IN THE COURT OF COMMON PLEAS
FOR THE STATE OF OHIO
COUNTY OF LORAIN

HUBERT PORTER, ADMINISTRATOR
OF THE ESTATE OF
BRAD J. PORTER, DECEASED

VS. NO. 96 CV 115689

MANHAL A. GHANMA, M.D.,
ET AL

ORAL DEPOSITION OF DR. ARABA B. QUANSAH
Taken November 16, 1996

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ORAL ANSWERS AND DEPOSITION OF DR. ARABA B. QUANSAH, taken November 16, 1996, beginning at about 9:25 a.m., in the offices of Permian Court Reporters, 605 West Texas, Midland, Texas, before Debra D. Guthrie, Certified Shorthand Reporter for the States of Texas and New Mexico, pursuant to the Rules of Procedure.

I N D E X

EXHIBIT INDEX

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1	drawing	--

DR. ARABA B. QUANSAH

the witness, was duly sworn on oath by the Court Reporter to tell the truth, the whole truth, and nothing but the truth, whereupon the witness testified as follows in answer to the questions propounded by Counsel:

EXAMINATION

BY MR. LANSDOWNE:

Q. Doctor, would you state your full name for the record, and spell it, please?

A. Araba, A-r-a-b-a, middle initial B, and the last name is Quansah, Q-u-a-n-s-a-h.

Q. Doctor, you are going to have to keep your voice up.

MR. LANSDOWNE: Can you hear her, Don?

MR. SWITZER: Just barely.

A. The name is Araba Quansah. The first name is A-r-a-b-a, middle initial of B, and the last name is Quansah, Q-u-a-n-s-a-h.

Q. Okay. Doctor, what is your date of birth?

A. February 17, '48.

Q. Where were you born?

A. In Ghana, West Africa.

Q. Could you tell me about your educational background?

A. Yes. I did my primary education and secondary education in Ghana. And I came to the U.S. to go to college. And I did my bachelor's at Drake University in Des Moines, Iowa.

And I worked for a year, went home for a while, came back, worked for another year and went to graduate school at the University of Michigan, where I got my master's in mathematics. And then 1 wait another five years before I decided I wanted to go to medical school.

After that, I went to Brinmar College in Pennsylvania for one year, to get my premed requirement. In between, I went back to the insurance company and worked for almost another year before I enrolled at the University of Pennsylvania School of Medicine.

Q. Okay. So how long in between your bachelor's degree and entering medical school?

A. I finished my bachelor's in 1971. And I started medical school in 1984.

Q. Okay. But you had gone back to Brinmar to do some premed work?

A. Yes. I needed to get my science

requirements, because it had been a while since I did it.

Q. Okay. And you graduated, you got your M.D. in May of '89?

A. Yes.

Q. And what did you do after that?

A. I went to do my internship at St. Vincent's Medical Center in Bridgeport, Connecticut.

Q. Okay. And was that a general internship?

A. Yes, rotating internship.

Q. One year?

A. Yes.

Q. And after you completed that, what did you do?

A. I went to Baylor College of Medicine in Houston, Texas.

Q. For your residency?

A. Yes.

Q. And that was a one-year residency?

A. No. I left after one year to continue in Michigan.

Q. Why did you leave after one year?

A. I decided to leave within a few months after I had been there, that I wasn't happy with

their program. But I wanted to finish the whole year and get the whole year credit before moving on.

Q. Why weren't you happy with the program?

A. I just didn't like it for personal reasons.

Q. Okay. Then you finished your residency two years at Jackson --

A. Yeah, it is three total. Since I had done one year, I had two more years to do.

Q. And that was at University of Miami, Jackson Memorial?

A. Yes.

Q. What did you do after that, after you completed that residency?

A. I finished end of July, '93, and then I went to Ghana the same day I finished, and stayed for about three months, came back and started looking for a job.

Q. Okay. And where did you first find employment?

A. I discovered that the market was saturated, and so I started doing some locum-tenency.

Q. What is that?

A. That is temporary assignments as an

independent contractor.

Q. Is that an agency that assigns you somewhere?

A. Yes. Sometimes I find it myself. Other times the agency -- when I worked in Fort Myers, Florida, that was a personal arrangement by myself.

Q. All right.

A. And then I also worked with Compel Cron, which is an agency.

Q. And Whitaker Medical Services, that is an agency, too?

A. Yes.

Q. Compel's Cron, where are they located?

A. They used to be in Durham, North Carolina. I understand they have moved from there. I don't know. They may be in Salt Lake City. I am not sure.

Q. Okay. So from December of '93, through June of '94, you were working in the Florida area?

A. Uh-huh. Yeah.

Q. Several different hospitals?

A. Yeah. Actually I did Florida Medical Center at Kissimmee and then Fort Myers Hospital, the hospital in Fort Myers.

Q. Okay. And that was as part of an

independent contractor arrangement?

A. Yes.

Q. And then how was it that you got up to Lorain, Ohio?

A. I had applied to premed, And sometime in May of '94, they called me and said they had an opening, and if I would come and interview for it. So I went to Lorain to interview for the position.

Q. Premier Anesthesia of Lorain?

A. Yes.

Q. What is that?

A. It is an -- Allegiant used to be called Premier Anesthesia. And they have a contract -- they had a contract with the hospital in Lorain to provide anesthesia, so they get people that is independent contractors to provide the services.

Q. Okay. And you actually worked for Premier or Allegiant?

A. As an independent contractor, yes.

Q. Well, how did that work? I mean, tell me how the arrangements were made between you and Allegiant.

A. You have a contract with Allegiant, or at the time it was called Premier Anesthesia, where you have your -- you sign over all billing rights to

them. They do the billing. And they guarantee you an income.

And then there is a formula in there where after a certain amount, you know, there is some kind of profit sharing or something like that.

Q. So there was some kind of contract that you had with Allegiant?

A. Yes.

Q. Do you still have a copy of the contract?

A. I do not have it with me right now.

Q. I understand you don't have it with you right now, but do you still have it?

A. Probably, but 1 have been moving around so much, I have to look for it.

Q. Okay. Well, I am going to request a copy of that contract. Okay? If you can provide it to your counsel.

A. Okay.

Q. Did Allegiant tell you where to go to perform your anesthesia service and what hours to be there?

A. I interviewed with Premier Anesthesia of Lorain. And at the time, the contract was with St. Joseph's Hospital, before it merged with Lorain Community Hospital. So all my services were

provided at that facility.

Q. And St. Joseph's?

A. Yes, which it later became East Campus of Lorain Community St. Joseph's.

Q. Did you have regular working hours at St. Joseph's?

A. Yes.

Q. And what were your hours?

A. We start cases in the morning. And usually cases start at 7:30 or 8:00 on weekdays. And then we have a call schedule which we rotate around. The call schedule is made every month. And we take calls by that schedule.

Q. Is there a particular area of anesthesia that you specialize in?

A. Over there, we did everything. We were not doing cardiac, but we did everything else, including obstetrics. And I did everything -- anything that was assigned to me.

