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

IN THE COURT OF COMMON PLEAS

ESTATE OF LAWRENCE BROWN, :
plaintiff,

vs. : Case No. 346342

UNIVERSITY HOSPITALS OF
CLEVELAND, et al.,
defendants.

Deposition of JAI .LEE, M.D., a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at University Hospitals, 11100 Euclid Avenue, Cleveland, Ohio, on FRIDAY, AUGUST 14TH, 1998, commencing at 1:35 p.m. pursuant to agreement of counsel.

APPEARANCES:

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ALSO PRESENT:
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I N D E X

WITNESS: JAI LEE, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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

MISS KOLIS: Dr. Lee, just for identification purposes on the record we've already met, my name is Donna Kolis. I represent the Estate of Lawrence Brown.

You obviously sat through Dr. Furey's deposition this morning, I'm assuming you were listening, heard my preliminary remarks to him regarding answering all the questions verbally, correct?

THE WITNESS: Right.

MISS KOLIS: Same advice I gave him applies, if there is something I ask that you don't understand, work with me, I'll try to rephrase it.

If for any reason you and Mr. Malone need to confer about an answer or question, that s acceptable to myself

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CROSS-EXAMINATION

BY MISS KOLIS:

Q. Having said that, could you state your name and your professional address for the record?

A. Dr. Jai, J-a-i, Lee, 11100 Euclid Avenue, Cleveland, Ohio. I'm in the division *of* cardiothoracic surgery

Q. Prior to coming here today your counsel supplied me with a copy of your curriculum vitae. I would like to hand it to you to make sure that is the most current CV you have?

A. No, it's not the most current, but it will do.

Q. Are there any additions in terms of hospital responsibilities or committees that are not listed on that CV?

A. No.

Q. Do you have some publications in press that didn't make it to that CV?

A. Yes.

Q. Would any of the publications you currently have in press be relevant to the diagnosis of pulmonary embolism, diagnosis or treatment thereof?

A. Not specifically pulmonary embolism.

Q. Is there anything in press germane to the

issue of pulmonary embolism?
A. I don't think so.
Q. My understanding from briefly reviewing your CV, you work at the hospital as a cardiothoracic surgeon; that's a fair assessment?
A. Yes.
Q. How long have you been at University Hospitals of Cleveland?
A. I trained here so my training covered 1989 to 1991, my staff privileges began from 1992 to the present.
Q. If I read your CV correctly, there was a one year period of time you left town, went to California?
A. Yes.
Q. You went to work for Kaiser for a short stint, you decided you rather come back to Cleveland?
A. I was invited to come back by my chairman, yeah.
Q. Fair enough.
What position do you hold here at the hospital?
A. I'm a staff cardiac surgeon, cardiothoracic surgeon.

Q. Good enough.

Have you been sued before this lawsuit for medical malpractice?

MR. MALONE: It's in your answers to the interrogatories, Donna, there are two.

Q. Did Mr. Malone represent you in those cases?

A. No.

Q. Someone else?

A. Yes, someone else.

Q. I can get that information from the index, that is fine.

Did you give depositions in both of those cases?

A. No.

Q. Neither one of them got to the stage where you needed to give a deposition?

MR. MALONE: Both voluntarily dismissed, one in '95, one in '96.

MISS KOLIS: I don't need to do a docket search, it's in the answers to interrogatories. I didn't look at those, I apologize.

Q. Have you had the opportunity to serve as an expert witness in a medical malpractice case?

MR. MALONE: I think she means retained, have you ever been hired as opposed to being yourself as a party, as an expert by definition?

A. No.

Q. You haven't done any medical/legal reviewing and testifying?

A. No.

Q. Before coming here today, did you have an opportunity to review Mr. Brown's medical records?

A. Yes, I did.

Q. Did you review his autopsy?

A. Yes, I did.

Q. Did you have an opportunity to review any medical records that were generated before he became a patient at University Hospitals?

A. Records from another hospital?

Q. Yes.

A. No.

Q. In reviewing the records, if you need to refer to them at any time you understand that is acceptable, at any point in Mr. Brown's confinement here did you yourself consider having him undergo a ventilator perfusion scan?

