State of Ohio,)
) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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Nola Vargo, Admx., et al.,)
Plaintiffs,)
vs.)
Case No. 447160
The Cleveland Clinic)
Foundation, et al.,
)
Defendants.
)

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DEPOSITION OF PATRICK WHELAN, M.B.

WEDNESDAY, APRIL 7, 2004

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The deposition of PATRICK WHELAN, M.B., called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Reminger & Reminger, 1400 Midland Building, Cleveland, Ohio, commencing at 10:50 a.m., on the day and date above set forth.

APPEARANCES:
On Behalf of the Plaintiffs:
John F. Norton, Esq.
Cambridge Square Building - Suite 204
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On Behalf of Defendant Cleveland Clinic Foundation:

Jeffrey M. Whitesell, Esq.
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On Behalf of Kaiser Permanente:
Marc W. Groedel, Esq.
Reminger & Reminger
1400 Midland Building
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PATRICK WHELAN, M.B.
the deponent herein, called for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MR. NORTON:

Q Tell me your full name, please.
A Patrick Noel Joseph Whelan.
Q And do you still reside at 21521 Lake Road?
A Yes, I do.
Q Doctor, thank you for making yourself available a second time to be deposed in this case, I appreciate it.
You are licensed in Ohio?
A Correct.
Q And you are Board certified in pulmonary medicine?
A Correct.
Q Have you had an opportunity to read the deposition that was taken before?
A My own personal deposition?
Q Yes.
A Yes, I have.
Q Are there any changes you would like to make in that deposition?
A At this point, no.
Q Are there any additions or corrections?

A No.
Q Are there any explanations that you intend to make later on --
A No.
Q -- of answers you gave in the deposition?
MR. GROEDEL: Objection.
I think that's a vague question, but you can answer the question to the extent you know.
A I will answer your questions. I have nothing to change at this point.
Q But do you intend to explain any of your answers?
MR. GROEDEL: Objection. It depends upon who is asking the question, obviously.
But go ahead, you can answer.
A It is a question and answer session, Mr. Norton, and I will answer your questions.
Q Do you intend to qualify at trial any of the answers you gave in your deposition?
MR. GROEDEL: Objection.
A I haven't thought about that, no.
Q You are Board certified in pulmonary medicine. What was the length of your pulmonary Fellowship?
A Three years. To be more specific, I did a pulmonary/critical care combined Fellowship which was three years.

Q Now, that three years of training, is that some classwork and some hands-on, or how does that break down? Are you in a classroom setting for part of that?
A No, it is mostly direct clinical experience. People have the option of doing research or taking elective time as part of that period of time.
Q And what did you do?
A Mostly clinical work.
Q And by clinical work, you mean actually taking care of patients?
A Correct.
Q And those would be patients with pulmonary problems?
A Pulmonary consults and critical care consults. They don't always have to have pulmonary problems.
Q Right.
So you were either taking care of critical care patients or patients with pulmonary problems?
A Predominantly pulmonary disease, correct.
Q Now, are there any basic texts on pulmonary medicine?
A Fraser and Pare.
Q Any others?
A Not that I can think of off the top of my head.
Q Have you ever heard of a textbook of respiratory

medicine, Murray and Nadel?
A Yes, I have.
Q In pulmonary medicine, is the chest x-ray a primary diagnostic tool?
A Most of the time, yes.
Q Are there other diagnostic tools in primary medicine -- pulmonary medicine, rather?
A There are numbers, yes.
Q Can you tell me what they are?
A CAT scans of the chest, and there are different types of those, V/Q scans, occasionally PET scans.
You are just talking about radiological studies?
Q Well, any pulmonary study, test.
A Pulmonary function tests, exercise tests, there are a number of different things.
Q So given that chest x-rays are a primary diagnostic tool, as a part of your pulmonary training, do you gain some familiarity with chest films?
A Yes, I do.
Q You acquire some basic understanding of a chest film?
A How to interpret it, yes.
Q Does this mean you actually looked at the films?
MR. GROEDEL: What are you talking about?
Looked at Mrs. Hasto's films?

