC placement? The chart indicates and you've acknowledged --

A Well, it was right around that time. That's when I seriously started thinking about it.

Q That's my question. You didn't like go sit somewhere in a laboratory -- I don't mean a laboratory.

Let's put it this way. You didn't go to the desk at SICU. You go through every clinical sign and symptom you knew based on what you knew at that time that that was the right decision, correct?

A I thought so, yes. At that time I thought so.

Q Doctor, part of caring for people in the surgical intensive care unit includes making, shall we say, adjustments or provisions for their nutrition, and that would have been part of your responsibility also in this matter.

A Yes.

Q Doctor, on the morning of June 4th, in fact, was Mr. Brown actually receiving enteral nutrition through an NG tube?

A On the morning of June 4th?

Q Sure. Oh, excuse me. I am so sorry. June 3rd.

A I believe that he was. We were also -- at some point during that period of time his feeding tube was being adjusted. So his tube feeds were on and off during that period of time.

Q Doctor, it would be important, I think, for the context of this question for you -- and we have time. Would you check in the chart and see when the tube feeding was turned off that morning to adjust for the problem?

A At ten -- let's see. The order is written at 10:00

to start Isocal, that's the name of the tube feed, at 30 cc's per hour. 30 milliliters per hour.

Q And that was a verbal order from yourself?

A No. My nurse wrote it down here.

Q Your nurse. Once again, I apologize for not -- what is her name again?

A Mrs. Popovich.

Q Mrs. Popovich, okay. And she did that with your aid and assistance, correct?

A She did that at my -- because I told her to.

Q Okay. And you're saying that that was a verbal order at 10:00, correct? I keep calling it a verbal order. It's in the chart that that's what was going to happen.

A The way that it works is I say -- what was happening earlier in that day was that the feeding tube became dislodged. It was out of position. So they had a series of x-rays on his tummy to make sure the feeding tube's in the right spot because if it's not in the right spot you can't put the liquid material down there. And after we determined that it was in the right spot, then when we looked at the x-rays and checked that they were okay, then we said start it up again. Start the tube feeds up again.

Q How long had he been off tube feeds at the time that this order was placed back that he was going to be

restarted?

A I can't give you am exact time. It was off when we came in that morning.

Q Okay.

A I believe it was anyway.

Q All right. Now, Doctor, so -- because I don't want the jury to be confused and I'd like them to hear it from you probably better than anyone else. When you do these tube feeds? It's not like a person's eating a whole meal. You're -- to use Mr. Groedel's word, you're titrating. You're telling them how much will go in per hour; is that an accurate statement?

A It's like a milkshake. It comes in a can. It's like a milkshake. They even advertise it on TV, Ensure. That's almost exactly what it's like. And it's poured into a bag and it's dripped through a tube that goes in people's nose, in back of their throat, into their stomach, and we start it off at a slow rate to make sure that it all doesn't come bubbling back up. And as the patients show that it goes through their system okay, then we increase the rate.

Q Okay. But once again, you know, we have thrown a lot of numbers around here and I'm afraid the jury might get lost, not because they are not following but because we're talking about different numbers for all different

kinds of things.

This is set in a machine to come out at a certain rate per hour. Is that generally how it is?

A Yeah.

Q At your SICU and every other one, I know that. What rate of feeding had he been receiving before it was off in the morning?

A We're talking about on the morning of June 2nd?

Q Well, right. Because there was a problem with that tube and so he would have been off feeding, and how long had he been off feeding?

A I'm going to have to look it up.

Q Like I said, we have time. We have time.

A Okay. That is before I got there, so this might be tough for me to find in here, but I'll make a shot at it.

Well, the most recent note I see about it is from that Saturday, the 31st, before I got there, when the nutritionist suggested starting it at 50 cc's an hour, 50 milliliters an hour, and increasing it to 95 cc's an hour. And I'm sorry, I don't see what it was running at prior to that, prior to me coming in on Sunday.

Q Okay. I wasn't worried about the rate. What I was worried about is when you came on in the morning of the 3rd, Mr. Brown had been off tube feeds. Otherwise, your nurse wouldn't be writing the orders to put him back on

tube feeds, correct?

A That's right.

Q Okay. What was your understanding about the length of time he had been off of tube feeds at that point, that point being -- obviously late dates it. She was there at 8:45 and you were there at nine.

A On the 2nd?

Q No. On the 3rd. We're talking about the 3rd.

