

1 THE STATE of OHIO,
2 : SS:
3 COUNTY of CUYAHOGA.

4 IN THE COURT OF COMMON PLEAS
5

6 ESTATE OF LAWRENCE BROWN, :
7 plaintiff,

8 vs. : Case No. 346342

9 UNIVERSITY HOSPITALS OF
10 CLEVELAND, et al.,
11 defendants.
12

13 Deposition of JAI .LEE, 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 1:35 p.m. pursuant to agreement
21 of counsel.
22
23
24
25

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I N D E X

WITNESS:

JAI LEE, M.D.

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(NO EXHIBITS MARKED)

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JAI LEE, M.D.

of law~~s~~l ag~~s~~ a defendant herein call~~e~~d say the
plaintiff for the purpose of cross-examination
pursuant to the Ohio Rules of Civil Procedure,
being first duly sworn, as hereinafter certified,
was ~~e~~xamin~~e~~d and t~~e~~stified as ~~s~~ollows:

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 ^dnd
Mr. Malone need to confer about an answer or
question, that s acceptable to myself

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

1 issue of pulmonary embolism?

2 A. I don't think so.

3 Q. My understanding from briefly reviewing your
4 CV, you work at the hospital as a cardiothoracic
5 surgeon; that's a fair assessment?

6 A. Yes.

7 Q. How long have you been at University
8 Hospitals of Cleveland?

9 A. I trained here so my training covered 1989
10 to 1991, my staff privileges began from 1992 to the
11 present.

12 Q. If I read your CV correctly, there was a one
13 year period of time you left town, went to
14 California?

15 A. Yes.

16 Q. You went to work for Kaiser for a short
17 stint, you decided you rather come back to
18 Cleveland?

19 A. I was invited to come back by my chairman,
20 yeah.

21 Q. Fair enough.

22 What position do you hold here at
23 the hospital?

24 A. I'm a staff cardiac surgeon, cardiothoracic
25 surgeon.

1 Q. Good enough.

2 Have you been sued before this
3 lawsuit for medical malpractice?

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

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

8 A. No.

9 Q. Someone else?

10 A. Yes, someone else.

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

13 Did you give depositions in both of
14 those cases?

15 A. No.

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

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

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

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

1 MR. MALONE: I think she
2 means retained, have you ever been hired as opposed
3 to being yourself as a party, as an expert by
4 definition?
5 A. No.
6 Q. You haven't done any medical/legal reviewing
7 and testifying?
8 A. No.
9 Q. Before coming here today, did you have an
10 opportunity to review Mr. Brown's medical records?
11 A. Yes, I did.
12 Q. Did you review his autopsy?
13 A. Yes, I did.
14 Q. Did you have an opportunity to review any
15 medical records that were generated before he
16 became a patient at University Hospitals?
17 A. Records from another hospital?
18 Q. Yes.
19 A. No.
20 Q. In reviewing the records, if you need to
21 refer to them at any time you understand that is
22 acceptable, at any point in Mr. Brown's confinement
23 here did you yourself consider having him undergo a
24 ventilator perfusion scan?
A. No.

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

1 regarding a patient's condition.

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

3 You do have a specific recollection
4 that on or about I believe May 31st --

5 A. Yes.

6 Q. Trying to be specific if we can.

7 A. Yes.

8 Q. -- there was a note in the chart where the
9 suggested diagnosis was respiratory distress, COPD
10 versus PE; are you with me?

11 A. Yes.

12 Q. That is what it said in the chart?

13 A. Yes.

14 Q. Was there a suggestion consideration should
15 be given to a pulmonary angiogram?

16 A. Yes.

17 Q. What I'm asking you is, that note was written
18 by SICU; do you agree with that?

19 A. I'm going to focus in on that particular note
20 so I can answer for you accurately.

21 MR. MALONE: Go back a
22 little bit, these are the clinical notes.

23 MR. MOSCARINO: What date?

24 MISS KOLIS: 5-3, top of the
25 page.

1 A. Yes.

2 Q. So this was written by Dr. Popple?

3 A. Dr. Popple.

4 Q. You would have read that note?

5 A. Yes.

6 Q. So my question to you is, trying to prompt
7 your memory, if you read that -- first of all you
8 don't have a recollection you were contacted
9 directly to discuss that consideration?