Q. Okay. Would basically you get an operating room each day, and that was your room for that day?

A. Yeah. Whoever is on call that day assigns for the next day, so we all did assignments. Like if I am on call today, I will do the assignment

tomorrow.

Q. So you know ahead of time what OR you are going to be in?

A. Yes.

Q. You know what kind of cases you are going to have coming up the next day?

A. Yes.

Q. Was this a one-year contract?

A. No. It is -- it was a five-year contract, but it lasts as long as Premier has a contract with the hospital.

Q. Well, you left -- when did you leave Premier?

A. The 28th of July, 1995.

Q. Why did you leave?

A. After that incident, I just -- I was so devastated. I didn't want to work in the OR anymore, so I told them to assign me to the preop evaluation clinic, and obstetrics unit until the end of two weeks, for them to find somebody else.

Q. You are talking about the incident with Brad Porter?

A. Yes.

Q. Okay. So after Mr. Porter's death, you decided that you didn't want to work in the OR

anymore?

A. At that time, yes.

Q. So you asked to be -- I missed part of that, I guess.

A. We have a preanesthesia test in the clinic where patients for elective surgeries come in for evaluation for anesthesia. Okay. They do preop testing, all of the lab work, EKG, and then they call anesthesia to come and evaluate the patient for anesthesia.

Whoever is assigned this is also assigned to the obstetric unit for the day, so you do both obstetrics and the PAT. And that is what I was doing for the last two weeks.

Q. And then you left all together?

A. Yes.

Q. Is that because they couldn't keep you in that type of position any longer or what?

A. This is a -- we all work as a group. Okay? We rotate through different departments. I have to take call. You will be needed -- so I can't tell them, "Look, don't put me on the call schedule. I will only do PAT."

I just wanted to leave. I also wanted to spend some time preparing for my exams. I was going

to take my boards.

Q. So what did you do then? You went to Ghana Dominican Republic?

A. Yes. I went with a group, a mission group. They go there every year to do some medical work. One of the surgeons asked me if 1 can go with them to do the anesthesia.

Q. So you were down in the Dominican for a month?

A. No, for a couple of weeks.

Q. A couple of weeks? Okay. And then what did you do?

A. Then I just stayed home. I went to my sister's and spent some time there.

Q. Where does your sister live?

A. She used to live in Silver Springs, Maryland.

Q. So you didn't work for a period of time?

A. Yes.

Q. How long did you not work?

A. From the time I came from the Dominican Republic in the middle of July, I stayed in Ohio until end of -- middle of August. I stayed in Ohio until the end of August, and then I went to Maryland. And I stayed there until the end of

November, when I moved to Texas.

Q. What made you move to Texas?

A. I decided I will come and -- at the time, after I had passed my boards and so on, I decided I wanted to gradually get back into anesthesia.

And I did have privileges with one hospital in Dallas, so I decided to come there and start gradually working, you know, try to get some cases from some surgeons and start working.

Q. When did you take your boards?

A. October 18, '95.

Q. There is an oral part and a written part of the boards?

A. Yes.

Q. You took them both?

A. No. I took the written July of '93.

Q. And you passed it?

A. Yes.

Q. Okay. That is the first time you took it?

A. Yes.

Q. And then the oral in October of '95?

A. Yeah.

Q. And you passed that?

A. Yeah.

Q. First time?
A. No. Second time.
Q. Okay. When did you take it the first time?
A. October '94.
Q. All right. So you have been board certified since the fall of '95?
A. Yes.
Q. And what have you been doing since November of '95?
A. I have been doing a combination of an independent contractor working in Dallas and locum-tenancy.

In Dallas, you get privileges. It is opened privileges, so you get privileges at the hospital. And then you have to go and see the surgeons and so on and try to solicit cases from them. And then I also worked with a locum-tenancy agency.

Q. Which one is that?
A. Nation Wide Medical Services.
Q. How long have you been working with them?
A. I worked with them at one facility -- no, two, so I spent two weeks at the Doctor's Hospital in Corpus Christi, sometime early February.

And then at the end of February, I came to work at Texas Tech Medical -- Texas Tech University Medical Center in Lubbock, from the end of February to end of June.

Q. On this locum-tenancy program?

A. Yes.

Q. How often do you normally work? I mean, how many days a week do you normally work?

A. For the locum-tenancy work, it was full-time, five days a week, at the University Medical Center.

Q. But you are not doing that anymore, right?

A. After I finished that, I went to Ghana, came back and started working again the same way I used to in Dallas. And then I got a call that they needed a locum-tenant here in Odessa for a week, so I came and worked with them for a week. And at the end of the week, they asked me to join them permanently, so that is why I am here.

Q. Okay. So now you are with an anesthesia group in Odessa?

A. Yes.

Q. What is the name of that group?

A. Advanced Anesthesia Concept.

Q. And how long have you been with them?
A. Since October 2nd.
Q. Of this year?
A. Yes. I worked a week with them in February, and then I got the contract and everything worked out so that I came -- I got here October lst, and started working with them October 2nd.
Q. What do you do? General anesthesia?
A. Yes.
Q. At what hospitals do you have privileges?
A. Right now I am at Medical Center Hospital in Odessa.
Q. Working full-time, five days a week?
A. Yes, and whenever I am on call.
Q. Do you do all -- the whole range of general anesthesia?
A. Yeah, except cardiac.
Q. Okay.
A. And we don't do OB here. I do OB, but our group doesn't do it.
Q. In addition to that work for that group, are you doing any other work? Are you doing any moonlighting?
A. No. My contract excludes that.
Q. Have you ever given a deposition before?

A. No.
Q. Well, you understand that I am here to ask you some questions about what occurred in the care that was provided to Brad Porter --
A. Yes.
Q. -- leading to his death?
A. Uh-huh.
Q. And let me just remind you of a few things. I am sure your counsel probably told you. If you don't understand my questions for some reason, please tell me that. Okay?
A. Okay.
Q. And if you don't hear my question, please tell me that, as well. All right?
A. Yes.
Q. And as you have been doing, please answer out loud, and keep your voice up, rather than answering uh-huh or huh-uh, something like that. Okay?
A. Okay.
Q. If you need to take a break at any time, tell me that as well, and we will certainly do that.
A. Okay.
Q. And if at any time you feel during the

deposition that you want to go back and correct an answer that you previously gave, feel free to do that as well. All right?

A. Uh-huh.

Q. You have to answer yes.

A. Yes.

Q. You will get the hang of it. Have you ever given testimony in a courtroom?

A. No, except for traffic.

Q. Have you ever been named as a Defendant in a lawsuit, other than the one we are here about today?

A. Yes.

Q. How many?

A. One.

Q. Where was that?

A. In Ohio.

Q. When was that?

MS. HENRY: My usual objections throughout this.

MR. LANSDOWNE: Sure.

MS. HENRY: Go ahead.

