IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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MICHELLE KASCHAK, et al.,
Plaintiffs,
vs. Case No.
UHHS BEDFORD MEDICAL
CENTER, et al., 359360
Defendants.

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DEPOSITION OF AMIR DAWOUD, M.D.
Wednesday, November 15, 2000

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Deposition of AMIR DAWOUD, M.D., a Witness herein, called by the Plaintiffs for examination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice of counsel, at the offices of Bedford Medical Center, 44 Blaine Avenue, Cleveland, Ohio, on the day and date set forth above, at 10:20 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiff:

Becker & Mishkind Co., L.P.A., by
HOWARD MISHKIND, ESQ.
Suite 660 Skylight Office Tower
1660 W. 2nd Street
Cleveland, Ohio 44113
(216) 241-2600

On behalf of the Defendant Bedford UHHS:

Moscarino & Treu, by
KEVIN NORCHI, ESQ.
Suite 630 Hanna Building
1422 Euclid Avenue
Cleveland, Ohio 44115
(216) 621-1000

AMIR DAWOUD, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF AMIR DAWOUD, M.D.

BY MR. MISHKIND:

Q. Doctor, good morning.

A. Good morning.

Q. Would you please state your name for the record.

A. Amir Dawoud.

Q. As I understand it, you are an anesthesiologist; true?

A. Yes, I am.

Q. Since you and I have never met before, what I'd like to have you do initially is to just tell me, first, by whom you are employed.

A. I am employed by Kamal Barsoum, Kamal Barsoum, M.D., Inc. It's a private group of anesthesiologists.

Q. Could you spell the last name.

A. Barsoum, B-A-R-S-0-U-M, and for that incident, it's -- I'm employed by the Southeast House Physicians as an independent contractor

with them.

Q. Let me just try to clarify a couple of things that I understand you to have just told me.

You are an anesthesiologist employed by an anesthesiology group; true?

A. That's right.

Q. And the incident that you referenced was the incident involving the baby, and you were working as an independent contractor through Southeast House Physicians?

A. That's right.

Q. And they provided coverage in terms of house officers or house physicians at Bedford Medical Center?

A. At night, yes, and the weekends.

Q. Do you still work from time to time through Southeast House Physicians?

A. Occasionally, yes.

Q. Just to give me an idea, how do you divide up your time in terms of who your employer is?

A. Oh, it's like 80 to 90 percent in anesthesia; like maybe ten percent or less into the house physician.

Q. When you are working as an anesthesiologist, are you working through M.L. Barsoum?

A. Kamal, with a K, Kamal, K-A-M-A-L.

Q. Kamal Barsoum & Associates?

A. Barsoum.

Q. But my statement was accurate?

A. Yes.

Q. You have on today a Bedford Medical Center jacket with your name, and it says Department of Anesthesiology. Does it say anywhere on any of your signs or insignias that you are employed by this --

A. Hospital.

Q. -- employed by this anesthesiology group?

A. No.

Q. Would you agree that, based upon what you have on, it appears as if you're employed by the hospital?

MR. NORCHI: Objection. Go ahead.

A. It's a jacket, you know, supplied by the hospital, but it doesn't mean that I'm employed by the hospital.

Q. Are you an employee of Bedford Medical

Center?
A. No.
Q. Have you ever been an employee of Bedford Medical Center?
A. No.
Q. The anesthesia services that you provide, are they exclusively at Bedford Medical Center?
A. Yes.
Q. Do you have a private office?
A. No.
Q. So when you see patients, it would be here at the hospital?
A. Yes.
Q. I know that there's an office building contiguous or connected to the hospital.
A. This is outpatient, but you mean the office building for physician?
Q. Yes.
A. No, I don't have any office there.
Q. So your office is exclusively within the hospital here?
A. Yes.
Q. So any mail that you receive would be sent in care of Bedford Medical Center?

A. I have mail that comes to my house; I have mail that comes to the hospital. That's all the mail that I get.

Q. The corporation, or the group, the anesthesia group that you are employed by, do they have an office outside of the hospital?

A. There is an address at Dr. Barsoum's house. That's where that corporation would be.

Q. And where is Dr. Barsoum's house?

A. In Pepper Pike.

Q. What street?

A. I can't recall that right now.

Q. Does Dr. Barsoum also provide anesthesia services here?

A. Yes.

Q. Besides yourself and Dr. Barsoum, who else are the anesthesiologists?

A. There is Dr. Bostelman and Dr. Arslanian, and there's a Nurse Heil.

Q. When you're working for Southeast House Physicians, are there other employees of that group?

A. At that time?

Q. Yes.

A. No.

Q. How about now, are there other employees of Southeast House Physicians?

A. During the shift it's only one. You mean during the shift?

Q. No. Southeast House Physicians, is this a medical professional group?

A. Yes. It depends on, you know, the period. There's another anesthesiologist from my group that works in the group, and we contract somebody from outside, too, that comes, you know, to that group.

Q. I presume that there would be some type of document that would explain the relationship between Southeast House Physicians and Bedford Medical Center; true?

A. Right. You know, the hospital contracted with the house -- Southeast Physician for coverage. That's all. There's a contract between them.

Q. Is there an office that Southeast Physicians has, for example, that sees patients outside of the hospital?

A. No.

Q. Who is the head of Southeast Physicians?

A. Dr. Kamal Barsoum.
Q. Where are you originally from, sir?
A. Egypt.
Q. Were you educated here in the states or in Egypt?
A. I finished my medical school in Egypt, Alexandria, Egypt, and then I did training here.
Q. You're an anesthesiologist; true?
A. Yes.
Q. General anesthesiologist?
A. I do anesthesia and pain management.
Q. You're not a pediatric anesthesiologist, are you?
A. No.
Q. Tell me, in terms of your current time, how do you divide your services between that which is provided for pain management and that which is provided for general anesthesia?
A. I would say about 20 percent of my time to pain management and the rest of the time to anesthesia.
Q. When you're providing the pain management, is it through Dr. Barsoum & Associates?
A. That's right.

Q. And, again, I don't mean to belabor the issue, but someone that sees you for pain management would see you here at the hospital; true?