MR. NORTON: No, no, in training, the training aspect of pulmonary medicine.
A We looked frequently at chest x-rays during the course of my training, yes.
Q And do you go over them with the radiologist, is that how you learn how to read them?
A Not necessarily, but I would go over them with the attendings that were training me in the Fellowship program, I would study textbooks how to read chest x-rays and would just gain general hands-on experience.
Q Do you sometimes do that in association with radiologists?
A I would sometimes review a film with them, yes, but it wouldn't necessarily be considered a formal learning experience.
Q And as part of your training, then, you gained some basic understanding of the radiological manifestations of pulmonary disease?
A Correct.
Q After your Fellowship and you were in practice taking care of patients with pulmonary problems who had chest x-rays, would you read the films yourself or read them in conjunction with the radiologist?
A I would let the radiologist read the films, because they are the people who are experts in that, but I would

frequently look at them myself. But I don't read them formally in the legal sense.
Q Okay.
But when you look at them, do you look at them in association with the radiologist, or you just look at them independently? Or is there any --
A There is no particular pattern. I would frequently go to x-ray to look at the films myself. Occasionally we go to x-ray, and if there are radiologists there, you would look at them in conjunction.
Q And good patient care in pulmonary medicine would suggest, then, that you do take a look at chest x-rays when there is something to be -- when you are checking for some specific pulmonary manifestation?
A Most of the time, if there is a specific concern, it is a good idea to look at the films, but I don't always do so if the suspicion is not very high.
Q Would you agree that without access to a radiology department for purposes of obtaining chest x-rays and other radiological films of the chest, that the practice of pulmonary medicine would be severely limited?
A Yes, it would be limited. I don't know if you could say it would be severely limited, but it would be limited.
Q Because the services performed in the radiology

department in the filming of a patient's chest are of considerable importance to a pulmonary specialist in caring, treating, and even diagnosing the patient's condition; isn't that correct?
A That's correct.
Q Doctor, I am handing you a document that's marked Plaintiffs' Exhibit 1, which is the V/Q scan taken of Nola Hasto in March, 2000 and interpreted by Dr. Neumann.
When a pulmonary specialist requests a V/Q scan, is it customary to provide the radiology department with some -- with the pertinent clinical history of the patient?
A Usually some clinical history is provided, that's correct.
Q And is it also customary when requesting a V/Q scan for a patient to indicate to the radiology department what conditions you are concerned about, what you would like to have ruled out or excluded or included?
A In general with the V/Q scan, there is a particular report given by the radiologist, and the general assumption is that pulmonary embolus is the reason one is -- to rule out pulmonary embolus is the reason for doing the scan. If one had another request, such as a split perfusion scan, which is a slightly different V/Q scan, one would make that clear to the radiologists. In

this case, that split perfusion factor did not apply.
Q Have you just suggested there are two kinds of V/Q scans?
A There is another kind of V/Q scan that can be done in a circumstance different than this, that's true. But it would have to be specifically ordered.
Q Okay, what kind of a V/Q scan was ordered in this case?
A A standard V/Q scan.
Q Standard V/Q.
With reference to a standard V/Q scan, is it customary for the pulmonary specialist to indicate to the radiologist what specific condition is of concern to the pulmonary specialist?
MR. GROEDEL: Objection, asked and answered.
Go ahead.
A Not always. There is usually some clinical history provided, but a V/Q scan can be interpreted by a radiologist without input from anyone on the clinical team, if necessary.
Q Is it your testimony that when a radiologist gets a request for a V/Q scan, that it is generally assumed by the radiologist that they are looking for a pulmonary embolus?
A Most of the time, yes.

Q So is a V/Q scan, in terms of the clinical history that's provided to radiology, an exception to the general rule, that some indication of what the pulmonary specialist is looking for is not indicated necessarily?
A No, we provide information to the radiologist, but we don't always necessarily say, rule out pulmonary embolus. We give them a history which they use to help them with the general situation.
Q And when a pulmonary specialist is requesting a V/Q scan of the chest -- of the lungs, rather, because the specialist is concerned about a pulmonary embolus, what would be the customary history that would be given?
A Give some basic information about the patient on the req.
Q Pardon?
A Put some history about the patient on the requisition.
Q And what would that history be?
A In this case, it said chest pain and shortness of breath.
Q I am not asking what that said. I am asking what the customary information would be to give to a radiologist?
A Some basic clinical information.
Q What would be the specific most pertinent