A. This was December of last year.

Q. December of '95?

A. Yes.

Q. Is that case still ongoing?
A. No.
Q. What happened to it?
A. Settled for -- should I say the amount? Settled for $2,000.00 as a nuisance claim by the insurance company.
Q. What was the name of the case?
A. Nancy Gonzales versus Hays.
Q. But you never gave a deposition in that case, correct?
A. No.
Q. That is correct, you didn't?
A. No, I didn't.
Q. Any other lawsuits that you remember?
A. No.
Q. Any other lawsuits in which there was a question about the care that you were providing, whether or not they named you specifically?
A. No.
Q. You answered some interrogatories in this case. Do you recall doing that?
A. Yes.
Q. Did you have a chance to review them over yesterday, perhaps?
A. I didn't go through them.

Q. Okay. When is the last time that you saw them?
A. When I did it.
Q. Okay. Do you still have an active license in Ohio?
A. Yes.
Q. Have you ever had your license suspended or revoked by any state?
A. No.
Q. Have you ever had your staff privileges revoked or curtailed at any hospital?
A. No.
Q. Have you ever been put on any kind of suspension from the practice of medicine?
A. No.
Q. Mr. Porter was at Lorain Community Hospital, correct?
A. Yes.
Q. And had you worked at that facility prior to this case?
A. Yes. That is where I had been working since I got into that hospital -- I mean, joined Premier.
Q. Okay. So this was after the merger of Lorain and St. Joseph's?

A. Uh-huh.
Q. You have to answer out.
A. Yes. I am sorry. That is the way 1 talk with my language.
Q. That is okay. Had you ever worked with Dr. Ghanma before on a case?
A. No.
Q. Do you know Dr. Ghanma?
A. Not before that case.
Q. You had worked that operating room before, hadn't you?
A. Oh, yes, Uh-huh.
Q. In preparation for your deposition today, what did you do?
A. I reviewed the chart.
Q. Did you review anything else?
A. Mostly the chart.
Q. Mostly the chart, but was there something else that you looked at?
A. No. I just tried to recollect.
Q. Did you review any deposition testimony?
A. No.
Q. Did you look at any medical literature?
A. I look at medical literature all the time in connection with my work, but not purposefully for

this.

Q. Okay. Have you ever since this incident looked at any medical literature specifically in relation to Mr. Porter's situation?

A. Yeah.

Q. What did you look at?

A. I have looked at literature on trauma and preop complications and so on in connection with my work, but they are all related.

Q. I think I understand what you are saying. You look at literature all the time to do your job, correct?

A. Uh-huh.

Q. If you answer yes, it will be better.

A. Yes. Okay.

Q. What I really was asking is did you at any time go seek out literature to try and explain for yourself what happened with Mr. Porter?

A. Not specifically.

Q. Okay. Did you find just in the course of your general reading, any literature that helped to explain to you what happened with Mr. Porter?

A. I don't understand the question very well. I mean, explain what happened to the patient or what caused the problem? You will have to ask --

Q. Sure. You have looked at some literature, as you said, in connection with your job. Some of that had some relationship to Mr. Porter's situation. I was wondering if you had found anything in the course of that reading that explained to you what caused Mr. Porter's death?

A. No. No.

Q. Other than your counsel, have you discussed Mr. Porter's situation with anybody?

A. When we did the quality assurance meeting in which we discussed the case.

Q. When was that done?

A. Before I left Lorain Community. We had a quality assurance meeting in which the case was discussed with my place at Lorain Community St. Joseph's Hospital East Campus.

Q. Anybody else that you discussed this case with?

A. Not specific details, but my family knows that something happened that made me leave my job, and they know that a patient did not survive surgery.

Q. After Mr. Porter died, did you -- other than the medical records, did you write up a summary of what happened, so you could keep it fresh in your

mind?

A. No. I had a copy of my summary on the chart.

Q. Okay. Did you make any kind of notes anywhere as to things that occurred so you could later on refresh your recollection?

MS. HENRY: Other than her chart note?

Q. Other than her chart note.

A. No.

Q. Have you ever read a summary or a chronology, other than the medical records, prepared by somebody else?

A. No.

Q. Without telling me what it might be, were yau given anything by the quality assurance committee that you have looked at since the time of that meeting?

A. No.

MR. TREU: Objection.

Q. So I am clear then, what you will be talking about today in response to my questions would be based upon your recollection of the events, and also based upon the medical records, correct?

A. Yes. Uh-huh.

Q. Okay. Can you tell me then what caused Brad Porter's death?
A. I don't know.
Q. Has anyone ever told you what caused his death?
A. The only thing is from the chart, from the coroner.
Q. You did read the coroner's report?
A. Yes.
Q. Do you agree with it?
A. I don't know. That is not my specialty, because I don't know what caused the death.
Q. You don't have any basis to either agree or disagree; is that correct?
A. Yes.
Q. I take it from some earlier responses that you gave, that this was an event that you found I think devastating is what -- the term you used?
A. Yes.
Q. Did you ever try to figure out what caused Mr. Porter's death?
A. Well, anything I tell you will be speculating, and I don't want to do that.
Q. Well, I am not asking you to speculate. I am just asking, did you ever try and figure out --

I mean, here is this patient who died.

A. Yeah, I did, but they are all speculations.

Q. Well, what did you do to try to figure it out?

A. I just went through my mind, the sequence of events that happened. And I cannot think of anything that I could have done to have caused the death, so I -- it has just been -- that is why it has been devastating to me.

Q. When did you first have any knowledge of a patient by the name of Brad Porter, that you were going to be --

A. That morning of July 15th.

Q. And how did that come about?

A. I think sometime between 6:00 and 6:30, I got a call from the nursing supervisor that Dr. Ghanma wanted to do an IND on the patient.

I was on call that Saturday, and calls start at 7:00, so they called to inform me what I had for the day, and that it was supposed to be at 9:00 in the morning.

Q. Uh-huh. So what did you do?

A. I got to the hospital around 7:00. I was involved in the obstetrics suite. And when I was

done there, I went to the operating room, and it was, I think, around 8:00. And I went there and set up my room and waited for the patient to arrive.

Q. What does that mean, you set up the room?

A. Turned on the anesthesia machine, turn on my morning test and check the machine and get the drugs from the narcotic cabinet, and then draw the drugs that I will need for this surgery.

Q. Did you have any part of the chart to review?

A. Not at the time.

Q. You had just been informed that it was going to be a debridement?

A. Yes.

Q. Were you told how long the procedure was going to take?

A. From IND, I didn't think it would take that long, maybe 45 minutes to an hour was my estimate.

Q. And I guess based on the fact that you were already turning on your machines and everything, you planned to do a general anesthesia?

A. Every patient that comes into the OR is a potential general anesthesia, so we prepare for

general anesthesia for every patient,

Q. With respect to Mr. Porter, what was your plan at this point, before you seen him?

A. At that point, I had not talked to the patient, so I didn't have any specific plan.

Q. All right. What happened next then?

A. After I finished, I went out and the patient came in. He was placed in front of the preoperative care unit, so I went to him, introduced myself and got the chart and reviewed the chart and asked him some questions.