A. No.

Q. Would that have been an appropriate thing to do for a person who they suspected there might be a ?E?
A. Probably inappropriate in this patient.
Q. Why would you think it would be inappropriate?
A. He had abnormal chest x-ray findings, those notoriously give you false information.
Q. The ventilator perfusion scan?
MR. MALONE: I think it isn't ventilator, it is ventilation.
MISS KOLIS: We stand corrected, or I stand corrected in any event.
Q. Were you yourself consulted at any point before the patient's demise regarding whether or not pulmonary angiography should be done?
A. I don't exactly recall. I think there was a mention in the chart about consideration, I don't recall that it was ever directly asked of me whether pulmonary angiogram was in order.
Q. That's a decision you would customarily participate in postoperatively in one of your patients?
A. I would participate in those types of situations regarding my patients in any matter

regarding a patient's condition.
Q. Let me ask the question a different way.
You do have a specific recollection that on or about I believe May 31st --
A. Yes.
Q. Trying to be specific if we can.
A. Yes.
Q. -- there was a note in the chart where the suggested diagnosis was respiratory distress, COPD versus PE; are you with me?
A. Yes.
Q. That is what it said in the chart?
A. Yes.
Q. Was there a suggestion consideration should be given to a pulmonary angiogram?
A. Yes.
Q. What I'm asking you is, that note was written by SICU; do you agree with that?
A. I'm going to focus in on that particular note so I can answer for you accurately.
MR. MALONE: Go back a little bit, these are the clinical notes.
MR. MOSCARINO: What date?
MISS KOLIS: 5-3, top of the page.

A. Yes.
Q. So this was written by Dr. Popple?
A. Dr. Popple.
Q. You would have read that note?
A. Yes.
Q. So my question to you is, trying to prompt your memory, if you read that -- first of all you don't have a recollection you were contacted directly to discuss that consideration?
A. Yeah, my recollection is that it was considered but not -- disregarded, not taken seriously because of the known risk of a pulmonary angiogram in a fairly moribund patient.
Q. Did you have an understanding what the known risks of the angiogram were in a patient such as Mr. Brown?
A. I'm sorry?
Q. My question was did you have an understanding of what the risks of angiogram would have been in a patient such as Mr. Brown?
A. Yes.
Q. What did you understand to be the risk?
A. I think the risk of a pulmonary angiogram is something that would entail a risk of renal failure; two, death because of his underlying lung

disease, i.e. pulmonary hypertension; and he also had evidence of right ventricular failure.

It may have been we discussed pulmonary angiogram, just looking at the risk/benefit ratio at that time period, we simply did not pursue aggressively the notion of pulmonary angiogram.

Q. Is it possible with you, with the experience you have as a cardiothoracic surgeon, to quantify in a percentage -- first of all let's talk about the risk of renal failure due to angiogram, when you say there is a risk of renal failure do you mean irreversible renal failure or renal compromised function, temporarily compromised?

A. Both.

Q. What did you think the percentage risk was that would become an eventuality if an angiogram would have been performed?

A. We're not really worried about a renal failure as an entity. We're more concerned with renal failure causing death.

Q. I appreciate that, so my question to you is: Assessing the patient as he existed clinically by laboratory studies on May 31st, what would you estimate to be his percentage possibility or

probability of death from renal failure had you done an angiogram?

A. I don't know.

Q. Is that outside your area of expertise?

A. Yes.

Q. In answering your question that would be a question you had, would you rely upon the expertise of a pulmonologist?

A. Perhaps.

Q. What other specialties would you think would --

A. A nephrologist.

Q. Pulmonologist or nephrologist?

A. Yes.

Q. Can I conclude, if I can't you'll let me know, that your concern about his pulmonary hypertension would be some statistical probability that he would suffer respiratory arrest?

A. Yes.

Q. Can I also assume that you do not know what that statistical probability would be?

A. Right.

Q. Why did you determine in this particular patient with this presentation that he needed a bypass?

A. He came in with a myocardial infarction, he had an angiogram that demonstrated a stenosis causing ischemia of the myocardium supplied by that.

Q. Prior to coming here you were aware by history that he had received TPA at I think Ashtabula Hospital, right, just by way of background, then he was stabilized, underwent a cardiac catheterization; am I stating that correctly?