A. Exactly, yes.

Q. You said that you have trained, after finishing medical school in Egypt, you trained in the U.S.?

A. Yes.

Q. Where did you do your training?

A. I did, after I finished my -- I had to take my boards again here, you know, equivalent for my board, and I did training a year and-a-half in neurosurgery in Massachusetts as a fellowship, and then I did two years of general surgery in Harlem Hospital in New York, and then I did two years of anesthesia in Brookdale, Brooklyn, and came to Cleveland Clinic. I did a year and-a-half at Cleveland Clinic.

Q How long have you been affiliated with the anesthesia group that we've been referring to?

A. Since January 1995.

Q. I should have asked you this at the beginning, and I apologize: Have you ever had

your deposition taken before?

A. No.

Q. Thus far you're doing fine, but let me just caution you on a couple items just so that you and I are on the same page. If you don't understand something that I'm asking after you have heard the question completely, tell me you don't understand. I'll try to rephrase it.

A. Okay.

Q. Also, I'll wait until you're done, so please wait until I'm done as well so we don't overlap each other.

A. All right.

Q. Hopefully my questions won't be too convoluted or difficult to understand. I can rephrase it, or I'll have the court reporter read it back to you. Okay?

A. Okay.

Q. The reason I tell you this is that I intend to rely on your testimony; it's under oath, and I intend to rely on it for purposes of the preparation of this case for trial. Okay?

A. That's right.

Q. You understand that?

A. I understand.

Q. Great. You have not had your deposition taken before. Have you ever served as an expert in terms of reviewing anesthesia negligence cases?

A. No.

Q. Have you ever had the misfortune of being sued?

A. No.

Q. As I understand it, in reviewing the records, you provided the anesthesia services at the time that Megan Kaschak was born; true?

A. Yes.

Q. And then you were called at the time of the arrest?

A. Yes.

Q. I'm going to talk a little bit about the birth, and then I'm going to go to the arrest, okay, just to give you sort of a road map.

Aside from the record that you have in front of you, have you had an opportunity to review any medical literature that would be relevant to this case?

MR. NQRCHI: You mean with respect to his whole training, all the years of training, or

do you mean specific to this deposition, in preparation for the deposition and review of the medical records here?

MR. **MISHKIND:** Your latter statement.

Q. In other words, have you reviewed any medical literature in the recent past that would relate to any **of** the issues that are relevant to the Kaschak case?

A. Like -- you know, just -- no. I don't have any other, really, thing that **I** reviewed other than this. For this case, no.

Q. So you have had a chance to take a look at the baby's chart and the labor and delivery; true?

A. Yes, I did.

Q. Putting that aside, have you seen any deposition transcripts that have been taken in this case?

A. **No.**

Q. Have you seen any summaries of any depositions?

A. **No.**

Q. Have you been provided any type of verbal summary of what anyone has testified to in this case?

A. No.

MR. NORCHI: Objection, but go ahead.

A. No.

Q. Sherry Davenport was one of the nurses that was in the newborn nursery when Megan arrested, when the code was called. Do you know Sherry?

A. I cannot recall the -- you know, the names, I'm very bad with the names. I cannot recall the person right now.

Q. Are you able to recall any of the caregivers that were involved at the time that the code was called?

A. No.

Q. Dr. Abu-Shaweesh was the neonatologist; true?

A. I cannot recall anybody.

Q. Do you know Dr. Abu-Shaweesh?

A. No.

Q. Dr. Miller is a neonatologist that came over from Rainbow -- or is on the staff at --

A. I could know them, but I don't know them personally, and I don't recall them that, you know, vividly from that incident. I could

have talked to them, contacted them, but I don't recall their names and I don't know them personally that I can recall them right now.

Q. Let me just again caution you, I may not have been framing the question very artfully, but what you did was you started answering before I finished, and you may have in fact given me an answer to something I wasn't asking. So Mr. Norchi doesn't want you to answer before I'm done and either do I, okay?

A. Okay.

Q. I'm not criticizing; I just want to be fair to you in terms of you understanding what I'm asking.

I take it from what you said that, while you may know certain of these people that were involved, as you sit here right now, you're not able to recall any specific conversations that you may have had with any of the nurses or the caregivers; is that true?

A. That's true.

Q. Let's talk first about the birth of the baby. Take a look at the mom's records, if you would. Tell me what type of anesthesia was provided during the delivery.

A. I gave an epidural. This was for labor.

Q. And you were present then at the time that Megan was delivered?

A. Yes. But there was a neonatologist present, too. So I didn't take care of the baby at that time.

Q. That would have been Dr. Abu-Shaweesh, at least according to the record?

A. Yes.

Q. Let me further try to understand what you mentioned to me a moment ago. Do you know a doctor, a neonatologist, by the name of Dr. Abu-Shaweesh?

A. I don't know him personally.

MR. NORCHI: He wants to know if you're familiar with the name. Do you know the name Abu-Shaweesh?

A. Like -- you know, I know somebody -- that name would mean neonatologist?

Q. Yes.

A. No, I cannot recall that.

Q. Fair enough. Do you recall being present at the time that the baby was born?

A. Yes.

Q. You recall it independently or you just recall it because it reflects --

A. Because of the circumstance.

Q. I take it you don't recall giving the epidural and being involved in some aspect of the delivery process; true?

A. I recall giving the epidural, yes.

Q. You do recall that?

A. Yes.

Q. And what is it about about giving the epidural that you recall?

A. I recall that there's -- you know, there was a -- this lady that's coming from, I think, Columbus, she had, you know, a couple hours' drive and her membranes were ruptured, and I gave her an epidural. That's something that I can recall about that case.

Q. You're able to picture the mom in your mind's eye?

A. Vaguely, yes.

Q. Do you recall having any conversations with mom at or around the time that the epidural was given?

A. I don't recall exactly what the conversation was, but, you know, I must have

talked to her, yes.

Q. Can you tell me, in generalities, what you recall talking with her about, if you have a recollection of any conversation with her?