Q. What is the preoperative care unit?

A. During the day when -- weekday, when we have a regular surgery day, patients are brought into the preoperative care unit. Okay. They have curtains, drapes to separate patients. And then we go and talk with them.

And usually they have had a preoperative evaluation before. It may or may not be done by you, so you go and review the chart. The nurse will put an IV in.

You give your preop medication, like medicine to relax them or any other medications they may need. If you have to put in and do a regional anesthetic, they have monitors there where you hook

up the patients and do your regional, like epidural or a block.

On weekends, that place is not open, so the patient is brought into the hallway in front of that place and you can talk to the patient.

Q. So the preoperative care unit is locked up on the weekends?

A. No, it is not locked up, but there is no -- there are no nurses taking care of that place. Okay? So all of the preoperative vital signs and everything is done on the floor.

Q. Okay.

A. And then they bring the patient down for the anesthesiologist to talk to the patient and review the chart before taking the patient in.

Q. And this is done in the hallway? You meet with the patient in the hallway?

A. Yes.

Q. Did you administer preoperative or preanesthesia drugs in the hallway?

A. On weekends, it is probably only one patient. And this is a really private area. So there is no other patient there, except for people in the operating room.

Q. I am just asking, is that -- to get the

sequence, did you administer the drugs in the --

A. Oh, okay. Mr. Porter, I didn't give him any preoperative drug, because he had already gotten Ritalin and Valium from the floor.

Q. All right. Who had ordered that?

A. One of my colleagues who was on call Friday night was told about the case. And he went to try to see the patient, but at the time the patient was just --

MS. HENRY: Just answered who ordered it.

A. Okay. Dr. Boidman.

Q. And he had tried to see the patient Friday night?

A. Uh-huh.

Q. You have to answer yes.

A. Yes.

Q. And why wasn't he able to see the patient on Friday night?

A. The patient was asleep.

Q. What time did he try and see him?

A. As I recall, I think it was around midnight or so.

Q. What was the purpose of him going to see him on Friday night?

A. He was the one on call. And they told him there is going to be surgery in the morning. That is what we usually do if something is coming in the morning that is an add-on or an emergency, they call whoever is on call to go in and evaluate the patient.

Q. The night before?

A. Yeah, if it is scheduled the night before.

Q. Why do you see the patient the night before?

A. Because you may need some other information that is not on the chart or something, so that you get everything together.

Q. Did you have a conversation with this doctor before meeting with Mr. Porter on Saturday?

A. No.

Q. How do you know that he had -- is there something in the chart that he put in there? There is a preanesthesia evaluation note dated 7-15-95, correct?

A. Yes.

Q. And that was filled out by doctor what is his name?

A. Boidman.

Q. Boidman?
A. Uh-huh.
Q. And you reviewed this?
A. Yeah.
Q. When did you review it?
A. When I saw the patient.
Q. Dr. Aoidman writes up in the section on -- well, first of all, he indicates he had a previous spinal anesthesia, correct?
A. Yes. If you will look at the right, it says chart only.
MS. HENRY: He wants to know did he write that.
A. Oh, yeah.
Q. Right. You are pointing out the history was from the chart only, correct?
A. Uh-huh. Yes.
Q. So that is how you knew that Dr. Boidman hadn't seen Mr. Porter?
A. Yes.
Q. And later on, you learned that the reason he didn't see him was because he was asleep?
A. Yes.
Q. Okay. When did you talk to Dr. Boidman about that?

A. The quality assurance meeting.

MS. HENRY: Anything that came out in the quality assurance is -- you can't testify to.

Q. Did you talk to Dr. Boidman at any time about Mr. Porter, other than at the quality assurance meeting?

A. I just wanted --

MS. HENRY: Yes or no?

A. Yes.

Q. When?

A. The day after, when he went to see the patient.

Q. The day after what? The day after he died?

A. That was Saturday. Monday.

Q. You went to see Dr. Boidman and talked to him about this --

A. No. No. We were all standing there. I just asked when he found out about the surgery.

Q. And he told you what?

A. They called him that night.

Q. Told you that they had called Boidman on Friday night, and he went to see Mr. Porter, correct?

A. Uh-huh.

MS. HENRY: Yes?

A. I am sorry. My language, that is the way I talk.

Q. It is all right.

A. Okay. Yes.

Q. What else did Dr. Boidman tell you?

A. Nothing. He didn't know the patient.

Q. You have to keep your voice up.

A. I said not much. He couldn't tell me much, because all he knew is what is written here.

Q. He told you that he went to see the patient, and that the patient was asleep Friday night when he went to see him?

A. No. He told me that he was called that night, late that night about a patient. And it was late that night, and he couldn't call me. But the discussion as to whether he was -- he actually saw the patient or whether he was --

MS. HENRY: Wait a minute. If you are going to say anything about quality assurance --

THE WITNESS: Don't speak?

MS. HENRY: Can we go out in the hall a minute and discuss this?

(PAUSE)

MS. HENRY: I just took a break with the doctor, and I have -- some of these questions

have been objected to. And we have now explained what quality assurance means in the State of Ohio.

And as you well know, anything that happens in quality assurance is privileged and is not divulged, therefore I told her that she is not to answer any questions about quality -- anything that happened in quality assurance.

And so when she answers your question, she is going to be answering based on anything that occurred outside of quality assurance. Okay?

MR. LANSDOWNE: Very good.

Q. Doctor, I was asking you about your discussions with Dr. Boidman, right?

A. Uh-huh.

Q. And did Dr. Boidman tell you that the patient was asleep when he went to see him?

A. No.

Q. How do you know that the patient was asleep when Dr. Boidman went to see him?

A. Because -- well, I didn't know he was asleep, outside --

Q. Outside of what occurred in quality assurance, you mean?

A. Yes. But we have on the chart wherever it says chart only. Okay? When somebody sees --

tries to see a patient and they can't see the patient -- the patient in person, maybe the patient has gone for a test, maybe the patient is asleep, maybe it was late at night when the person found out, they indicate chart only, so that whoever is doing the case knows that the person who did the preop did not see the patient in person.

Q. Okay. Dr. Boidman also wrote question mark, dif airway, question mark. Do you see that?

A. Yes.

Q. What does that mean?

A. I think from the previous chart, there was a mention of being a difficult intubation.

Q. Okay. You think that Dr. Boidman picked that up from the previous preanesthesia record, correct?

A. I think so.

Q. Because he didn't see him, so he wouldn't really be in a position to know that, would he?

A. Yes. Uh-huh.

Q. Did you go back then on the 15th the morning of the 15th and look at the previous preanesthesia evaluation?

A. Yes. I look at it and I talk to the patient and go over whatever is on the preanesthetic

record.