A. He had a cardiac catheterization at University Hospitals after the transfer, the stabilizing.

Q. Right. If I read the catheterization report correct, so you don't have to dig it out, have you seen this before?

A. Yes.

Q. It said, at least as far as I can interpret it, that the patient had one significant stenosis that was 50 percent proximal left anterior descending artery; would you agree that this concludes that?

A. Yes.

Q. Was there medical therapy available to treat the situation, that situation?

A. Of course.
Q. What would have been the medical therapy?
A. Medications.
Q. Did you make the decision he should undergo the bypass versus an initiation of a trial of medicines for that condition?
A. No.
Q. Who made that decision?
A. The decision is made by the cardiologist in the coronary care unit.
Q. The reason I'm asking that question, or 'at least one of the reasons I'm asking, I could not locate a consultation from cardiology where they determine he should be bypassed; did I simply miss that document?
A. Let me clarify.
Q. Sure.
A. The patient gets admitted to the coronary care unit, he's on the cardiology service, the cardiology service is the primary care taker for the patient so there is no separate consultation.
Q. I understand that. Thank you for clarifying it.

I guess what I'm asking is, he came in, was stabilized, sent for catheterization, these

are the results of the cath, did you order the catheterization or did someone else?

A. Someone who was in coronary care taking care of the patient,

Q. When you are called in, are you called in after the decision is made?

A. Pretty much.

Q. Do you have a right to disagree with the decision?

A. Absolutely.

Q. What are the benefits of immediately proceeding to a bypass surgery in a person with a 50 percent LAD stenosis, versus a trial of medicine?

A. The risk/benefit ratio is pretty clear.

Q. Okay.

A. The natural history of blockage in the left anterior descending artery in that location is pretty ominous.

So there is really -- in my mind there is no question that a bypass surgery is indicated. The other option would be have an angioplasty. We need to do something with that blockage. We call that the widow maker.

Q. I was just asking what the reason was.

Do you have an opinion as to whether or not undergoing a bypass surgery contributed to the formation of clot that was found in the lower extremity?

A I think we all appreciate that major surgery is a risk for pulmonary embolism. I can't tell you when the pulmonary embolism occurred

Q Prior to taking Mr Brown for bypass surgery were you aware of his pulmonary status I guess is the easy way to ask it?

A. Yes.

Q. What did you believe his pulmonary status was?

A. Menwous

Q. On what did you base that conclusion?

A Chest x-ray

Q Chest x-ray alone?

A Smoking history Mhe fact he required a high degree of supplemental oxygen to maintain saturation in the coronary care unit

Q Anything else?

A No.

Q Let me ask you a couple of questions about what you said about his oxygen requirement n coronary care prior to surgery

Did you investigate to see whether he had a prior history of pulmonary insufficiency that had received any treatment?

A. No. We had received a report that he has chronic obstructive pulmonary disease, he was on medical therapy for that.

Q. Who did you receive that information from?

A. It was part of his admitting evaluation.

Q. What medical therapy was he on for COPD?

A. Bronchodilators.

Q. Bronchodilators bronchodialators?

A. Yes.

Q. Did you believe or I don't like to ask do you believe questions, let withdraw that.

Based upon the chest x-ray, the oxygen requirements, the history of smoking, did any of those factors when you saw him clinically prior to surgery lead you to draw a conclusion that part of his problem was that he already had PE?

A. No.

Q. So you weren't thinking that at all?

A. No.

Q. When you did your operative report, I'm reading this, prior to induction the patient's arterial saturation was found to be quite low. PO_2

of 40 on 4 liters of nasal cannula. That finding just prior to induction, Dr. Lee, did that give you an idea how much lung capacity Mr. Brown had?

A. I had suspected it even prior to that because we had -- if you look at the anesthesia record, we had determined that arterial blood gases were quite poor. We knew that going in.

Q. When you are referring to his arterial blood gases, what numbers or what assessments were you looking at?

A. pH, PO_2, pCO_2.

Q. During the course of his hospitalization did you see him every day?

A. Yes.

Q. Every day when you saw him did you also review lab values, bicarb?

A. Yes.

Q. Would you say that his PO_2 improved or

I mean?