information that would be given in a history given to the radiology department?
A We use shortness of breath, pleuritic chest pain. It would depend upon the context of the individual circumstance of the patient.
Q We are talking now in terms of PE.
A If that's the consideration, if that's the reason the V/Q is ordered. And that's mostly the reason for doing this test, correct.
Q Right, but I am saying, when you order it because of a concern about a PE, what is the most pertinent clinical information you would provide to radiology?
MR. GROEDEL: Objection, asked and answered.
Go ahead.
A Some basic history about the patient.
Q I know, but what would that history include?
A Shortness of breath, symptoms.
Q What kind of symptoms?
A Shortness of breath, just like I said.
Q Anything else?
A Pleuritic chest pain, if it were present. Some other information about the patient. But typically just the immediate presenting complaint.
Q This patient, Nola Hasto, didn't have any pleuritic chest pain.

A That's correct.
Q The only chest pain she had was chest pain associated with her unstable angina; is that correct?
MR. GROEDEL: Objection.
You may answer.
A We don't know exactly what the cause of her chest pain was. We postulated initially that it was a result of her previous cardiac disease. But then the cardiac catheterization did not show significant progression of her disease to the point of intervention being necessary, so then other causes for the chest pain and her other complaints needed to be looked at.
Q But isn't it true that in the case of Nola Hasto, the complaints of chest pain pretty much resolved after the catheterization of March 7th?
MR. GROEDEL: Objection to pretty much resolved.
You may answer.
A I would need to review the records to answer that question.
Q Any particular part of the record you need to review?
A Well, I do not recall exactly when the cath was done.
Q March 7th.

A On the 12th, in this note here, there is a comment from Dr. Boyle that anterior chest wall is sore to cough and deep inspiration.
Q Does that equate to chest pain?
A I think so, yes.
Q What other evidence do you have after the 7th of chest pain?
A Other than what I just referred to?
Q Other than what you just read.
I am talking, Doctor, up to the date of the 13th. You are beyond that, I believe.
A So just -- no, I don't see any further reference of chest pain in the record.
MR. GROEDEL: Just so the record is clear, you have looked at the progress notes, you haven't looked at any nursing notes, correct?
THE WITNESS: Correct.
BY MR. NORTON:
Q Now, in terms of the nursing notes -- let's see here, Doctor, I am handing you a document that's marked Plaintiffs' Exhibit 10, which is the entire nursing note from March 13th. That was the day after, I think, you ordered the V/Q scan.
And on the narrative of that note, which is on Bates numbered Page 141, the top of the page, the 9:00

o'clock nursing note, patient denies complaint of chest pain or shortness of breath; do you see that?
A Yes, I do.
Q So the nurses notes, as of the 13th, were not reflecting chest pain or shortness of breath; is that correct?
A On this particular note in question, yes. It is just one moment in time.
Q Okay.
And do you have the nurses notes for the 12th in front of you?
A No, I don't. I can look for them.
Q Do you have them, Doctor?
A I am looking for them.
I do.
Q I wasn't able to find any note in the nursing -- any of the nursing notes on the 12th where the patient was complaining of shortness of breath or chest pain, and of course that may be because I couldn't read the writing. Maybe you can review it and tell me if you find any?
MR. GROEDEL: Objection.
John, I want you to know that I am allowing this questioning only to a limited degree, because it goes beyond the extent of the parameters of your letter set forth to me on March 11 about what you

were going to question Dr. Whelan about.
This is Dr. Whelan's second deposition. You had ample opportunity to ask him these questions at the first deposition. For whatever reason, you didn't do so.
I am going to give you some leeway, but I am going to shut it down pretty soon.
Let the record show that the doctor is reviewing some nursing notes. Whether they are the complete nursing notes from March 12th remains to be seen.
MR. NORTON: And the notes he is reviewing are counsel's notes.
MR. GROEDEL: No, they are not counsel's notes. They are notes from the Cleveland Clinic chart, a copy of it.
MR. NORTON: Provided by you, Marc, to the witness. Otherwise, I will provide my copy of the notes and represent that they are the complete nursing notes for the 12th.
A I can just tell you, Mr. Norton, on the notes you have provided me, I see no evidence of chest pain being recorded.
Q Thank you.
Now, with reference to Plaintiffs' Exhibit 1, the