10 A. Yeah, my recollection is that it was
11 considered but not -- disregarded, not taken
12 seriously because of the known risk of a pulmonary
13 angiogram in a fairly moribund patient.

14 Q. Did you have an understanding what the known
15 risks of the angiogram were in a patient such as
16 Mr. Brown?

17 A. I'm sorry?

18 Q. My question was did you have an understanding
19 of what the risks of angiogram would have been in a
20 patient such as Mr. Brown?

21 A. Yes.

22 Q. What did you understand to be the risk?

23 A. I think the risk of a pulmonary angiogram is
24 something that would entail a risk of renal
25 failure; two, death because of his underlying lung

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

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

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

15 A. Both.

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

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

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

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

3 A. I don't know.

4 Q. Is that outside your area of expertise?

5 A. Yes.

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

9 A. Perhaps.

10 Q. What other specialties would you think
11 would --

12 A. A nephrologist.

13 Q. Pulmonologist or nephrologist?

14 A. Yes.

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

19 A. Yes.

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

22 A. Right.

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

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

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

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

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

17 A. Yes.

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

23 A. Yes.

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

1 A. Of course.

2 Q. What would have been the medical therapy?

3 A. Medications.

4 Q. Did you make the decision he should undergo
5 the bypass versus an initiation of a trial of
6 medicines for that condition?

7 A. No.

8 Q. Who made that decision?

9 A. The decision is made by the cardiologist in
10 the coronary care unit.

11 Q. The reason I'm asking that question, or 'at
12 least one of the reasons I'm asking, I could not
13 locate a consultation from cardiology where they
14 determine he should be bypassed; did I simply miss
15 that document?

16 A. Let me clarify.

17 Q. Sure.

18 A. The patient gets admitted to the coronary
19 care unit, he's on the cardiology service, the
20 cardiology service is the primary care taker for
21 the patient so there is no separate consultation.

22 Q. I understand that. Thank you for clarifying
23 it.

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

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

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

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

7 A. Pretty much.

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

10 A. Absolutely.

11 Q. What are the benefits of immediately
12 proceeding to a bypass surgery in a person with a
13 50 percent LAD stenosis, versus a trial of
14 medicine?

15 A. The risk/benefit ratio is pretty clear.

16 Q. Okay.

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

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

25 Q. I was just asking what the reason was.

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

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

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

11 A. Yes.

12 Q. What did you believe his pulmonary status
 13 was?

14 A. Mentous

15 Q. On what did you base that conclusion?

16 A Chest x-ray

17 Q Chest x-ray alone?

18 A Smoking history He said he required a high
 19 degree of supplemental oxygen to maintain
 20 saturation in the coronary care unit

21 Q Anything else?

22 A No.

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

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

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

7 Q. Who did you receive that information from?

8 A. It was part of his admitting evaluation.

9 Q. What medical therapy was he on for COPD?

10 A. Bronchodilators.

11 Q. Bronchodilators bronchodialators?

12 A. Yes.

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

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

20 A. No.

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

22 A. No.

23 Q. When you did your operative report, I'm
24 reading this, prior to induction the patient's
25 arterial saturation was found to be quite low. PO₂

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

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

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

11 A. pH, PO₂, pCO₂.

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

14 A. Yes.

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

17 A. Yes.

18 Q. Would you say that his PO₂ improved or

19

20 I mean?

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

23 Q. If you looked at the labs every day, were you
24 following what the PO₂s were?

25 A. Yes.

Q You and I would agree PO₂ of 40 on 4 liters of nasal cannula is not a normal number?