MR. MALONE: I was going to make you wait for her to finish the question,

Q. If you looked at the labs every day, were you following what the PO_2s were?

A. Yes.

Q You and I would agree PO_2 of 40 on 4 liters of nasal cannula is not a normal number?

A Correct may be normal for him.

Q When you say it may be normal for him what do you mean?

A. There are lots of people walking around with PO_2s of 40

Q You don't know whether that is normal for him or not, do you?

A We surmise that it was

Q Based on a history of COPD?

A based on his chest x-ray history of COPD his smoking history and the fact that he was reasonably comfortable with a PO_2 of 40.

Q. When you say reasonably comfortable what do you mean?

A. In other words his level of consciousness was adequate, he was conversing, he was functioning with a PO_2 of 40 we've seen other patients under similar circumstances with similar laboratory values.

When you see that you can sometimes make the assumption some patients like at that PO_2 they are compensated one of the things that leads you to that is his bicarbonate is high he is

somewhat retaining CO_2, that is a compensatory mechanism that takes quite a while for the human body. We surmised he had compensated COPD.

Q. How long does the compensatory mechanism take to develop?

A. I can't say specifically. I don't know the days or weeks. We see that in patients with a history of COPD.

Q. Would you defer to the judgment of a pulmonologist on the issue?

A. (Indicating affirmatively.)

Q. Every time I think I know every single thing that could be in the University Hospital chart I don't.

When I read these lab values, I highlighted them in pink, these are the PO_2s, it says LP; do you know what LP means, PO_2, pCO_2?

A. No, I don't.

Q. I'm sure those are the same ones I showed you. There are only two pages. Let me ask you some different questions.

Obviously you were here for Dr. Furey's questions and answers?

A. Yes.

Q. To what extent did you participate in the

decision to delay the placement of the IVC filter?
A. He asked me whether it was appropriate to delay it given the circumstances, I told him I thought it was appropriate.
Q. Let's ask, I need a good explanation of what you were thinking. As you know that is what the issue is to me in this case.
A. Yes.
Q. You say that he asked you if it was appropriate to delay. What did you mean when you say that, what did he ask you?
A. I can't really tell you the particulars of his conversation because it was a while ago. There is no written record of what I said to him. The situation was presented to me as he had testified -- is that a testimony?
MR. MALONE: Yes. You are testifying now, he testified this morning.
A. Yes, my recollection is he was accurate.
Q. Let me see if I can sort this out.
I'm going to take a guess Lawrence Brown is not the first patient that has been under your care that needed the placement of a filter or am I guessing wrong?
A. I don't know.

Q. You don't have a recollection one way or another if any of your other patients postoperatively have needed a filter for clots?
A. (Indicating negatively.)
Q. What is your degree of expertise based upon what you do daily about making a decision on placements of filters?
A. Very peripheral.
Q. Very?
A. Peripheral.
Q. Did you yourself have a conversation with the radiologist about what kind of sedation was needed for this patient to undergo this procedure?
A. No.
Q. Did you yourself have an opinion when you had -- let me back this up, do you remember if you spoke with Dr. Furey in person? As you recall this morning he couldn't recall,
A. I couldn't recall if it was in person or via phone call. One of those two mechanisms, I don't know if by phone or directly.
Q. Would you have been in a position based upon your training and what you do to assess the risks of sedation to this patient?
A. No.

Q. Were you in a position to assess the risks of intubation, rapid sequence as discussed by Dr. Furey and placement of an ET tube to prevent aspiration?
A. That's not my area of expertise, no
Q. Were you relying upon Dr. Furey's interpretation of the medical risk in that particular situation?
A. Yes.
Q. Then going back around the circle, when you say that he asked you if under those circumstances you thought it was appropriate --
A. Yes.
Q. -- to delay, were you relying upon what he told you the risks would be for undergoing the procedure?
A. Yes.
Q. You had no independent medical reasoning as to what the risks would be?
A. Enough to concur with him.
Q. Let's go backwards.
What did you perceive the risk to be?
A. High.
Q. When you say high, let's break this out. As

You know we discussed a couple of different venues I suppose.

Did you hold a medical belief that this person was unable to undergo the placement of this filter without some decision?