V/Q scan, did you provide the clinical history that is reflected in the note?
A Probably not.
Q Who would have?
A Either one of the residents or one of the interns.
Q Now, did you speak with Dr. Neumann about this particular V/Q scan?
A I do not recall doing so, but there is clearly a note here stating that he discussed the case with me.
Q In the V/Q scan itself?
A Correct.
Q But you don't have any specific recall of having spoken with him?
A I cannot remember at this point. It is almost -- I believe it is more than four years ago.
Q Do you know whether you went to the radiology department to review the films?
A I do not recall.
Q As a pulmonary specialist, do you engage sometimes in a risk/benefit analysis when considering a treatment to be given to a patient?
A Yes.
Q And where the treatment itself has some potential risk of harm, are you concerned that the risk of harm to the patient from the treatment should be less than the

risk of harm to the patient from non-treatment?
A Risk/benefit analysis is always considered when giving most therapies.
Q So the risk of non-treatment would have to be greater than the risk of the treatment?
A Correct.
Q And similarly where the treatment presents some risk, would you want to have an appropriate confidence level in the diagnosis for which the treatment is being ordered?
A One would have to think hard about it, yes.
Q By think hard, do you mean that he would want to have a fairly confident level or -- a fairly high level of confidence in your diagnosis?
A One would have to have a reasonable level of confidence. I think what we are discussing here is relative, sir, so it is hard to be precise.
Q A reasonable level of confidence?
A Yes.
Q Would your personal review of the V/Q scans have enabled you, as a pulmonary specialist, to improve your level of confidence in the diagnosis of pulmonary embolism?
A I don't think so.
Q You don't think so?

A No.
Q Because why?
A Because a properly trained nuclear medicine radiologist would definitely be in a better position to interpret a V/Q scan than I would.
Q Would it be fair to say that in this case that you relied on Dr. Neumann's interpretation of the V/Q scan in reaching the conclusion that Nola Hasto would benefit from anticoagulant therapy, specifically a Heparin IV bolus followed by IV infusions?
A His reading of the V/Q scan was an important determinant in making that decision, yes.
Q In fact, if the scan had been read as low probability, rather than high probability, would you have ordered an IV Heparin bolus of 6,000 units?
MR. GROEDEL: Objection.
You may answer.
A Most likely not.
Q You saw Nola Hasto every day from March 2nd through, I think, the 15th; is that correct?
A Let me review my notes.
I cannot absolutely tell you I saw this lady on the 2nd, but I definitely started seeing her on the 3rd. She may have come in later in the day.
Q From the 3rd on, then, through the 15th?

A Let me just verify the other date.
Yes.
Q And you knew that she had fallen?
A I was aware of that, yes.
Q And you knew she had a hematoma on her left parietal area?
A She had a hematoma on her head, yes.
Q And I am handing you -- you have these -- Plaintiffs' Exhibit 3, that's a photo of the face of Nola Hasto taken at the coroner's autopsy. Do you see the hematoma on the forehead?
A Yes, I do.
Q Do you remember seeing that while you were taking care of her?
A I remember seeing a hematoma, but obviously we are talking a number of days later, so I can't compare it.
Q I am handing you what has been marked as coroner's photograph -- Exhibit Number 5, rather, Plaintiffs' Exhibit Number 5, the coroner's photograph of Nola Hasto's left breast and torso, trunk. Do you see the ecchymotic areas shown?
A Yes, I do.
Q Do you recall that she had ecchymosis on her body?
A I recall reading it in Dr. Boyle's notes, yes. I do not remember specifically remembering myself that she

had an ecchymosis.
Q And similarly, Plaintiffs' Exhibit 5, a coroner's photograph of Nola Hasto showing, again, the posterolateral aspect of her trunk on the left. Do you recall seeing that, or you just recall reading about it?
A I do not recall seeing it. I need to refer to the notes to see if there is any mention of it in the notes.
Q By notes, you mean nursing notes or doctors notes?
A Doctors notes.
Q If it was in the nursing notes, would you have noted it? I mean, is it something a treating physician becomes aware of when the nurses chart a condition of the patient?
A Generally if there is a concern from the nurses, they will verbally inform me. But I do not read the nursing notes always.
Q Did you ever consider infection as a cause of any of this woman's problems when you were taking care of her?
A It was lower down the possibility. We were mostly concerned with what we thought was her pulmonary embolus at the time, and then her need for blood transfusion, and then there was a possibility of a GI bleed towards the end of her hospital stay.
Q Was that suggesting infection to you, her GI bleed?
A No.