A. No, I don't recall.

Q. You said that you must have, because before you give an epidural, you're going to talk with the patient; true?

A. That's true.

Q. You have a certain routine?

A. Yes.

Q. You don't have any reason to believe that you didn't follow that routine, do you?

A. No.

Q. Aside from your custom and practice of following a certain routine and the fact that the record shows that you gave an epidural, do you have any other recollection of being involved at the time that the baby was delivered beyond what you have told me?

A. No.

Q. What was the baby's condition at the time of birth, according to the record, or according to your recollection, whatever you need to rely on?

MR. NORCHI: Object to the question, but go ahead. The record speaks for itself. And if he has no recollection --

A. I cannot recall, but if I would read the notes, I will tell you, but it's nothing -- I can't give you an expert opinion about that, because I will read you the same record what's in there.

Q. When you say you can't give me an expert's opinion, you don't know whether the baby's condition, based upon the Apgars and based upon the initial labs that were drawn, whether or not the baby was in any extremes or whether the baby was --

A. Yes. From the record, it looks like the baby was okay.

Q. Now, once the baby was delivered, was the neonatologist in charge of the care, according to what you understood?

MR. NORCHI: Care of the baby?

A. The care of the baby.

Q. Once the baby was born, the neonatologist took over the primary responsibility for the care of the baby?

A. Exactly, yes.

Q. Do you have any recollection of assessing mom immediately after the delivery in terms of what her condition was?

A. Yes.

Q. Tell me about that, please.

A. Her blood pressure was 130 over 70; pulse was 80; respirations 16.

Q. And are those normal?

A. Normal.

Q. Do you have an independent recollection of talking with mom after the delivery, before we get to the event that brought you back into the picture?

A. No.

Q. Fair enough. Now, this delivery was about what time in the evening on the 24th?

A. 1910. That would be 7:10.

Q. This is January 24th; true?

A. Yes.

Q. Were you working under the umbrella of Southeast Physicians or were you working under the umbrella Dr. Barsoum?

A. When we -- it's under the umbrella of the house, house physician. The house physician job is to provide anesthesia for the epidural.

Q. Is this something, again, that would be specified in some type of policy or procedure from the hospital?

A. I cannot say that, what is exactly, you know, but --

MR. NORCHI: Do you know? He's asking if you know there's a particular document that specifies what the relationships are between these entities that we're talking about. Is there a document?

Q. Actually, more specifically, I'm talking about in terms of the house officer providing the anesthesia.

A. Yes.

Q. Would there be some type of a document or policy or procedure that would specify who provides what?

A. Yes.

Q. You provided the anesthesia services, and then you would have signed the anesthesia record at the time of the delivery; true?

A. Yes.

Q. And your name is on there and it's timed; true?

A. Yes.

Q. After that, what likely would you have done at 7:00 p.m. or so on the 24th, or what do you remember doing?

A. I don't remember doing particular things, but I have to take good care of the, you know, any house problems like, you know, any patient that's in trouble, like I go and see him, or they need any help of any patient, I would help them.

Q. Any recollection of what you did that evening in terms of other patients or what other emergencies might have existed?

A. No.

Q. Do you know how many other deliveries were being attended to late afternoon, early evening, on the 24th?

A. I cannot recall right now.

Q. Did you, by chance, maintain any type of private notes on any paper that would not otherwise be reflected in the medical charts, sir?

A. No, I don't.

Q. The next time that you knew anything about mom or the baby was when you responded to an overhead call?

A. Yes.

MR. MISHKIND: Would you please mark this as Plaintiffs' Exhibit 1.

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(Thereupon, PLAINTIFFS' Deposition Exhibit 1 was mark'd for purposes of identification.)

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Q. In front of you, doctor, is a page from the hospital record which the court reporter has been so kind to put an exhibit sticker on it. I think it says Plaintiffs' Exhibit 1; true?

A. Yes.

Q. Is that a page from the hospital record that had some handwriting by you?

A. Yes.

Q. As it relates to the code, is there anything else that you have authored or written in the hospital record aside from that page?

A. No.

MR. MISHKIND: I'm going to take Exhibit 1 back and, Mr. Norchi, if you would be so kind as to let him look at the original perhaps.

MR. NORCHI: Okay.

Q. Doctor, before we talk specifically

about this, I want to ask you a couple other questions, so don't focus in on the exhibit.

Have you seen the autopsy on the baby?

A. No.

Q. Have you seen any of the records from Rainbow Babies and Children's Hospital?

A. No.

Q. Have you any information from any sources other than Mr. Norchi, who, my guess, would be your attorney?

MR. NORCHI: I am. He responded to the code under these circumstances, and we are including him, we are embracing Dr. Dawoud, if you will. He did respond to an emergency room.

Q. Other than conversations you had then with your attorney, have you had any conversations with any caregivers as it relates to the events that ensued after the code during the transfer to Rainbow or once the baby was transferred to Rainbow?

A. No.

Q. The orders that were written in the chart, you have seen those; true?

A. I have now.

Q. Well, you have seen the orders. There aren't a lot of orders. You have seen the orders that were written after the delivery of the baby?

A. I saw them when I reviewed it now, but at that time when I went to see the patient, I didn't, you know.

Q. I'm not suggesting that you would have looked at the orders before going to see the patient, but the specific order I'm referencing, I think you had just turned to an 8:10 p.m. order that starts with Ampicillin. Do you see that at the top there?

A. Yes, I do.

Q. Then it continues on. That's not an order that you wrote, is it?

A. No.

Q. I believe that's an order by Dr. Abu-Shaweesh. Are you able to confirm that for me?

A. Confirm his signature?

Q. Well, let's start with that.

A. No, I cannot confirm his signature.

Q. Does this appear to be an order by the neonatologist, regardless of who it is?

A. From the kind of order, it could be a neonatologist, yes.

Q. That order indicates that the child, the baby, Megan, was to be on continuous pulse oximetry and CP, cardiopulmonary, monitors. Do you see that?

A. Yes.

Q. Do you know why such an order was given by Dr. Abu-Shaweesh?

A. No, I don't.

Q. Do you know whether Megan had pulse oximetry connected to her at any time during the late evening or early morning hours prior to your arrival on the scene?