A I thought we were talking about the 2nd. I'm sorry.

Q That's okay.

A I'm confused. And you want to know what the tube feeds were going at the night of the 2nd and when I came in on the morning of the 3rd.

Q Right, exactly.

A Let me see if I can look that up. I don't recall offhand.

Well, it looks like at seven o'clock the previous night they were turned up to 70 cc's an hour.

Q And let me just interrupt you. 70 cc's an hour is about how many ounces?

A I don't know.

Q About two and a half? Or am I doing the math wrong?

A Well, I don't remember the conversion factor. That sounds okay.

Q All right. Go ahead.

A Well, that's what it says, 70 cc's an hour. That's the last note I see about it. And then the last note I see about it is at seven o'clock at night. Tube feeds were running at 70 cc's an hour.

Q Then sometime after that in the early morning hours, if you can discern this, the tube feeds were shut off; is that right?

A Apparently.

Q Okay. And that was as you were relating -- unless we were confused -- because there was a problem with the tip of the feeding tube, the placement of it?

A That would be the most common reason for it, yeah.

Q And I'm asking you if you know approximately how long the feeds had stopped at that point.

A No, I don't. I don't know.

Q Doctor, to process this material, this enteral nutrition that a person's receiving, you add medications to their regimen to make sure that it is moving 70 in, 70 out, 70 in, 70 out, don't you?

A We'd like it to do that.

Q You don't want anyone with a distended stomach; is that right?

A That's right.

Q As a matter of fact, Mr. Brown had within his medication regimen, I believe, Regulin?

A Um-hum.
Q And was he not also receiving an H2 blocker, Rofetadine, to reduce acid production?
A No, that's not the name of it. It's probably Zantac.
Q I thought he was receiving Rofetadine, but if you say it's Zantac that will be all right.
A I don't know any medicine by that name. I think it was Zantac.
Q Okay. So at that time he was receiving both a medication to reduce the acid content of the stomach and a medication to make sure that this two and a half approximate ounces in the stomach would be moving out at a normal pace, correct?
A That's right.
Q What do you think the content of his stomach was when you were arrived at 9:00, if you have a way of estimating what the actual stomach contents were at nine on June 3rd?
A You can not predict it.
Q You can't predict it but let's put it this way. Was there any evidence that he had a distended or bloated stomach?
A Not that I recall.
Q Is there any evidence in the chart that he was not

processing the enteral nutrition that you were giving him?
A Not that I recall.
Q There is evidence in the chart, however, and you're just not sure how long, that he was actually off tube feeds when you first saw him in the morning.
A Yes.
Q Okay. Doctor, what time did the tube feeds restart?
A Well, I thought we said it was 10:00.
Q Well, that's when the order's in the book -- let me ask you if you and I -- and I don't like to approach people to be in their there space, but I'm just a little confused about this.
A Me, too.
Q Obviously you had ordered a Doppler, right, at that point in the morning. You already had the ultrasound set to go, right? And then -- I'm reading from the charting, 10:15 -- I'm sorry. 10:15, Doppler in process, right?
A Yes.
Q Can you read that?
A Um-hum.
Q Then across from it is a parallel entry that you were notified; am I right about that?
A Yes.
Q Okay. And this is the point where -- I'm sorry, I don't mean to be that casual. This is the point where you

made the determination that a filter was needed, correct?
A Around that time.
Q Am I misreading this because the way that is charted, it says tube feed starts, but before that, there's a note at 1321 -- and they do military time in the hospital, correct?
A Yeah.
Q So that's 1:21. Doesn't it look to you that the tube feeds were restarted after 1:21?
A Yeah. That says 1623, which is 4:23. That's what you're looking at there.
Q I'm sorry. I just want to be perfectly clear before I walk away from you that that's right and that we're not confused.
A Yeah.
Q You were indicating that to the best of your ability that the time that the tube feeds are restarted is 1400?
A Well, no. What happened was, the explanation for that is they were restarted in the morning, 10:00 or so, whatever, as we established, and when I found out that they were going, and that he had what we consider a full stomach, then we stopped them. And then they were restarted again in the afternoon.
Q Doctor, is there any indication whatsoever that the tube feeds were actually restarted different than a time

that you and I just looked at, because that isn't 1400, is it? If you want to look at it one more time, that's fine with me. 1400 being 2:00 is the documented time that the tube feeds were restarted. And then at a later time they are discontinued.