A. Yes.

Q. What led you to that conclusion?

A. I think getting a cooperative picture this is not a procedure that is done under general anesthesia. My recollection Mr. Brown at that stage of his recovery was -- he simply was not able to cooperate with any of our instructions that would allow them to do the pulmonary angiogram and place the filter.

Q. Can we separate this out for purposes of these questions; we're not discussing a pulmonary angiogram, correct, just the placement of the filter?

A. They are intricately connected because I'm not aware you can do an IVC filter without doing a pulmonary angiogram.

Q. Let me ask you this question -- let me skip to this: Mr. Brown was described as lethargic on numerous occasions; do you agree with that?

A. Can I?

Q. Sure.
A. Do you have --
Q. Yes, hold on, I think you have better notes than I do, at least on this page. He's alert and oriented on 6-1, can you read that is what the note says?
A. Yes.
Q. I assume that you heard Dr. Furey's testimony this morning that it was Mr. Brown's degree of lethargy, lack of energy that made it necessary to tube feed him; do you agree with that?
A. I think there are other factors. When the patient is moribund in the intensive care unit you need to supplement his nutrition somehow. It wasn't just that he was lethargic, he needed nutrition supplementation, period.
Q. When you say moribund, in your terms tell me what you are saying.
A. He had three of his major organs that were really not working at full capacity; kidneys, lung, heart.
Q. Now I know what you mean by moribund, you felt that would be another indication to do tube feeds?
A. (Indicating affirmatively.)

Q. I guess that I'm thinking of a description of lethargy that occurred before that date

Do you see any indication having these notes that he was in an agitated state and uncooperative?

A. Excuse me.

Q. That's okay.

A My recollection of Mr Brown is pretty consistent with Dr. Furey's testimony this morning I guess you are trying to look for a confirmatory event right?

Q Right.

A I think we may need to go to the original hospital chart because my xerox copies got truncated at certain points

There are a few nursing scribbles that I think shed light on this matter about his mental status and his level of cooperation.

Q Can you tell me what date you ll be referring to?

MR MALONE: June 3rd eight o'clock in the morning?

A. Patient assessed complaining of shortness of breath.

MR MALONE: I think that

is --
A. Without complaint of shortness of breath, restless in bed.
MR. MALONE: Planned to get out of bed today.
A. All I could determine was patient's name from response.
MR. MALONE: Patient's verbal response garbled. That is the morning of the 3rd.
Q. Thank you for pointing that out to me.
Let me ask you: It says the patient was restless in bed, would be getting out of bed that day, isn't it --
A. We make the effort to get the patient out of bed no matter, unless they are paralyzed. So I think the nurse was basically responding to our desire to get the patient mobilized, regardless of what their mental status was.
Q. After this became -- let me withdraw that.
You became aware that the doppler study was done as ordered by Dr. Furey, there was in fact evidence from that study that there was acute fresh clot and some old clot; am I stating that accurately?

A. It wasn't reported to me in those terms because the thing that we were responding to was a presence of thrombus in the femoral vein.
Q. I was trying to say the same thing you just said, I didn't say it correctly. Now that we've established that --
A. You date the thrombus by saying acute fresh. I think that is subject to interpretation.
Q. Do you think there was any fresh clot?
A. I don't know, I don't read sonograms. I don't think you can make that assumption.
Q. That there wasn't?
A. Right.
Q. From the nursing notes that I read this morning at Dr. Furey's deposition, it's rather clear that after the time that Dr. Furey was in and knew about the results, you were in at bedside doing a doppler study of the graft site; does that comport with your memory?
A. Yes.
Q. Did you try to have a conversation with Lawrence Brown at that time about what his medical situation or condition was?
A. I conversed with Mr. Brown every day.
Q. My question was did you talk with him at that

time about the medical situation, about his need for a filter?

A. I can't recollect that I spoke with him that day about that matter. All I can say is I know I spoke with him every day.

Q. Were you able to have a conversation with him on June 3rd?

A. The usual how are you, how are you feeling today.

Q. Was he able to respond to you?

A. Yes.

Q. Is there something that happened in that encounter on June 3rd, either based on uncooperativeness or unresponsiveness that could confirm or lead you to the opinion he would have been unable to follow directions in the angiography suite?