A. I cannot comment on that.

Q. Can you tell me whether Megan was connected to pulse oximetry or cardiopulmonary monitors when you arrived?

A. At that time, they were resuscitating the baby and they were checking the baby, but I do not recall exactly what was on the baby.

Q. So as to the clinical indications for cardiopulmonary monitoring, you're not able to tell me what those were; is that true, or do you know?

A. I cannot understand the question.
Q. Do you know what the clinical indications were for having the baby on cardiopulmonary monitors?
A. I don't know. I don't know why he requested that.
Q. Do you know the clinical indications for why continuous pulse oximetry overnight was part of the order by Dr. Abu-Shaweesh?
A. No.
Q. Fair enough. Again, if you have a basis, because of your training and experience and involvement, tell me. If you don't, I'm going to accept your answer.
A. I don't know exactly for this particular patient why he requested a pulse oximetry, but as a general, you know, when you request somebody to be on pulse oximeter, because if there's any difficulty in respiration, the baby is not, you know, delivering well and his condition is not stable, so you need a monitor to see that.
Q. I take it from what you just said that cardiopulmonary monitoring, along with pulse oximetry, is of value in arriving at early

recognition of an apneic event; true?

A. Not for just apneic event, just for the condition of the baby.

Q. And, certainly, if the baby stops breathing and is connected to cardiopulmonary monitoring or pulse oximetry, that will provide valuable information in terms of early recognition; true?

A. It can.

Q. Also, if the child becomes bradycardic and is properly connected to cardiopulmonary monitoring and pulse oximetry, that can also provide valuable information for early intervention; true?

A. It can.

Q. The type of cardiopulmonary monitors that are used at this hospital or were used back in 1997, can you just describe for me, since I wasn't there and you have seen these type of monitors used, there are multiple leads that are connected?

A. Yes, they are.

Q. Can you sort of explain to me --

A. Usually the EKG is about three leads connected to the chest, one on the right arm,

left arm and the leg or, you know, proximate to the one on the left leg. The pulse oximeter is a cord that has attachment to a finger or a toe, and there is a blood pressure cuff that usually has a tube that goes to the machine.

Q. And then there's certain alarms or certain parameters that are set on the machines; true?

A. Yes.

Q. And whose responsibility is it, as you understand it, to set the parameters for the machines?

A. The nurses usually do that.

Q. And if the respirations or the heart rate or the blood pressure falls above or below the parameters that are set, what type of indication is there, if any, from the monitors?

A. I cannot understand that.

Q. Sure. If the child's condition, by way of respirations, pulse, blood pressure, falls above or below the parameters that are set on the machines, what happens?

A. It alarms.

Q. And what's the purpose of the alarms?

A. To indicate that this limit is not met

or is exceeded or below that.

Q. Whose responsibility is it to check to make sure that the alarms are, and the monitors, for that matter, the alarms and the monitors themselves are in proper operation?

A. Usually the nurses do that.

Q. If Megan was on the CP monitor with pulse oximetry at the time that she arrested, what should have happened by way of the alarms?

A. The alarm would have gone off.

Q. To your knowledge, from anything that you have learned other than conversations with Mr. Norchi, do you have any way to tell me that any alarm sounded at the time that Megan arrested?

A. I cannot tell.

Q. Let me flip that question over and ask you whether anyone told you, any of the caregivers told you, that the baby was in fact connected to the cardiopulmonary monitor and the pulse oximetry at the time that she arrested?

A. I cannot recall that, no.

Q. If the baby stops breathing and is on the cardiopulmonary monitor with the pulse oximetry, in 1997, do you know whether the

equipment at Bedford were sensitive enough to be able to recognize central obstructive or mixed apneas when they occur?

MR. NORCHI: In January of 1997. Go ahead. If you recall, that's fine.

A. The pulse oximeter would not differentiate between central obstructive or anything. It would indicate if the oxygen level in the blood is at that level or lower than that level, and will alarm if it goes below a certain level.

Q. If a baby stops breathing, what, from a hemodynamic standpoint, would you expect to see relative to the pulse oximeter?

A. It will -- the pulse oximeter will drop, the reading is going to drop, and the light will alarm.

Q. In a neonate that is on pulse oximetry, what's the low level for alarm purposes?

A. Around 85.

Q. And is the standard of care essentially, once the baby's pulse oximetry alarms indicating the oxygen saturation has fallen below the prescribed limit, to assess and

manage the airway?

A. Yes.

Q. And to provide appropriate ventilation?

A. Yes.

Q. And to provide appropriate treatment to manage circulation?

A. Yes.

Q. Essentially, the ABC's of cardiopulmonary resuscitation; true?

A. Yes.

Q. Failing to do that would be below accepted standards of care; true?

A. Yes.

Q. Believe it or not, I am going to eventually ask you about your note. I promise it will be in a couple more minutes, okay.

Megan sustained severe hypoxic injury to her brain; true?

A. I cannot comment on that.

Q. According to the record and according to the information that I have, she did sustain severe hypoxic injury to her brain. I'm going to ask you, for purposes of the next couple of questions, to assume that to be true. If I'm

wrong, then I'll fall flat on my face based upon the hypothetical, okay?

A. Okay.

Q. As an anesthesiologist, in a situation where a baby stops breathing, can you explain to me under what circumstances, assuming there is prompt recognition of the cessation of breathing and appropriate ABC's of resuscitation provided, under what circumstances would that child still sustain severe hypoxic injury to the brain?

MR. NORCHI: Objection.

A. I cannot -- it's too many things. Let me -- I cannot understand the whole thing. You have a lot of things coming together.

MR. NORCHI: Plus he's here as a fact witness to talk about what he did. I understand you're trying to get into -- there's an area that is permissible, certainly, in this type of deposition as to what he knew at the time when he was treating this infant, but, you know, you're getting into the realm of neonatology, causation, a whole bunch of issues where he's not adequately reviewed any records to comment on that. It's just an unfair area of inquiry.

MR. MISHKIND: You know I like to be

fair in my questions.

MR. NORCHI: That's true. I understand that.