Q There is an item in the lab work, handing you what's been marked for identification as Plaintiffs' Exhibit 8, which is the laboratory work for Nola Hasto, I am interested in this glucose reading of 388 [sic] on March 10th. What do you attribute that to? I mean, it is a big increase in her glucose.
A You mean 338 on March 10th?
Q Yes, 338, right.
A I wouldn't call it a very big increase from the previous result which was 265, but it is an increase, I agree.
Q What would you attribute that to?
A Poor glycemic control.
Q Due to what?
A There are many, many possible causes, dietary noncompliance. I believe she had been getting steroids at some point, but I do not recall when they were started.
Q And similarly, on the 10th, there is an increase in her BUN to 53. What do you attribute that to?
A I do know that we were concerned that she had some dye from the cardiac catheterization, and that is mentioned in Dr. Boyle's note. There are many potential explanations for this, renal problems, catabolic state. There are a number of things to consider here.
Q Now, I am not sure if you answered this question, I

got sort of lost earlier, so I am going to repeat it. But between, say, the 10th and the 15th, which was your last day, I guess, were you ever concerned about infection in this patient?
MR. GROEDEL: Objection, asked and answered. Go ahead.
A Possibility, but it was lower down my list.
Q I have a question about the pulmonary function test, which is Plaintiffs' Exhibit 17. But before I ask the question, Doctor, I want to ask you, do you recall that Dr. Boyle -- who was a resident working under your supervision, I understand?
A Correct.
Q She had a note, I think in her March 12th clinical sheet, which states that questionable -- it is a question mark, I read that as questionable -- PFTs recorded. Were you aware of that?
A Not right now, I am not, but I am going to review the note.
Q I am not sure what date it is.
A I see the note to which you refer from March 12th, yes.
Q Do you have any idea what she meant by that?
A You would have to ask Dr. Boyle directly, but one of the concerns is whether she is talking about peak

expiratory flow rates, which are also known as peak flows.
Q As what?
A Flows.
Q Flows.
Now, you reviewed this pulmonary function test?
A Correct.
Q And in your note, I believe it was the 11th or 12th, your note of the 11th or 12th, you make a reference to your review of the pulmonary function test.
I think it is your note of the 11th, Doctor. As a matter of fact, I have got it right here, it is Plaintiffs' Exhibit 16.
A Okay.
Q You refer to the results of the test as relatively normal.
A Correct.
Q What did you mean by qualifying the word normal with the word relatively?
A No test -- to be totally normal, you would have to hit the hundred percent of the predicted of everything, but there are some parameters for interpreting pulmonary function tests. And by my way of looking, this is within the variabilities of the test, they seem to be within the normal range, as best as I could tell. And this is corroborated by the report that I see in front of me.

Q Yes.
The report states that the spirograms were normal, but there is a qualifying comment by the interpreter.
A That's correct.
Q And it is that qualifying comment that is of interest to me.
A Okay.
Q And I believe what it says is that the possibility of air flow obstruction could not be excluded because the expiratory time exceeded six seconds; do you see that?
A It did not exceed, it was less.
Q It was less than six seconds.
A Yes, I do see that.
Q And so I take it from that, that the validity -- diagnostic validity of the pulmonary function test depends to some extent on an element of time?
A It depends on how long the patient exhales, that's correct.
Q Does the patient have to exhale all of the patient's lung capacity within a certain time frame in order to get a reasonably accurate result?
A Ideally, it should be for six seconds. But ideally, we are talking about.
Q And if it is less than six seconds, that would -- that limited duration or that lesser duration of exhale