U Correct map a 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 PO₂s of 40

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

U 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 PO₂ 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 PO₂ 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 live at that PO₂ they are compensated one of the things that lead you to that is his bicarbonate is high he is

1 somewhat retaining CO₂, that is a compensatory
2 mechanism that takes quite a while for the human
3 body. We surmised he had compensated COPD.

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

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

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

11 A. (Indicating affirmatively.)

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

15 When I read these lab values, I
16 highlighted them in pink, these are the PO₂s, it
17 says LP; do you know what LP means, PO₂, pCO₂?

18 A. No, I don't.

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

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

24 A. Yes.

25 Q. To what extent did you participate in the

1 decision to delay the placement of the IVC filter?

2 A. He asked me whether it was appropriate to
3 delay it given the circumstances, I told him I
4 thought it was appropriate.

5 Q. Let's ask, I need a good explanation of what
6 you were thinking. As you know that is what the
7 issue is to me in this case.

8 A. Yes.

9 Q. You say that he asked you if it was
10 appropriate to delay. What did you mean when you
11 say that, what did he ask you?

12 A. I can't really tell you the particulars of
13 his conversation because it was a while ago. There
14 is no written record of what I said to him. The
15 situation was presented to me as he had
16 testified -- is that a testimony?

17 MR. MALONE: Yes. You are
18 testifying now, he testified this morning.

19 A. Yes, my recollection is he was accurate.

20 Q. Let me see if I can sort this out.

21 I'm going to take a guess Lawrence
22 Brown is not the first patient that has been under
23 your care that needed the placement of a filter or
24 am I guessing wrong?

25 A. I don't know.

1 Q. You don't have a recollection one way or
2 another if any of your other patients
3 postoperatively have needed a filter for clots?

4 A. (Indicating negatively.)

5 Q. What is your degree of expertise based upon
6 what you do daily about making a decision on
7 placements of filters?

8 A. Very peripheral.

9 Q. Very?

10 A. Peripheral.

11 Q. Did you yourself have a conversation with the
12 radiologist about what kind of sedation was needed
13 for this patient to undergo this procedure?

14 A. No.

15 Q. Did you yourself have an opinion when you
16 had -- let me back this up, do you remember if you
17 spoke with Dr. Furey in person? As you recall this
18 morning he couldn't recall,

19 A. I couldn't recall if it was in person or via
20 phone call. One of those two mechanisms, I don't
21 know if by phone or directly.

22 Q. Would you have been in a position based upon
23 your training and what you do to assess the risks
24 of sedation to this patient?

25 A. No.

1 Q. Were you in a position to assess the risks of
2 intubation, rapid sequence as discussed by
3 Dr. Furey and placement of an ET tube to prevent
4 aspiration?

5 A. That's not my area of expertise, no

6 Q. Were you relying upon Dr. Furey's
7 interpretation of the medical risk in that
8 particular situation?

9 A. Yes.

10 Q. Then going back around the circle, when you
11 say that he asked you if under those circumstances
12 you thought it was appropriate --

13 A. Yes.

14 Q. -- to delay, were you relying upon what he
15 told you the risks would be for undergoing the
16 procedure?

17 A. Yes.

18 Q. You had no independent medical reasoning as
19 to what the risks would be?

20 A. Enough to concur with him.

21 Q. Let's go backwards.

22 What did you perceive the risk to
23 be?

24 A. High.

25 Q. When you say high, let's break this out. As

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

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

6 A. Yes.

7 Q. What led you to that conclusion?

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

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

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

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

25 A. Can I?

1 Q. Sure.

2 A. Do you have --

3 Q. Yes, hold on, I think you have better notes
4 than I do, at least on this page. He's alert and
5 oriented on 6-1, can you read that is what the note
6 says?

7 A. Yes.

8 Q. I assume that you heard Dr. Furey's testimony
9 this morning that it was Mr. Brown's degree of
10 lethargy, lack of energy that made it necessary to
11 tube feed him; do you agree with that?

12 A. I think there are other factors. When the
13 patient is moribund in the intensive care unit you
14 need to supplement his nutrition somehow. It
15 wasn't just that he was lethargic, he needed
16 nutrition supplementation, period.