Q. Let me just ask you a few questions on this point. I'm not trying to take you out into areas you're not prepared to testify to or perhaps qualified to based upon your training and experience. I want to try and understand, as an anesthesiologist, what has to happen in order for a baby to sustain severe hypoxic injury to the brain at the time that the baby stops breathing.

MR. NORCHI: I'm just going to object. If you don't feel qualified or prepared to talk about that, don't.

A. Yes. I cannot.

Q. Do you know how long the baby needs to go, a neonate needs to go, from the time that there is the recognition of the apnea before the baby will sustain a severe hypoxic injury without adequate or effective resuscitation?

A. No, I don't know exactly during that time.

Q. According to the records that are before you, Megan had an IV, I believe an IV infusion pump and an IV, that had been started

about 10:00 p.m. on the date of her birth. If you could just take a glance at that and see if I'm accurate.

MR. NORCHI: Can you direct him to where in the record that is? We're not quite there yet.

A. Right. I don't know. IV started on the right hand on second attempt per Dr. Abu-Shaweesh at -- that was at 2105.

Q. Can you tell, from what you have reviewed, what was infusing or what was in the IV that was started at I guess that would be 9:05?

A. Yes, it would be 9:05. It doesn't say right here. Let me see in the order. It's -- it appears that there's a hep flush. That is like a hep lock. It doesn't -- it doesn't appear to be that there's an IV solution running.

Q. In fact, according to the record, would you agree with me that there doesn't seem to be any infusion of any agents, if you will, or any --

A. Right.

Q. -- medications prior to the code and the interventions that were provided? Is that accurate?

A. From what I see right there, yeah. I cannot pick up something that quickly that -- it says there is an IV fluid running, but it could be, you know, if we have to go into details, there may be something there.

Q. What you have looked at is the progress notes and then you went to the orders?

A. Orders.

Q. And the medications?

A. And the medication chart, yes.

Q. There's nothing in there that would suggest that, other than the IV infusion pump and the IV being connected, that there was infusing; true?

A. Yes. There is antibiotic to be infused, and that's what they connected to the pump when they infused this medication, but usually there is hep lock, and that means that there's a little bit extension to where the intravenous is so they can inject the medication through.

Q. Nothing that indicated any dextrose was being provided to the baby, for example?

A. I cannot see that.

Q. As an anesthesiologist, doctor, are

you familiar with the concept or the phenomenon of apparent life-threatening events?

A. No.

Q. Have you ever heard that concept before?

A. No.

Q. Are you familiar with **SIDS** or near **SIDS?**

A. Yeah. I hear about that, but I'm not an expert about that. No, I cannot give you an expert opinion about that.

Q. ***So*** if I asked you whether apnea is the most common presenting symptom of apparent life-threatening events and cyanosis usually accompanies that event, would you be able to confirm or to refute that as being accurate?

A. **I** cannot comment on that.

Q. What happens to a newborn that does not have an airway established in a timely manner with efficient ventilation when the newborn or the neonate stops breathing? What happens to the body?

A. The heart will start slowing down and it may stop.

Q. And what happens, if the heart slows

down, to the body, to the organs?

A. It decreases the oxygen supply to the body and the organs, yes.

Q. And when there's decreased oxygen supply, is that referred to as inadequate or decreased perfusion to the organs?

A. Yes.

Q. And what happens to the organs when there's decreased oxygen or decreased perfusion?

A. They -- there's toxic material that can accumulate in the blood.

Q. And what does that result in if this process is not reversed in a timely manner?

A. It can cause damage to the organ, yes.

Q. And can lead to severe hypoxic injury to the brain?

A. It can.

Q. Do you have an opinion as to the most likely mechanism or cause of why Megan stopped breathing in this case?

A. No.

Q. Are there any etiologies or mechanisms that you considered as to potential or possible causes?

MR. NORCHI: Meaning what his guessing

was at the time?

MR. MISHKIND: Well --

MR. NORCHI: He doesn't have an opinion. Now you're asking him to guess.

Q. I'm asking you whether you have anything within a differential that may not necessarily arise to a probability, but did you consider within the differential as to what were some of the potential mechanisms or causes for this baby of roughly 12 hours of life to stop breathing?

MR. NORCHI: Objection. You can answer.

A. I don't know anything offhand that, you know, can cause that right away, but --

Q. Did you consider any etiologies as possible causes?

A. I cannot speculate on something that I don't know.

Q. That's fair enough if you don't. Based upon your knowledge and experience and training and presented with what you were presented with, did you have any thoughts as to potential etiologies within your mind?

A. No.

Q. Certainly not all babies that experience a cardiorespiratory arrest suffer a hypoxic ischemic encephalopathy; true?

A. True.

Q. Certainly if there's a delay in resuscitative efforts following a cardiorespiratory arrest, a neonate can suffer hypoxic ischemic encephalopathy; true?

A. True.

MR. NORCHI: Objection. Go ahead.

Q. Now I'm going to move back to the exhibit which I promised I would do.

Where were you when you responded to the overhead call?

A. I was in a room provided by the hospital to -- you know, accommodation room in the hospital.

Q. Where is that accommodation room located?

A. Second floor.

Q. And I take it that if you're not seeing patients in the middle of the night, there's a cot in there so that you can lay down?

A. Yes.

Q. Do you have a beeper on?

A. Yes.
Q. Were you napping at the time that you got the call?
A. I was in bed, yes.
Q. How long had you been in the accommodation room?
A. I cannot recall how long it was I was there.
Q. Can you tell me what time it was that you heard the overhead call based upon your record or any independent recollection you might have?
A. I remember quite well that I heard the overhead page and I jumped right away because it was -- I'm familiar to hear code blue in the nursery and I responded quickly.
Q. So the overhead call that you heard, I take it, woke you out of your sleep; true?
A. Yes. I was like -- yes, I heard it right away, yes.
Q. I'm not suggesting that you didn't. But before the overhead page, overhead call occurred, you were getting some rest?
A. Yes.
Q. And, in fact, you were asleep; true?