Q. Okay. July 13th, '95, is the previous preanesthesia evaluation, correct?

A. Yes. Yes.

Q. Now, what does it say up there under airway?

A. "Appears anterior, wide neck, could be difficult." And it also says, "Patient quite sedated, difficult to assess airway."

Q. It also says, "Small chin"?

A. Small chin, yeah. "Full set of teeth."

Q. "Appears anterior." What does that refer to?

A. We usually check with the fingers here. Some people have a rather -- nobody here -- where you put three fingers, you can only get two.

The way the chin is can indicate whether your airway is anterior, so we assess that with how many fingers.

Q. You measure the chin with fingers underneath the jaw?

A. Yes. Yes.

Q. Correct?

A. Yeah. Hyoid distance.

Q. And if that distance is only two fingers,

you call that a small chin?

A. Yeah. And the trachea will be anterior.

Q. And so that the trachea is -- what is the significance of that in terms of doing --

A. When you do a laryngoscope, it is more difficult to observe the vocal cords and the glottic opening.

Q. Why? Just anatomically you can't visualize it as well?

A. Yes. Most times.

Q. The significance of the anterior airway, that is really one problem then? A small chin and anterior airway are one in the same problem or is that two different problems? Do you know what I mean?

A. Having the small chin and the anterior airway?

Q. Is that one in the same problem?

A. Yeah. Usually somebody having that will have an anterior airway.

Q. Okay. I mean small chin, if you don't have an anterior airway, does that present a problem in and of itself?

A. If the person has a small chin and doesn't have an --

Q. An anterior airway.
A. No.
Q. Okay. So it is a related thing, correct?
A. Yes.
Q. Is the problem only in the intubation, or is it in the intubation and maintenance of the airway?
A. Intubation.
Q. Only in putting the tube in?
A. Yes.
Q. Anything else about this patient that was significant in terms of -- preoperatively, we are talking, about in terms of your anesthesia management?
MS. HENRY: Wait a minute. We were just talking about what was on this particular 7-13 note, which was not done by her. We are not talking about her assessment of this patient and the anesthesia management, so that question is pretty misleading actually.
Q. Well, I didn't mean it to be. But we -- what I meant to do is then move to what your preanesthesia evaluation was.
A. Okay.
Q. Okay?

A. Uh-huh. I saw the patient. I read the chart. I read the preanesthetic evaluation, and then I did my own evaluation of the patient's airway.

Q. That morning, the morning of the 15th, correct?

A. Yes.

Q. And did you chart that evaluation?

A. No.

Q. Why not?

A. The preop evaluation had been done already, and I didn't write over. I just did my own as I took the patient to the operating room, so I didn't write over. This is the preanesthetic record. I just didn't write over it.

Q. Okay. What did you find in your preanesthesia evaluation?

A. I thought it would be difficult, too. And since he had difficult airway, question, I just left it the way it is. When I asked him to open his mouth -- we also look into the mouth. Okay. And assess, yourself.

You check if you can see the tonsil, the uvula, and how much of the uvula you can see, and we give a classification for that.

Q. What is the classification?

A. Malan pati classification, m-a-l-a-n, p-a-t-i.

Q. And how does that classification work?

A. If somebody opens their mouth, bring their tongue forward and you can see the whole uvula and the anterior and posterior tonsil palate and the soft palate, that is class one. That means the patient will be easy. It predicts that the patient will be easy intubation.

If you see only the soft palate and the part of the uvula, the base of the uvula is covered, you see only part of it, that is class two. That also predicts relatively easy intubation.

Class three, which I found this patient to be, is you do not see the uvula. What you see is the soft palate. Okay? That is also relatively difficult intubation.

Q. How far does the classification go up?

A. Four.

Q. Did you chart that he was a three anywhere?

A. I didn't write over the preop. It says difficult airway, and I checked and I thought it may be difficult, but I didn't write it down.

Q. But you just remember that that is what you classified him as, a three?

A. Uh-huh. Yeah. I remember I agreed with this.

Q. And that would mean he was a three?

A. Uh-huh. Well, I found that he was a three.

Q. Okay. Well, what is the significance of that, that he is a three going in? What is the risk involved?

A. It is just a predictability. Sometimes you find somebody like that, but you go in and the intubation can be easy.

Sometimes the patient's cooperation -- it can also depend on the patient cooperation on how wide they open their mouth. So all that it does is it gives you an information that the patient may be difficult to intubate.

Q. Okay. Did you have -- you mentioned before you had a discussion with Mr. Porter in the hallway, correct?

A. Yes.

Q. Tell me what you said and tell me what he said.

A. Looking at the chart, I found out that he

had his first surgery by spinal, and he did well. So I talked to him about spinal anesthesia, and he refused. Okay?

Q. Why did he refuse? Did he tell you why he refused?

A. He just didn't want it, want to have a spinal.

Q. Okay. Did you recommend a spinal?

A. Yes. I told him he did well with a spinal the day of his accident, and if he would consider having a spinal, and he said no.

Q. Did you ask him why don't you want to have a spinal?

A. He said he didn't like it. He just didn't want it.

Q. Did you explain to him that he had a potentially difficult airway?

A. Yes. Yes, I did.

Q. What did you tell him?

A. I told him that he has a potentially difficult airway, and if he wants a general -- you know, patient's refusal is an absolute contraindication for a procedure. Okay.

So I told him I will do general, but if I cannot intubate him, I will wake him up and do an

awake intubation or spinal. That is what I told him.

Q. So you explained to Mr. Porter that there was a difficult intubation, but he still wanted to go ahead?

A. If it was a difficult intubation, okay. We get patients like that. Sometimes we can intubate them. And as I said, some of it is also due to patient's cooperation, so we have a way of dealing with it.

And 1 told him how I am going to deal with it, and that if he is asleep and I cannot intubate him, I will wake him up and do an awake intubation.

Q. How were you going to wake him up?

A. You cannot wake the patient up. What you use for -- as a polarizing agent is short acting, so you can mask ventilate him until they wake up.

Q. Who was with Mr. Porter when he had this discussion?

A. Some of it the nurses were around.

Q. And do you remember any of the nurses that were around?

A. I know Eugenia was there. I don't know if he was the one in the holding area.

Q. Who?
A. Eugenia.
Q. Was any of -- anyone from Mr. Porter's family there when you had this conversation?
A. I don't recall it.
Q. There might have been, you just don't recall?
A. Uh-huh.
Q. You have to answer yes.
A. Yes.
Q. How long was this conversation with him?
A. Probably 10 minutes.
Q. Was he -- he had already been sedated by this time, hadn't he?
A. He got the Valium, but it was not long before he came down. He appeared alert to me.
Q. How long ago had he had the Valium?
A. I think the chart said 8:30, but let me check to make sure.
MR. TREU: 8:30.
MS. HENRY: 8:30? I am looking for it.
MR. TREU: It is on the med sheet.
Q. It is on the med sheet. 1 don't know what it is charted at in the nurse's notes. He had

Valium at 8:30?