time would suggest that it is being influenced by other factors in the patient?
A It is hard to say what's influencing the patient.
Q But there would be some factors that --
A Either patient cooperation -- I really would have to speculate here, Mr. Norton.
Q Right.
A All I can tell you is, it is ideal for people to exhale for at least six seconds during this test.
Q But the act of exhaling, in terms of patient cooperation, requires the ability to properly flex the chest muscles?
A I mean, exhaling is a complicated activity, and the chest muscles are a part of the process.
Q And there are conditions of the lung which would -- the lung itself that would influence the duration of the exhale time?
A It would make it more difficult to exhale, yes. But I think you are asking me to be very general here, so it is very difficult for me to do that.
Q An important element of the pulmonary function test is the ratio between forced expiratory ventilation and forced vital capacity, right?
A Between FEV1 and FVC, that's correct.
Q And when the ratio between those two numbers is

decreased, that would indicate airway obstruction?
A It is suggestive of it, yes.
Q And that's often expressed as a percentage, correct?
A The ratio?
Q The ratio.
A Yes, it is.
Q And what was her percentage?
A According to what I read here -- let me just double check these numbers -- 86 percent, 86.5 percent.
Q And how did you regard that?
A It is a little elevated, as you can see by the percentage here to the right of it, which says 118 percent.
Q 118 is the predicted value?
A No, it is the percentage above -- in other words, it is 118 -- the 86.5 percent calculated for Mrs. Hasto, based on her body size and a number of other factors, the predicted was 73.5, as far as I can tell here.
Q Okay.
So the ratio itself, on this report, would not suggest obstruction?
A Correct.
Q But that ratio, because it is time dependent, is also affected by a limited expiratory time, correct?

A Yes.
Q Have you ever seen the V/Q scans in this case?
A I do not recall seeing them.
Q Handing you Plaintiffs' Exhibits 2 and 3 marked in Dr. Neumann's deposition, Doctor, a person with a pulmonary embolism would be classified as somebody having a vascular occlusive state, right?
A Yes.
Q And in the vascular occlusive state, ventilation is preserved in the region of pulmonary vascular abnormality; is that correct?
A That's not always true. There may be other confounding factors. But it is true that the pulmonary embolus predominantly affects the vascular system, that's correct.
Q And in your review of Plaintiffs' Exhibits 2 and 3, do you see any impairment --
MR. GROEDEL: Objection.
I am sorry, go ahead.
A I have to tell you --
MR. GROEDEL: Hold on, let him finish his question.
Q -- of the vascular system of the lung?
MR. GROEDEL: Objection. This doctor is not an expert in interpreting these films.

A I completely concur with Mr. Groedel, I have only had limited training in interpretation of V/Q scans. I can tell you the general principles, but I would never, ever interpret a V/Q scan without a radiologist.
Q I understand that.
MR. GROEDEL: And that's why he is not going to give you any testimony regarding the V/Q scan.
MR. NORTON: Marc, in all fairness, he studies them in pulmonary medicine, he reviews them.
MR. GROEDEL: No, he doesn't.
A I would like to --
Q Let me say, I only covered that aspect of your training in terms of chest x-rays.
A Mr. Norton, if I read a legal textbook, would that make me an attorney?
Q No, but it would give you some good legal knowledge.
A That's the answer to the question.
Q So I am not asking you to give me any answers based on your expertise as a radiologist, all right?
MR. GROEDEL: He is not a radiologist, we agree with that. And because he is not a radiologist, he is not going to testify about what these films show.
MR. NORTON: I am not asking him to testify as

a radiologist.
MR. GROEDEL: You are asking him to testify as to what these films show. And because he is not a radiologist, he is not going to testify about what those films show.
Q (Continuing) Let me go back, then.
Doctor, in pulmonary medicine, is V/Q scan an important diagnostic tool in the management of people with pulmonary disease?
A Yes, it is.
Q Do you, in pulmonary medicine, familiarize yourself with V/Q scans?
A The general principles of them, yes.
Q And did you review V/Q scans during the period of your training in pulmonary medicine?
MR. GROEDEL: Does he interpret them?
MR. NORTON: Yes, review was the word.
A I have had occasions when I have reviewed a V/Q scan with a radiologist, yes.
Q And do you also review them yourself?
A Independently?
Q Independently.
A Generally not.
Q Can you tell me, just as a general wide range of numbers, whatever comes to your mind, how many times in