A. I guess what you are trying to say is, was there a change in his level of cooperativeness between June 3rd and June 2nd or June 1st.

Q. What I'm first of all asking, not anything about any changes, the comments that I've heard today about his not being able to get a filter seemed to be predicated on the fact it was incompetence, unable to follow directions, he would

be unable to lie still?
A. I don't know that was an overwhelming reason. Certainly to my recollection that wasn't the overwhelming reason.
Q. To your recollection what was the overwhelming reason that this man did not receive an IVC filter on June 3rd?
A. Constellation of various factors.
Q. Tell me what they are.
A. We discussed his -- you would accept the term uncooperativeness, you buy that.
Q. I don't know that I buy that he was uncooperative. That's an assertion that is being made, that is on your list of factors.
A. I think we outlined earlier some of the medical contraindications for pulmonary angiogram which Mr. Brown had.

I guess the bottom line was as physicians taking care of him we were concerned that by doing a procedure we would end up with a very high likelihood of causing him harm.
Q. That very high likelihood of causing him harm was in your opinion predicated on the possibility that he could aspirate during the procedure: I'm asking you if that is what your issue was?

A. That may have been Dr. Furey's issue, I think there are known risks to pulmonary angiogram that would also have to be considered. I think that was also in our minds when we decided on the risk/benefit ratio at that time.

Q. What ability did Lawrence Brown's lungs have to sustain another pulmonary embolism on June 3rd?

A. It all depends on the size of the embolism. Embolism could be a small as one millimeter in size, could be as large as a golf ball, so it all depends on the size of the embolism.

Q. Do you have any way scientifically of predicting the size of the embolism that would be thrown from the site in the left leg into the lung?

A. That is just conjecture. It would be nice for us as clinicians to be able to predict that. Not all clots in the veins go up to the lungs. There are people walking around with clots in their legs. We just have no scientific way of predicting that.

Q. You and I would be in agreement there is no way to know if the embolism is going to happen, what size it will be?

A. Actually there are some clues but I'm not an expert on that area so I don't know.

Q. I would have to talk to someone who was an expert to find out what the clues were or do you know what they are?
A. No.
Q. What in your opinion was more likely to cause his death, the sustaining of another embolism into his lung given the condition he was in, or the possible risk he could have undergone due to sedation and placement of the filter?
MR. MALONE: Pulmonary angiography?
A. Counselor, I think you've made an assumption I can't agree with, which is that a clot somehow went to his lungs at a time period when he was anticoagulated therapeutically because -- I have to look at the autopsy and try to determine exactly when the clot got lodged in the pulmonary arteries because it seems to me he's had chronic pulmonary embolisms before. So you have to date all his clots that they found in the lungs to some time period.
Q. Have you done that?
A. No.
Q. Have you looked at the lung tissue sample?
A. (Indicating negatively.)

Q. Once again I was asking you, I appreciate the information that you've given me, my question was this: If you were assessing, what did you think was the larger risk, that he would die from an embolism, that he would die from initiating sedatives that would undergo the placement of the filter?

A. The later.

Q. What did you think the respective percentages of risk were in this particular patient?

A. I can't give you a specific number. I think that would be just guesswork.

Q. Because that's not your area?

A. (Indicating affirmatively.)

Q. You just said something in one of your answers that led me to decide I probably need to ask you a question.

When a person is being managed who is one of your patients for anticoagulation with Heparin, do you manage that and follow it or does someone else do that?

A. It's a team effort.

Q. What do you consider to be therapeutic management with Heparin, in other words what numbers are you looking for?

A. One and a half times normal.
Q. Until it gets to one half times normal we're fairly certain it's not therapeutic; is that right?
A. It all depends on what you mean by therapeutic.
Q. Okay.
A. The reason is because I work with Heparin every day. The effects are almost immediate. I see it in the operating room, I know the effects of Heparin quite well. You measure blood levels, you don't have therapeutic levels. The physiological effect of Heparin may be different than what I see.
Q. What do you mean when you say therapeutic, we will come at it in reverse?
A. One and a half half times normal. On the other hand one and a quarter times normal is therapy given to the patient, you can't just make the assumption because the PTT is one and a quarter times normal -- I use the one and a half as a cut off -- that the patient is not getting some form of therapy.
Q. I understand that.
So my question is this: Were you in agreement with Dr. Furey that although he had

been Heparinized, you were not saying that was going to prevent embolism because of the clot that was seen?