A No. I'm getting turned around here.

Q Okay, I'm sorry. But this is right out of the records.

A It says -- here it says eleven o'clock Isocal up at 30 cc's an hour. That's the time the nurse charted it, at eleven o'clock.

Q So at eleven o'clock they restarted tube feeds and so this charting is wrong?

A Which charting?

Q Okay. Doctor, I am showing you the sheet and I think you'll have to acknowledge that this sheet is from --

A We're looking at the same one.

Q Are we looking at the same sheet?

A Yeah.

Q My print's just a little bigger than yours. That's why we had these blown up a little bit.

A Okay.

Q Show me where you see Isocal at 11.

A I'm not sure we're looking at the same day here. We're looking -- I'm looking at the 2nd.

Q I was afraid you were looking at the 2nd.
A I'm sorry.
Q That's all right.
A So what's the question again?
Q Okay. You come in in the morning. Do you have your right page?
A I'm on the 3rd.
Q Okay. You're on the 3rd now, okay?
A Um-hum.
Q You come in in the morning. You know that he needs to have an ultrasound study done. You order one, correct?
A Um-hum.
Q Meanwhile, he's not on tube feeds because there's been a problem with the tube placement. You don't know how long he hasn't had this tube in his stomach, but at least he's been off, rights?
A Can you just -- I'm sorry here. Give me a minute here?
Q Absolutely, Doctor.
A Since I was on the wrong day. Okay. As far as I can tell, the time that we have the tube feed stopped was on the 2nd when I first came in, Monday morning, and we restarted them.

Now, as far as I can tell they -- and here it says they were turned up at eleven o'clock on the 2nd, that

Monday. And as far as I can tell, they were kept going. So they were not off on the morning of the 3rd.

Q Doctor --

A On the morning of the 3rd at 9:00, my nurse writes to give 250 cc's of tap water every four hours -- that's down the feeding tube -- and to increase the tube feeds to 95 cc's an hour. That was at 9:00 on the morning of the 3rd.

Q Okay. And I agree with you that she made notes early in the morning that you came in. I want to know why there is a note that says tube feed restart in the afternoon at the time that's indicated on this sheet.

A I don't know. I don't know.

Q Doctor, are you absolutely certain that he had not been off tube feeds before that time?

A No, I'm not. I'm not. It's been three years. I can't tell you absolutely.

Q Well, you have your chart available to you and that's why I'm asking.

A Well, from what it looks like on my chart, he's been getting tube feeds all day on Tuesday, the morning of the 3rd.

Q Doctor, a suggestion has been made and we won't really attribute it to anyone, but let's discuss this one for the jury. You're an anesthesiologist, correct?

A Yes.

Q I gather that you've been requested to do anesthesia in emergency situations in your career.

A Yes.

Q I gather that not every single person who arrives at the hospital, whether a trauma victim or otherwise, comes in with a completely empty stomach.

A That's correct.

Q I gather that if these people have full stomachs, of course there is a risk of aspiration, but the necessary surgery takes precedence over that risk, doesn't it?

A Yes.

MS. KOLIS: That's all the questions I have for you today. Thanks.

THE COURT: Thank you very much. Doctor, you may step down.

MS. HANOBIK: Thank you.

THE COURT: Ladies and gentlemen, we're going to recess until tomorrow morning. You're reminded about my ongoing admonition in this case.

Could I have counsel at side bar real quick?

(Thereupon a sidebar discussion was had off the record.)

THE COURT: Okay. Ladies and gentlemen of

the jury, we're in recess until tomorrow morning. We'll call for you at about 9:00 and we hope to be on the record about nine, 9:15, shortly thereafter, okay? So we'll see you tomorrow morning and thank you very much.

(Thereupon proceedings were adjourned.)

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C E R T I F I C A T E

I, Suzanne Vadnal, an Official Court Reporter for the Court of Common Pleas, Cuyahoga County, Ohio, do hereby certify that I am employed as an Official Court Reporter, and I took down in stenotypy all of the proceedings had in said Court of Common Pleas in the above-entitled cause; that I have transcribed my said stenotype notes into typewritten form, as appears in the foregoing Excerpt of Proceedings; that said transcript is not a complete record of the proceedings had in the said cause, but constitutes a true and correct Excerpt of Proceedings had therein.

Suzanne Vadnal, RMR
Official Court Reporter
Cuyahoga County, Ohio