A. Yes.

Q. And when did you have this conversation with him?

A. Around 8:45.

Q. I am just trying to get my timing here.

A. We were in the OR --

Q. I see you have an anesthesia start at 09:00.

A. Yes. That is the time in the room.

Q. That is the time in the actual operating room?

A. Yes. If you look at the nurse's record, it says in room at 9:00.

Q. Okay.

MS. HENRY: What are you looking for?

MR. LANSDOWNE: I was just looking at when he was moved out of the room, if there was a note indicating when he was moved out of the room. I don't know that I see one.

MR. SWITZER: What is the question?

MR. LANSDOWNE: I was looking for a note as to when he was moved out of the room on his way to the OR, but we haven't found a note anyway.

We are going to go on.

Q. So then he gets into the room -- the operating room at 9:00?

A. Yes.

Q. Okay. What is the procedure then once he gets in the room? He is still awake when he gets in the operating room?

A. Yes. Yes. We put our monitors on, the blood pressure cuff, the EKG and the pulse oximeter.

Q. When you say we, who are you referring to?

A. The nurse sometimes helps with putting the monitors on.

Q. All right. Is he moved from his hospital bed to the table yet?

A. No. Because he is going to be in a prone position, we induce on the stretcher that they come in.

Q. All right. Go ahead. I interrupted you. I am sorry. You put on the monitors and then what?

A. Yeah. And before we -- well, let me go on. We put on the monitors. He was moved down in bed, so I tried to get him to move up towards the head of the bed. Okay?

Q. Uh-huh.

A. Because I have to intubate him and so on. So I wanted him to move. And he complained of pain with movement. So I gave him --

Q. Pain where?

A. In the leg, with movement.

Q. Okay.

A. So I gave him some pain medication, which was Fentanyl. And then we got him up. And then I put a mask on his face, and I gave him the tubal curari.

But to go back, first we take the vitals before we induce. So then I started inducing. I gave the curari, which is a defasciculating agent. So I gave him the curari, waited about a minute or two, then gave him some more Fentanyl and then gave him propofol, which was the induction agent. That is what gets him to sleep.

Q. Okay.

A. So I gave him propofol, and mask to make sure I can ventilate him. And the reason for that is if I cannot intubate, at least I can ventilate him until the stuff wears off.

So I check to see if I can ventilate him with mask, and yes, I could, so I give him the

succinylcholine to paralyze him for the intubation. And actually he was an easy intubation. I could see the vocal cord. I could see the glottic opening.

Q. You remember that?

A. Yes, I do. I do. He wasn't a difficult intubation. I went in one try, and it was in. And we checked for the intubation on the capnograph, which shows us the tube that is in the trachea.

And then we check for equal breath sounds on the chest, to make sure it is not endobronchial intubation. It hasn't gone off to one side. So I checked that.

Then I turned -- at the time I was checking this, I had nitros, so I turned it to 100 percent oxygen, because when you move the patient, you disconnect briefly, so you want the maximum oxygen in their system.

Q. Okay. Can you stop there for a second?

A. Okay.

Q. This is all second nature to you, but for me, it ta es a little while.

MS. HENRY: Before we go on, can we have a bathroom break?

Q. Sure.

(PAUSE)

Q. Doctor, as I understand it, when you intubated him, you had no difficulty, correct?
A, No, Yes.
Q. Did he have an anterior airway?
A. No.
Q. And it was one attempt?
A. Yes.
Q. And you checked the ETCO2?
A. Yes.
Q. And that is checked on your monitor?
A. Yes.
Q. It is a reading that is taken from the mask, or how is that reading taken?
A. There is a sensor that goes to the elbow of the endotracheal tube. There is a sensor. And the sensor analyzes the air, the exhaled air. And it gives the carbon monoxide, and it comes in a graph that goes up like this.
Q. A graph that you are watching on your machine?
A. Yes, continuously.
Q. Okay. It doesn't print out a graph, does it?
A. No.
Q. And you are watching the ETCO2, because

that is an indication of whether the patient is breathing or not, correct?

A. That is the best indication that the patient is intubated well in the trachea, because that is where you get the carbon dioxide. It measures the carbon dioxide in the exhaled air.

Q. At this point that you have now -- in the sequence of things we have been talking about, the patient has now been intubated. He has been paralyzed, intubated and is now under your anesthetic management?

A. Yes. The succinylcholine wears out quickly, so I gave him something which is paralyzed for a longer time.

Q. You are giving him that to paralyze him throughout the procedure?

A. For most of the procedure.

Q. Okay. And then you chart each of these drugs that you give him?

A. Yes.

Q. And you also chart in terms of airway management, that it was one attempt, that ETCO2 was present?

A. Yes.

Q. Breath sounds equal bilaterally?

A. Yes.

Q. What do you do then to get the patient over in position for the operation?

A. We put the hands on the side, and roll them. We put the two beds together. Okay. We put the hands on their side, and we all roll the patient over onto the operating bed. And we put a chest roll here, to make sure that his stomach is hanging and that it is not squished in by the table.

Q. You just said here. You put a chest roll --

A. Down the side.

Q. Down the sides of his chest?

A. Yeah.

Q. Okay. When he is being rolled, do you disconnect the airway?

A. Yes. I disconnected the Y piece. I disconnect the Y piece from the endotracheal tube, so that -- because that is the source of traction on the tube. So I -- the tube is taped in place.

So I take care of the head, just the head only, and the airway. Okay. So I hold onto it, and we roll the patient over.

Q. Okay. Let me ask you about that taping. How did you tape this ET tube in place?

A. Okay. We have a tape for it. Okay. And the tube is coming out here.

Q. Coming out of the side of his -- sort of the side of his mouth?

A. Yeah. I usually have it on the right side.

Q. On the right side?

A. Yes. And you put a piece of tape here and wind it around the piece. After you listen for equal breath sounds, and it is equal, you have -- there are numbers on it.

Q. Numbers on the tube?

A. Yes. So you know how far it is in, that the breath sounds are equal. So you wind the tape around where it is at the mouth, and then tape it here.

Q. To the side of his face?

A. Yes. From here, around, and then I put one over it.

Q. Okay. So let me see if I can describe that so it comes out on the record. You have a piece of tape that goes basically below the mouth and then comes --

A. Around here.

Q. On the chin essentially, below the lower

lip?

A. Yeah. I try not to get this part.

Q. Try not to get the lip itself?

A. Yeah.

Q. Below the lip, around the tube a couple or three times?

A. Yeah. Around the mouth and then continues.

Q. And then continues to the side of the face?

A. Yes. Yes.

Q. And is this your standard taping procedure --

A. Yes. Yes.

Q. -- for any ET intubation?

A. Yes. And especially for prone position, I reinforce it, by putting tapes over, and sometimes I do it twice for people in prone position.