17 Q. When you say moribund, in your terms tell me
18 what you are saying.

19 A. He had three of his major organs that were
20 really not working at full capacity; kidneys, lung,
21 heart.

22 Q. Now I know what you mean by moribund, you
23 felt that would be another indication to do tube
24 feeds?

25 A. (Indicating affirmatively.)

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

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

6 A. Excuse me.

7 Q. That's okay.

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

12 Q Right.

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

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

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

21 MR MALONE: June 3rd

22 eight o'clock in the morning?

23 A. Patient assessed complaining of shortness of
24 breath.

25 MR MALONE: I think that

1 is --

2 A. Without complaint of shortness of breath,
3 restless in bed.

4 MR. MALONE: Planned to get
5 out of bed today.

6 A. All I could determine was patient's name from
7 response.

8 MR. MALONE: Patient's
9 verbal response garbled. That is the morning of
10 the 3rd.

11 Q. Thank you for pointing that out to me.

12 Let me ask you: It says the
13 patient was restless in bed, would be getting out
14 of bed that day, isn't it --

15 A. We make the effort to get the patient out of
16 bed no matter, unless they are paralyzed. So I
17 think the nurse was basically responding to our
18 desire to get the patient mobilized, regardless of
19 what their mental status was.

20 Q. After this became -- let me withdraw that.

21 You became aware that the doppler
22 study was done as ordered by Dr. Furey, there was
23 in fact evidence from that study that there was
24 acute fresh clot and some old clot; am I stating
25 that accurately?

1 A. It wasn't reported to me in those terms
2 because the thing that we were responding to was a
3 presence of thrombus in the femoral vein.

4 Q. I was trying to say the same thing you just
5 said, I didn't say it correctly. Now that we've
6 established that --

7 A. You date the thrombus by saying acute fresh.
8 I think that is subject to interpretation.

9 Q. Do you think there was any fresh clot?

10 A. I don't know, I don't read sonograms. I
11 don't think you can make that assumption.

12 Q. That there wasn't?

13 A. Right.

14 Q. From the nursing notes that I read this
15 morning at Dr. Furey's deposition, it's rather
16 clear that after the time that Dr. Furey was in and
17 knew about the results, you were in at bedside
18 doing a doppler study of the graft site; does that
19 comport with your memory?

20 A. Yes.

21 Q. Did you try to have a conversation with
22 Lawrence Brown at that time about what his medical
23 situation or condition was?

24 A. I conversed with Mr. Brown every day.

25 Q. My question was did you talk with him at that

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

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

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

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

10 Q. Was he able to respond to you?

11 A. Yes.

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

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

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

1 be unable to lie still?

2 A. I don't know that was an overwhelming
3 reason. Certainly to my recollection that wasn't
4 the overwhelming reason.

5 Q. To your recollection what was the
6 overwhelming reason that this man did not receive
7 an IVC filter on June 3rd?

8 A. Constellation of various factors.

9 Q. Tell me what they are.

10 A. We discussed his -- you would accept the term
11 uncooperativeness, you buy that.

12 Q. I don't know that I buy that he was
13 uncooperative. That's an assertion that is being
14 made, that is on your list of factors.

15 A. I think we outlined earlier some of the
16 medical contraindications for pulmonary angiogram
17 which Mr. Brown had.

18 I guess the bottom line was as
19 physicians taking care of him we were concerned
20 that by doing a procedure we would end up with a
21 very high likelihood of causing him harm.

22 Q. That very high likelihood of causing him harm
23 was in your opinion predicated on the possibility
24 that he could aspirate during the procedure: I'm
25 asking you if that is what your issue was?

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

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

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

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

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

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

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

1 Q. I would have to talk to someone who was an
2 expert to find out what the clues were or do you
3 know what they are?

4 A. No.

5 Q. What in your opinion was more likely to cause
6 his death, the sustaining of another embolism into
7 his lung given the condition he was in, or the
8 possible risk he could have undergone due to
9 sedation and placement of the filter?