the course of your pulmonary critical care Fellowship you had occasion to review a V/Q scan with a radiologist?
A Very approximately, sir, about 20 times, and that's very approximately.
Q That's all, in three years?
A I am guessing. I am just giving you a figure. It could be more, it could be less.
Q That's fine.
So basically, with the exception of this limited review, any knowledge you have of the diagnostic -- or the radiological manifestations of pulmonary disease is from textbooks?
A And talking to attendings who provide information, yes.
Q With the understanding that you are neither a radiologist nor apparently a pulmonary specialist with a great deal of expertise in V/Q scans, but looking at it just as an average doctor, do you see much difference between the perfusion scan and the lung -- the ventilation scan in Plaintiffs' Exhibits 2 and 3?
MR. GROEDEL: Objection. He is not going to answer that question.
A I cannot answer that question.
Q You cannot?
A No.

Q It is --
A Because I --
Q Wait. It is beyond your competence to answer that question; is that correct?
A To compare these two films legally and accurately, yes.
Q No, that's not what I asked. I am asking you whether it is beyond your competence to express any opinion whatsoever as to whether or not Plaintiffs' Exhibits 2 and 3 show any difference between perfusion and ventilation?
MR. GROEDEL: Objection, asked and answered. Go ahead.
A When expressing an opinion, Mr. Norton, one has to rely carefully on one's own experience and ability to do so. I do not feel that I am expert enough or familiar enough with V/Q scans to offer you an opinion, sir.
Q That's perfectly all right with me. That's all I wanted to know.
Now, the person with emphysema or asthma, which are the two basic component parts of COPD, is considered to be in the obstructive occlusive state, correct?
A Well, let me -- COPD implies a fixed obstructive disorder, whereas asthma implies an intermittent obstructive disorder.

Q What does emphysema imply?
A Generally a fixed obstructive disorder.
Q So the difference between emphysema and asthma is one is fixed and the other is intermittent?
A That's one of the differences.
Q One of the differences.
But depending on what point in time you are testing for asthma, you would have -- you would classify that person as in an obstructive state?
A You mean if the PFT showed an obstruction --
Q No, the V/Q.
A V/Q is not very specific for diagnosis.
Q What about PFT?
A PFTs are more specific for diagnosing an obstructive state.
Q In your experience as a pulmonary specialist, can you tell me whether it is a common occurrence for somebody who is in an anticoagulated state to develop a PE?
A It can occur, but it is generally felt to be not very common.
Q And a pulmonary embolus, as I understand it, is a blockage of pulmonary vasculature?
A Pulmonary artery or one of its branches, yes.
Q And the blocking mechanism is a clot of some sort?
A Yes.

Q It would be a blood clot?
A Typically a blood clot, yes.
Q And this clot is made up of fibrin?
A Fibrin, possibly platelets, but generally it is a clot.
Q And in your experience as a pulmonary specialist, what is the likelihood of a person who has been on aspirin therapy for a considerable period of time, in this case, over ten days, developing a pulmonary embolus?
A It is generally taught that aspirin is not a good prophylactic drug against pulmonary embolism, so I cannot give you an exact figure. But I do not think aspirin prevents significantly, if one is at risk from pulmonary embolus, from preventing its development.
Q While not preventing significantly, it tends to decrease the likelihood?
MR. GROEDEL: Objection.
You may answer. I think you answered it already.
A I can tell you, Mr. Norton, aspirin is not considered to be a good prophylactic drug.
Q I understand that. And aspirin operates against what, antithrombin or something?
A It works against platelets.
Q Right.

And it inhibits thrombin?
A I do not know that specifically.
Q And thrombin is the element that develops fibrin?
A It is involved in it, yes. But this is not an area where I am an expert, I have to admit.
MR. NORTON: Doctor, thank you very much. I don't have any further questions.
MR. WHITESELL: I have nothing.
MR. NORTON: Signature will not be waived, correct?
MR. GROEDEL: Right.
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(DEPOSITION CONCLUDED)
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PATRICK WHELAN, M.B.

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named PATRICK WHELAN, M.B. was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 15th day of April, 2004.

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Ivy J. Gantverg, Notary Public
in and for the State of Ohio,
Registered Professional Reporter.
My Commission Expires November 5, 2008.