Q. How did you do it with Mr. Porter in this case?

A. Just the usual way I do my taping for prone position.

Q. Did you do it twice?

A. Yes.

Q. You remember that you did it twice?

A. Yes, I do.
Q. So when you say you did it twice, you repeated the taping procedure, one on top of the other?
A. Yeah. And sometimes I put it -- I put a repeat over here.
Q. You put a repeat over the top of the mouth?
A. Yes. Yes.
Q. Did you do that with Mr. Porter?
A. Yes. That is my usual for a prone position.
Q. Do you remember doing it with Mr. Porter?
A. Yes, I do.
Q. And the reason that you do extra in the prone position is because you want to guard against the tube coming out?
A. In the supine position, you can always put the tube back in. In the prone position, you don't have that option.
Q. Okay. But in the prone position -- so because of the fact that you would have a more difficult time getting the tube back in, in the prone position, you want to be extra careful about it not coming out, correct?

A. Yes.

Q. And also in the prone position, just because of the fact that the patient's face is going to be down, the tube itself is more likely to come out than in the supine position, correct?

A. Usually in the prone position I put the head on the side, and put a doughnut to protect the ear. For every patient, we tape the eye. But for a prone position, in addition, we put a goggle over the eye, to make sure the eye is protected.

Q. And with respect to that, even though the face is I guess sort of on the side of the head, is the way the head is positioned?

A. Yes.

Q. The tube can be more easily or can come out more easily than say the supine position where the head is face up?

A. No. It depends on how you tape it and how you put the head. You put it on the side, and the tube is coming out here. I think it is just as secure.

Q. You think it is just as secure?

A. Uh-huh.

Q. You have to answer yes.

A. If you secure it very well and have the

head on the side, yes.

Q. Is that something that you learn in preparing to become an anesthesiologist in your residency, that when you have a patient in the prone position, you have to use -- you should use extra taping on the ET tube?

A. Everybody has their own way of taping. And every patient has to have a secure airway. Every patient has to be taped well.

But you are always with the knowledge that somebody who is supine, I can intubate more easily. Somebody who is not supine is not, so it is on your mind. You take extra -- but, yes, every patient has to be securely taped.

Q. Is there a text that you would -- if you wanted to direct somebody like a student or somebody in taping procedures, that you would direct them to?

A. No. I mean, everybody has their own way. You observe how different people do their taping. Okay. And through observation, you do what is --

Q. Had you ever had a patient in a prone position become extubated during a procedure?

A. Never.

Q. How about in a supine position?

A. No.
Q. So just so I am clear about this now, I believe that the only reason that you do extra taping on a patient in the prone position is because of the concern that you might have reintubating, correct?
A. Uh-huh.
Q. You have to say yes.
A. Yes.
Q. Okay. It is not because of any concern that the tube itself is more likely to come out, correct?
A. No.
Q. That is correct?
A. Yes.
Q. Okay. All right. You say that in moving him over, you are in charge of the head?
A. Yes, and the airway.
Q. And the airway. Okay. Explain to me how you placed his head -- placed Mr. Porter's head on the operating room table.
A. You move them over, and then you turn the head to the side on a doughnut hole. It is a form with a hole in the middle. Okay. And that hole protects the ear, so that you don't cause pressure,

so I always keep it on the ear.

Q. What side of his face was down?

A. I usually put it on the right side, because I have the tube coming out this way. That is what I usually do.

Q. Well, what side was it in Mr. Porter? Do you remember?

A. I think that -- that is the way I usually do, so I am sure that is the way it was done.

Q. Well, my question is do you remember that it was the right side? I understand that it is your usual procedure. I am not quarreling with that. I am just wondering if you actually remember in this case, was his right side of his face down?

A. I do not recall exactly, but that is the way -- I do the same routine.

Q. I just wondered if there was a difference because they were going to be working on his left leg, I think, whether that made any difference to you.

A. No, it doesn't.

Q. Okay. Then do you tape the head down to the table?

A. No.

Q. Do you secure the head in any way?

A. On the doughnut. He will be lying on the form.

Q. The head is lying side down on the foam doughnut, correct?

A. Yeah. Uh-huh.

Q. Do you tape the head to the doughnut?

A. No.

Q. And who positions the rest of the body?

A. The nurses help position the rest of the body.

Q. Okay. Then where do you stand or sit during the procedure?

A. At the head of the bed.

Q. At the head of the bed?

A. Yes. That is where the airway is.

Q. Okay. And where are your monitors?

A. At the head of the bed.

Q. Are you in between the monitors and the bed?

A. The bed is here, the monitor is sitting here, and I am sitting here.

Q. Okay. This is what I want you to do for me, okay? This is the bed.

A. Okay. This is the head of the bed. The patient's head is here.

Q. Okay. Make a circle for his head, so we can see.

A. The anesthesia machine is to the side here. And I am sitting here, so that I look at the patient, and the monitor is facing -- the monitors are facing this way, so I can observe the patient and then the monitors.

Q. Okay. Write in there, put in there Dr. Quansah, so we know that is you. Okay?

A. Uh-huh.

Q. And write in there this is the anesthesia machine.

A. Okay. And the monitors are facing this way, so I can -- my observation goes around from the patient to the monitor.

Q. Okay. So you can sort of keep both the monitors and the patient in sight at once?

A. Yes.

Q. And the patient -- Mr. Porter would have been facing which way?

A. This way.

Q. So I put an arrow the way he is facing, okay?

A. Uh-huh. Okay. And the monitor sits on top of the anesthesia machine, the Hewlett Packard

monitor was on top of the machine,.' And the mask spectrum, that gives the carbon monoxide and so on, it is sitting on a shelf on the anesthesia machine.

Q. Say that again, the last part about the mask.

A. This is a machine. The Hewlett Packard, that gives the blood pressure, the saturation and the pulse and the EKG is sitting on top of it. And then there is a place here, like a mask spectrum that gives the end title C02.

Q. Mask spectrometer?

A. That gives the C02. That analyzes the exhaled air.

Q. Right.

A. It is sitting here.

Q. And you can see that, as well?

A. Yes.

Q. You can see all of that from where you are sitting?

A. Yes.

Q. And then the tube itself would be coming out of the side of the mouth -- actually it is coming out of the side of the mouth that is down towards the pillow?

A. Yes. So what happens is that this is the

doughnut. Okay. What I do is I make a tear here.

Q. Tear in the doughnut?

A. Yeah. Okay. So that the tube comes out flat on the bed.

Q. On the bed?

A. Uh-huh.

Q. Okay. The tape that you talked about, that is what is securing the ET tube in place, correct?

A. Yes.

Q. Anything else securing the tube in place?

A. Not the tube. The tape.

Q. With respect to your charting, where do you keep your anesthesia chart while the procedure is going on?

A. On the anesthesia machine, there is a space on top here. And you can put -- actually you draw -- there is a drawer. You draw a flat place. I don't know how to explain it.

Q. There is a little drawer that comes out that you can put your --

A. Yes, on a clipboard. Or sometimes when I am sitting down, I am holding the clipboard like this, and I watch the patient and watch the monitors.