MR. MALONE: I'm not sure Dr. Furey said that. If you are going to quote Dr. Furey, going to ask his assessment of the question, I don't think that we can agree with Furey, I don't have a transcript. I have no memory of him saying that. I was here too.

Q. Let me ask it in reverse. I know how I asked the question.

The decision to initiate the filter was predicated upon the fact that it was not reassuring that he actually had received therapeutic levels of Heparin; do you disagree with that?

A. Yes, I disagree with that.

Q. What did you think the decision to initiate this therapy was predicated on?

MR. MALONE: This therapy meaning Heparin or this meaning a filter preceded by angioplasty?

MISS KOLIS: Yes, the later.

A. I think I would have to defer to Dr. Furey

because he made the decision in the chart.
Q. Did you agree with the decision?
Let me withdraw the question. You said you were going to defer to Dr. Furey because it was a decision he made. Are you testifying you wouldn't be in a position as a matter of medicine to concur or dispute that decision?
A. Yeah. I'm sorry, Donna, could you rephrase the question.
Q. I don't want to misunderstand.
A. Dr. Furey made that decision, I concurred with that decision, is that sufficient?
Q. I think I better reask it so it's clear when I get the transcript.
I thought by your answer, your previous answer two questions ago you were implying that you can't conclude why the decision to go ahead and place the IVC filter and do angiography was made?
A. Right.
Q. That is something that is within the specialty of Dr. Furey. Because he recommended it, you concurred with it because there wasn't anything from a cardiac standpoint that would have interfered with that, is that more expansive but

inclusive of what you were thinking?
A. I think I've outlined some of the reasons why a pulmonary arteriogram was risky in this patient so that sense must be emphasized in all the decision making that we made, because the decision to proceed with an IVC filter is a pretty irrevocable decision.
Q. Undoubtedly.
A. So you don't make that decision lightly. Dr. Furey was the first one to initiate the inquiry to the benefit of the IVC filter.
Q. I understand that answer. I do appreciate it.

Let me ask this: Even though we don't have a transcript, if your attorney recalls the answer to be different he's certainly free to say that. Assuming that hypothetically that the transcript indicates that the primary reason the decision to delay was made was a risk of aspiration; do you agree that that is why?

MR. GROEDEL: Objection, asked and answered. Go ahead.

MR. MALONE: Listen to the question. Do you agree the main reason to delay was a risk of aspiration? Pretty simple straight

forward question.

A Yes

Q Because of that risk as it was explained to you, the procedure was going to be delayed until the following morning?

A Yes

Q The following morning if he had not had a massive event -- we will call it a massive event that's acceptable to you at the moment?

A (Indicating affirmatively.)

MR MALONE: Death is a massive event by definition

Q If he had not had that event he would have undergone the procedure?

A Yes.

Q Do you have an opinion based upon a review of the autopsy as to r Brown s cause of death?

A No I don't.

MISS KOLIS: Let me talk take fracy for one minute we might be done

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(Recess had.)

MISS KOLIS: I don't have any further questions at this time.

CROSS-EXAMINATION

BY MR. MOSCARINO:

Q. Doctor, do you have any criticism of the resident staff or nursing staff during their care that they gave to this gentleman?

A. No, none at all.

MR. MOSCARINO: That's all I've.

MR. GROEDEL: No questions.

MR. MALONE: I'll have him read it.

MISS KOLIS: I waive the seven days.

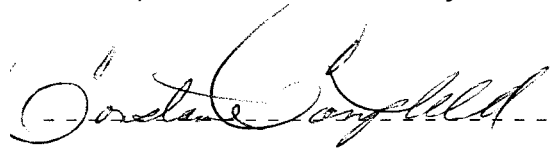
(Deposition concluded; signature not waived.)

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

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

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

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



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

Look-See Concordance Report

- - -

UNIQUE WORDS: 836
TOTAL OCCURRENCES: 1,888
NOISE WORDS: 385
TOTAL WORDS IN FILE: 6,353

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QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

- - -

DATES ON

- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE FORMS ON

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

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