A. It may not be asleep. I may be just napping, but not completely asleep, because I heard the overhead page right away.

Q. And this is on the second floor that the accommodation room is?

A. Yes.

Q. Was there anyone else in that room with you?

A. No.

Q. The nursery is on the fourth floor?

A. Yes.

Q. Tell me, if you would, how you got from the second floor to the fourth floor to the nursery.

A. There is a corridor that I walked through, then take an elevator to the fourth floor.

Q. Being that I'm not real familiar with the layout of the hospital, I take it that you would be responding as quickly as you possibly can; true?

A. Yes.

Q. Mow long, given the circumstances of you responding from the accommodation room, would it take physically to get down the hall to the

elevator and then up to the fourth floor?
A. Maximum would be a minute and-a-half.
Q. When you arrived, were there other people present?
A. Yes.
Q. Who was present?
A. I cannot recall.
Q. Do you remember, doctor, the process of being awakened by the call and physically going down the hall to the elevator and up to the fourth floor?
A. Yes. That I remember very vividly because, as I said, it doesn't happen that often.
Q. When you arrived, there were other people present; you just don't know specifically who they were?
A. Who they were, right. But at least two nurses was there, maybe more, but I don't remember.
Q. Do you know Dr. Loret de Mola?
A. No, I don't.
Q. I believe she --
MR. NORCHI: He.
Q. I believe he is an obstetrician. Does that help at all?

A. I know there is a house doctor for Ob. He could be there.

Q. Do you know whether a house doctor by any name was there prior to your arrival?

A. He would -- he's closer to me than --

MR. NORCHI: No. He's asking for your recollection. Do you remember another physician being present at the baby's bedside at the time of your arrival.

A. I cannot recall.

Q. Now, you started to say that he would be closer than you. Where would the Ob. house officer be situated?

A. Fourth floor.

Q. But you don't have an independent recollection of whether the Ob. house officer was there before you arrived; true?

A. I cannot recall that, no.

Q. Do you have a recollection at some time during your involvement that an Ob. house officer did come on the scene?

A. I cannot recall, no.

Q. Referring to Plaintiffs' Exhibit 1, the reference to a code blue on the fourth floor at 6:30 a.m., do you see that?

A. Yes.
Q. That's in your handwriting; true?
A. Yes.
Q. Where did you get the time of 6:30 a.m.?
A. From my watch.
Q. When you heard the call, the overhead page, in the process of running or moving very quickly to the elevator, you looked at your watch?
A. Yes, or, you know -- yes. It's like when you're going through -- when you start to write your note, you remember what time was it.
Q. I'm not suggesting that you didn't look at the time, so don't infer that I'm questioning you on it. I'm just wondering, that 6:30 time frame would have been gathered by looking at your watch; true?
A. Yes.
Q When you made your note, which was made at 7:00 a.m., you reflected back at having looked at your watch at 6:30; true?
A. Yes.
O Was the time of 6:30 when you arrived in the nursery or when you recall hearing the

overhead page?

A. Right now, I cannot exactly say, you know.

Q. Would it be your custom and practice where you are recounting events that occurred, if you say that you responded to an overhead call, would you reflect the time as to when you heard the call as opposed to the time that you physically arrived at the room?

A. Usually the time that I arrived there.

Q. Now, you indicate in your note that the baby, or the patient, was unresponsive, blue in color, no respirations, and a heart rate in the 20s.

A. Yes.

Q. Is that historical, or is that what you observed when you arrived?

A. That's when I arrived, that's what the nurses told me, you know, what is the heart rate at that time, and I assessed the patient that she was blue and without breathing.

Q. And at that point you observed chest compressions being performed?

A. Yes.

Q. Are you able to tell me who it was

that was doing the chest compressions?
A. I cannot recall exactly the person.
Q. Now, you mentioned that, as well as bagging, that was unefficient or inefficient?
A. Unefficient -- inefficient. What I'm saying is, you know, the babies sometimes, they -- they have soft tissue and the bag is not efficient to deliver enough oxygen to them. So I went to the next step right away.
Q. So what you observed, in terms of what was ongoing in terms of bagging when you arrived and assessed the baby, you determined that the ventilation was inefficient?
A. No. It was the bagging was not sufficient enough, so I reverted to another method of delivering oxygen to the baby.
Q. And that was to intubate the baby?
A. Yes.
Q. And to manage the airway in that manner?
A. Right.
Q. Do you know how long the baby had been inefficiently ventilated prior to your arrival?
A. No, I don't.
Q. The standard equipment that's

maintained in the nursery for codes would include equipment for airway management?

A. Yes.

Q. And that would include an Ambu bag as well as appropriate tubing?

A. Yes.

Q. And whose responsibility is it to check the equipment to make sure that all of the equipment necessary to assess and maintain the airway is in proper condition?

A. There is a cart, there is a crash cart, that's checked by the nurses and the pharmacy, and they -- there is a routine to check that and make sure that it has enough supply in there.

Q. That's to be done on a daily basis?

A. I don't know. The nurses, you know -- the nurse supervisor and nurses take care of that.

Q. We can certainly agree that it's important to have the equipment properly functioning in order to provide rapid ventilation of a patient during the code; true?

A. Yes.

Q. Did Cheryl Davenport, who was the

nurse that was present when the code occurred, did she ever share with you the fact that the corrugated tubing fell off when she attempted to use the Ambu bag?

A. I don't recall that she shared that with me.

Q. Are you able to tell me whether anyone indicated to you, other than Mr. Norchi, that Cheryl Davenport had difficulty with the corrugated tubing and the Ambu bag?

A. No.

Q. Would you agree that if the corrugated tubing falls off of the Ambu bag, then the ventilation to the baby is going to be inefficient?

A. But that's -- you can connect the tube right away and you can ventilate. It happens all the time with anesthesia machines and anesthesia bags that we have corrugated tubes there and it happens to disconnect and we connect it back again and start ventilating right away.

Q. Did Cheryl Davenport share with you that when the tubing fell off, her hands were shaking so much that she couldn't secure the tubing to the Ambu bag?

MR. NORCHI: Objection. Asked and answered. He's already told you that he doesn't recall talking to her about any of that. But go ahead.

MR. MISHKIND: I'm now giving him a different question.