10 MR. MALONE: Pulmonary
11 angiography?

12 A. Counselor, I think you've made an assumption
13 I can't agree with, which is that a clot somehow
14 went to his lungs at a time period when he was
15 anticoagulated therapeutically because -- I have to
16 look at the autopsy and try to determine exactly
17 when the clot got lodged in the pulmonary arteries
18 because it seems to me he's had chronic pulmonary
19 embolisms before. So you have to date all his
20 clots that they found in the lungs to some time
21 period.

22 Q. Have you done that?

23 A. No.

24 Q. Have you looked at the lung tissue sample?

25 A. (Indicating negatively.)

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

8 A. The later.

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

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

13 Q. Because that's not your area?

14 A. (Indicating affirmatively.)

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

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

22 A. It's a team effort.

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

1 A. One and a half times normal.

2 Q. Until it gets to one half times normal we're
3 fairly certain it's not therapeutic; is that right?

4 A. It all depends on what you mean by
5 therapeutic.

6 Q. Okay.

7 A. The reason is because I work with Heparin
8 every day. The effects are almost immediate. I
9 see it in the operating room, I know the effects of
10 Heparin quite well. You measure blood levels, you
11 don't have therapeutic levels. The physiological
12 effect of Heparin may be different than what I
13 see.

14 Q. What do you mean when you say therapeutic, we
15 will come at it in reverse?

16 A. One and a half half times normal. On the
17 other hand one and a quarter times normal is
18 therapy given to the patient, you can't just make
19 the assumption because the PTT is one and a quarter
20 times normal -- I use the one and a half as a cut
21 off -- that the patient is not getting some form of
22 therapy.

23 Q. I understand that.

24 So my question is this: Were you
25 in agreement with Dr. Furey that although he had

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

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

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

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

17 A. Yes, I disagree with that.

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

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

23 MISS KOLIS: Yes, the
24 later.

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

1 because he made the decision in the chart.

2 Q. Did you agree with the decision?

3 Let me withdraw the question. You
4 said you were going to defer to Dr. Furey because
5 it was a decision he made. Are you testifying you
6 wouldn't be in a position as a matter of medicine
7 to concur or dispute that decision?

8 A. Yeah. I'm sorry, Donna, could you rephrase
9 the question.

10 Q. I don't want to misunderstand.

11 A. Dr. Furey made that decision, I concurred
12 with that decision, is that sufficient?

13 Q. I think I better reask it so it's clear when
14 I get the transcript.

15 I thought by your answer, your
16 previous answer two questions ago you were implying
17 that you can't conclude why the decision to go
18 ahead and place the IVC filter and do angiography
19 was made?

20 A. Right.

21 Q. That is something that is within the
22 specialty of Dr. Furey. Because he recommended it,
23 you concurred with it because there wasn't anything
24 from a cardiac standpoint that would have
25 interfered with that, is that more expansive but

1 inclusive of what you were thinking?

2 A. I think I've outlined some of the reasons why
3 a pulmonary arteriogram was risky in this patient
4 so that sense must be emphasized in all the
5 decision making that we made, because the decision
6 to proceed with an IVC filter is a pretty
7 irrevocable decision.

8 Q. Undoubtedly.

9 A. So you don't make that decision lightly.
10 Dr. Furey was the first one to initiate the inquiry
11 to the benefit of the IVC filter.

12 Q. I understand that answer. I do appreciate
13 it.

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

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

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

1 error question.

2 4 Yes

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

6 A Yes

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

10 4 (Indicating affirmatively.)

11 MR MALONE: Death is a
12 massive parent by definition

13 Q If he had not had that parent he would have
14 undergone the procedure?

15 A Yes.

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

18 4 No I don't.

19 MISS KOLIS: Let me talk
20 take Tracy for one minute we might see how

21 -----

22 (Recess had.)

23 -----

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

CROSS-EXAMINATIONBY 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.)

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, JAI LEE, M.D. was by me
6 first duly sworn to testify the truth in the cause
7 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.

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