A. No, I cannot recall anything.

Q. If one is not able to secure the tubing when it falls off, would you agree that there would be inadequate ventilation to the baby at that time?

A. Yes, it would be, but this is very simple action. I don't know if that would be difficult, you know, for anybody.

Q. You would expect that a nursery, trained nursery, a newborn nursery nurse, would be able to secure the tubing and to provide appropriate resuscitation to a baby that has stopped breathing; true?

A. Yes.

Q. That's vital, is it not?

A. It is vital, yes.

Q. Was bagging being done, or when you arrived, did you attempt to do the bagging?

A. There was resuscitation going on when

I arrived. I remember the chest compression. I don't remember exactly what the bagging -- how they were doing it. But I took a bag and started ventilating the patient.

Q. And let me just make sure I verbalize what you're telling me. You remember independently chest compressions being done; true?

A. Yes.

Q. As to who was doing them, that you can't say; accurate?

A. Accurate.

Q. You remember taking the Ambu bag and attempting to ventilate the baby; true?

A. That's true.

Q. And that's when you determined that your attempt to ventilate the baby and to help the baby's breathing through the Ambu bag was inefficient?

A. Yes.

Q. Are you able to say that someone was attempting to ventilate the baby before you arrived?

A. Yes, they were.

Q. And can you tell me who that was?

A. No. I cannot remember.
Q. And as to whether or not the corrugated tubing had fallen off or whether it was connected at the time you arrived, do you have any recollection of that?
A. No.
Q. So when you arrived, there wasn't any mouth-to-mouth resuscitation being done?
A. I don't recall that at all.
Q. Certainly, if that was what was going on when you arrived, would you have noted that in your record?
A. I don't have to recall it in my record, but I would have noted it.
Q. And Cheryl Davenport never shared with you that she resorted to mouth-to-mouth resuscitation when she couldn't get the corrugated tubing back on the Ambu bag?
A. No, she didn't say, or I don't recall that she told me.
Q. Fair enough. Do you know where else the overhead call for the code blue was heard in the hospital other than where you were on the second floor?
A. Usually it would be heard along most

of the hospital. There are areas in the hospital that don't get that call, but usually it's on overhead, so -- but I don't -- I cannot say exactly which room that gets it and which room doesn't.

Q. Do you know for a fact whether the overhead call for code blue was heard on the fourth floor adjacent to the newborn nursery?

A. It's heard all over the hospital. You know, I heard it on the second floor. I don't know why wouldn't it be on the fourth floor, too.

Q. Did Cheryl Davenport share with you that she learned after the code that the alarms were not heard, that the code was not heard, on the nursery floor?

A. No, she didn't.

Q. Would you expect, if the system is working properly, that the code would be heard on the floor where the newborn nursery is located?

A. Yes.

Q. And, obviously, the sooner trained and qualified people arrive to assist, the better the baby's chances are to be appropriately resuscitated; true?

A. Yes.

Q. There's some indication in the record that after the code and after the baby was resuscitated that there was some seizure activity. Do you recall seeing any seizure activity?

A. No.

Q. Do you know what would cause seizure activity post-cardiorespiratory arrest?

A. Either could be there's --

MR. NORCHI: Don't guess. If you feel comfortable, fine, but there are other physicians who can testify about that.

Q. Go ahead. You were in the process of answering.

A. There could be a problem with the baby beforehand that could continue afterwards. You know, there's seizure activity beforehand, and that shows up.

Q. If there isn't any indication of seizure activity prior to the code, seizure activity occurs during the immediate post-code period, from an anesthesia standpoint, what do you understand to be the explanation for post-arrest seizure activity?

A. I don't know the whole causes of it,

no.

Q. Do you know some of the possible explanations for post-arrest seizure activity?

MR. NORCHI: Objection to the possibilities.

Q. In a neonate.

MR. NORCHI: Note my objection.

A. You know, it's -- it's very wide open. I cannot just summarize it in just a few things.

Q. Can you give me some of the major potential causes that you understand to be possible in a neonate that experiences a cardiorespiratory arrest and then has seizure activity, from a pathophysiological standpoint?

A. There's maldefects in the baby. It could be maldefects in the baby. It could be abnormal metabolism in the baby. There's a lot of different things that can cause seizure activities. I cannot just pinpoint --

Q. Would you agree that an ischemic encephalopathy or a deprivation of oxygen to the brain on a prolonged basis can also result in seizure activity?

A. It can. It can.

Q. Certainly you can't rule that out as being one of the causes in this case, can you?

MR. NORCHI: Objection.

Q. You can answer the question.

MR. NORCHI: If you can answer the question, you can answer the question.

Q. Can you rule out a hypoxic injury as being an explanation for --

A. It's not the sole cause for that. I mean, there's a lot of other causes that can be cause of that. I cannot say that this is the cause of it.

Q. I'm not suggesting that you're saying to a probability. I'm just saying, can you rule it out as being a possible cause, that being a hypoxic injury leading to seizure activity? Can you rule that out?

MR. NORCHI: I'm just going to object because it lacks logic. You can't rule it in or rule it out. He can't rule out a lot of things. That's just an unfair question.

MR. MISHKIND: If he tells me he can't rule it out, he can't say one way or another whether the hypoxic injury was the cause of the seizure activity in this case, then I'll accept

that.

A. I cannot say.

Q. You can reverse it and say I can tell you to a certainty that the seizure activity was not caused by a hypoxic injury; true?

A. True.

Q. Do you have any evidence that you're aware of to suggest that there was any type of a metabolic disorder that caused this baby to stop breathing?

A. I don't.

Q. Do you know of any metabolic condition that caused or contributed to the inability to efficiently bag the baby when you arrived?

A. No.

Q. Now let's talk about when you realized that the bagging was not efficiently ventilating the baby. What was it clinically that you saw that caused you to conclude that?

A. The baby wasn't pinking right away and the heart rate is not improving.

Q. And at what time -- how many minutes into your --

A. Seconds.

Q. Within seconds. So at that point, you

have still got a baby that is cyanotic; true?
A. Yes.
Q. That has a very minimal heart rate?
A. That's right.
Q. Very significant bradycardia?
A. Yes.
Q. And you then proceeded to do what a reasonable and prudent physician would do in terms of managing the airway, and that is to intubate the baby?
A. Yes.
Q. The 3.5 ET, is that an appropriate size endotracheal tube for a neonate?
A. That's right.
Q. Did you have to calculate the size, or was that right on the crash cart?
A. That's -- if the baby is not like premature or very small to the size, that's the standard, is 3.5.
Q. Was that on the crash cart, or did you have to have someone get it for you, if you recall?
A. No. It was right away. It was given to me right away.
Q. Do you have a recollection of who it

was that gave it to you?

A. No.

Q. Did you do the intubation on your own, or were you assisted?

A. No. On my own.

Q. Were you satisfied with the response that the intubation caused?

A. Yes.

Q. Heart rate responded quickly?

A. Yes.

Q. Now, the baby then became somewhat tachycardic?

A. No. That's the usual heart rate for a baby.

Q. ***So*** it was within normal limits at the point in time that you efficiently and effectively ventilated the baby?

A. Yes.

Q. Are you able to tell me, based upon what you observed and the time periods that you learned, how long the baby had gone, how long Megan had gone, without being effectively ventilated?

A. From the response to the intubation, and the baby came right away, that means that it

hasn't been too long, but I cannot exactly say the period of time, but, you know, because of the good response that I got, that means that it wasn't that long before that baby was resuscitated.

Q. Are you able to give me an opinion, in terms of minutes, as to how long the baby had been without appropriate management of the airway and without effective ventilation of the airway?

A. Minutes, no, I cannot tell you by minutes, but it doesn't look like it's a long period because the baby responded quite well quickly.

Q. Certainly a baby can respond quite quickly and have the heart rate that you were able to accomplish and still, depending upon how long the baby had gone without oxygen, without breathing, still can sustain an injury to various organs; true?

A. I cannot account for that.

Q. Is it because you don't know how long it would take to cause, for example, a hypoxic ischemic encephalopathy?

A. Yes. I'm not an expert in that.

Q. Fair enough. Now, the neonatologist,

you have a note here, took over at 7:00 a.m.?
A. Yes.
Q. Would that be Dr. Miller?
A. Most probably it would be, yes.
Q. Tell me what you were doing from the time that you intubated the baby until 7:00 a.m.
A. Ventilating the baby with a bag.
Q. And the oxygen saturation, you were able to pick that up to a hundred percent?
A. Yes.
Q. So once you got involved and realized that what was taking place before you arrived was not efficiently oxygenating the baby, your steps, your maneuvers, were successful; true?
A. Yes.
Q. Do you recall anything, by way of looking at your note or anything else in the hospital record, in terms of what people were doing from this 6:30 a.m. up until 7:00 a.m. when Dr. Miller arrived?
A. You know, we intubated the baby. We have to tape the tube into the baby and make sure that the breath sounds are equal, and that's done after we, you know, we established an airway, the baby is pinking and everything. We tape it up

and we listen to the lungs, and then we keep on breathing the baby until, you know, somebody take over for that. Either they got a ventilator for the baby or, you know, another person going to take over for the ventilation.

Q. When the neonatologist took over, what was the mechanism of ventilation at that time?

A. As I recall, we were bagging him until the ventilator comes up.

Q. Did the ventilator come up about the same time that the neonatologist arrived?

A. I cannot recall exactly when.

Q. Does the record, at least from what you have seen, indicate when the baby was placed on the ventilator?

A. No, nothing that I see here that I can pick up that.

Q. When you were doing the bagging initially with the Ambu bag, there would be the corrugated tubing that I referred to before; correct?

A. Yes.

Q. And that corrugated tubing then would be connected to what for the delivery of oxygen?

A. Oxygen supply.

Q. And essentially then that would be one hundred percent oxygen?
A. Yes.
Q. If the corrugated tubing is not connected to the Ambu bag, then the reservoir of oxygen that's being provided would certainly be less than a hundred percent; true?
A. Yes. It would be 21 percent, room air.
Q. And certainly 21 percent room air would not be adequate to resuscitate a baby that is in cardiorespiratory arrest; true?
A. It wouldn't be as good as a hundred percent, yes.
Q. It certainly would be preferable to have a hundred percent being provided by Ambu bag with appropriate corrugated tubing connected to the machines; true?
A. Yes.
Q. And, obviously, it would be preferable to intubate the baby sooner than later if in fact the bagging is not efficient in terms of pinking up the baby; true?
A. Yes.
Q. Cyanosis, is that a late stage when a

baby is experiencing apnea?
A. No.
Q. How long does it take for a baby to become cyanotic?
A. A baby becomes blue right away if it's not breathing.
Q. Do you know how long this baby was blue before you arrived?
A. No.
Q. Doctor, I'm almost done. In fact, I may be done. I'm going to give you an opportunity to tell me whether there's anything else as it relates to your involvement from the time you got summoned by the overhead page in the accommodation room on the second floor up until 7:00 a.m. when neonatology took over. Is there anything else that you recall that we have not talked about?
A. No.
Q. No conversations after 7:00 a.m. with any of the caregivers?
A. I could have, but I don't recall it at all.
MR. MISHKIND: Doctor, I have no further questions for you. Thank you very much.

MR. NORCHI: Doctor, you have the right to read the transcription of your testimony today. I would suggest you take that opportunity to review your transcript.

THE WITNESS: Okay.

(Deposition concluded at 11:50 o'clock a.m.)

(Signature not waived.)

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CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named AMIR DAWOUD, M.D. 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 testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 20th day of November 2000.

Karen M. Patterson

Karen M. Patterson, Notary Public
Within and for the State of Ohio

My commission expires October 7, 2004.

AFFIDAVIT

I have read the foregoing transcript from page 1 through 65 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE
41	15	was Unfamiliar

AMIR DAWOUD, M.D.

Subscribed and sworn to before me this 5 day of ~~1998~~ 2000

JANACE M. WILKINS
NOTARY PUBLIC, STATE OF OHIO
Recorded in Cuyahoga County
My Comm. Expires March 15, 2003

My commission expires _____

I N D E X