Q. Watch the patient, watch the monitors and chart, right?
A. Yes. Uh-huh.
Q. You have to say yes.
A. Yes.
Q. Okay. And with respect to the blood pressure, you chart that every five minutes?
A. Yes.
Q. Pulse, every five minutes?
A. Yes.
Q. The 02 saturation, how often do you chart that?
A. We chart it every five minutes. All these are continuous, but we chart them every five minutes.
Q. The monitors are going continuously, but you chart them every five minutes?
A. Yes, every five minutes.
Q. The end title C02, how often is that checked?
A. It is continuous, but we chart it every five minutes.
Q. Did you want to correct something about your charting that you just told me?
A. No. What I mean is that you chart the

rest of the chart every five minutes, but if you look at the end title C02, there is 15 minutes in totals. You are looking at it as you chart, but it appears on this in 15 minute intervals.

Q. So the BP you would chart -- for instance, you chart every 5 minutes, the end title C02 you chart every 15 minutes?

A. Yeah.

Q. Does the monitor make any permanent record?

A. The Hewlett Packard makes a record that you can look back and look at previous values. How long it stays in the machine, I don't know.

Q. You mean you can look back on it in the machine -- on the machine itself?

A. Yes.

Q. Does it print a paper chart?

A. It prints.

Q. Okay. Have you ever seen a printed chart of -- from the anesthesia machine in this case?

A. We tried -- we all tried to print the values, but we could not get it.

Q. Why not?

A. I don't know if something went wrong with the printer. We all tried. When we quit, one of

the nurses tried to take a Polaroid picture of the values on the machine, and it came out dark, so we could not do it.

Q. When did that happen? When did somebody try to take a Polaroid picture?

A. After the code.

Q. After the code?

A. Uh-huh. But all the values were in the machine at that time.

Q. All of the values were there?

A. Uh-huh.

Q. You have to answer yes.

A. Yes. Yes.

Q. And how do you know they were all there?

A. The machine, you push patient data, okay, push patient data, and the data comes on. And you can roll back to the beginning of the case, to an hour before. It rolls on this screen. So if you want to make a copy, you can make a copy.

Q. So you tried --

A. Yes.

Q. Go ahead. I am sorry. I interrupted.

A. No. If you want to, you can make a copy.

Q. So after the code, after Mr. Porter is pronounced actually, you punched up the patient

data, correct?

A. Yes. Me, the nurses and the people in the room, some of us, we tried to print the record. We just could not print the record.

Q. But you saw it on the screen?

A. Yes. Everybody saw it.

Q. Everybody saw it?

A. Some of us in the room who could look saw the record, the data.

Q. Who saw it?

A. The chief of anesthesia was there. He saw it.

Q. Who is that?

A. And the nurses was there. Dr. Boakye.

Q. What nurses saw it?

A. Eugenia, (inaudible).

Q. Spell that.

A. It is in the chart.

Q. Who else saw it?

A. The risk management lady came in. I think she saw it. I think.

Q. So there is a group of people looking at --

A. They were looking because we were trying to print it out, and we could not print it out. And

someone took a Polaroid camera and was trying to get a picture on the screen as the numbers were, and they could not. It just came out dark. All of the figures were there.

Q. So then what happened? What happened to that data?

A. I don't know.

Q. Did anybody -- while y'all are standing around, does anybody make notes of what the values were?

A. Not that I recall.

Q. Did you ever find out what was wrong with the machine, that it wouldn't print this data?

A. I think it is just a printer, because we don't really use it. Okay? I haven't had an occasion to go back and print it. So we don't usually use this, so I don't know what was wrong with it.

Q. Did anybody say, "We need to preserve this data"?

A. We left the machine there. We left the room. We closed the room. The data was there until the room was reopened.

Q. When was it reopened?

A. I think a day, a couple of days. This

was Saturday. And it may -- as I told you, I didn't go back to the OR area, but I think it was probably opened Tuesday or so.

Q. Who authorized the room to be reopened?

A. I don't know.

Q. I mean, did you discuss with anyone, we can't reopen that room, because we need to preserue that data?

A. I don't make that decision.

Q. Did you discuss with anyone that we needed to preserve this data?

A. All I know was that I was told the room is not to be used.

Q. Who told you that?

A. I believe it was a lady from Risk Management.

Q. She gets around. What did she tell you?

A. All I knew was that she was saying the room cannot be used, okay, for the weekend cases. The room cannot be used.

Q. Because you wanted to preserve this data?

A. I don't know if it is because of the data, but all I know is that they said the room should not be used.

Q. Okay. Well, when did you find out that

the room had been used?

A. As I said, you know, I was mostly at the OB section, and the preop evaluation clinic. That is where I was the rest of the time. But I come to the doctor's lounge in the OR once in a while, and I believe that sometime during the week the room was being used.

Q. Well, weren't you kind of upset that this room was used and now this data was going to be lost forever?

MR. TREU: Objection.

Q. You can answer.

A. The room was left not at my decision, Okay. It was a decision. So whatever they wanted to do with the room, look at the room, look at -- what I feel, they probably accomplished what they wanted to do. So that is as far as I know.

Q. But did you ever ask anyone, "Hey, did they ever get that printer working to get that data out?"

A. No.

Q. Never asked anybody?

A. No.

Q. Anyone ever tell you what happened to that data?

A. No.

Q. Anyone ever tell you that they weren't able to print it out ever?

A. No, they didn't. I didn't ask anybody.

Q. Anybody tell you that they were able to print it out?

A. I didn't talk to anybody about that data. I don't know whether it was printed or not.

Q. I don't really understand how this data works. If you started a new case after Mr. Porter's case, would all of Mr. Porter's data be wiped out?

A. No.

Q. How long -- you don't know how long it is preserved?

A. I don't know how long it keeps. Let's say I start a case at 10:00, and there was a case at 7:00. I can go back and get the data from 7:00 to 9:00, 10:00. But how long it is kept in the machine, I do not know.

Q. But so I am clear, the data that we are talking about would be a continuous recording of the end title CO2?

A. No. No. No. I am talking about the Hewlett Packard machine, which gives blood pressure, heart rate, oxygen saturation and other monitoring

you may do.

Q. Okay. Not the end title CO2?

A. No.

Q. But it would give us a continuous blood pressure reading?

A. Uh-huh.

Q. Yes?

A. Yes. Depending on how often -- you can set it to take blood pressure every minute, every 2 minutes, every 5 minutes, you know, every 10 minutes, whatever you set it to do, you can get that blood pressure data on the machine.

Q. What was it set in Mr. Porter's case?

A. I think three minutes.

Q. For blood pressure?

A. Yes. That is how I usually set my blood pressure data.

Q. How about pulse?

A. The pulse, it takes continuously, because the pulse oximeter is on all the time.

Q. How about 02 saturation?

A. Continuously.

Q. What else? What else would be in that data?

A. What I monitored that the Hewlett Packard

would give values would be the blood pressure, the heart rate and the temperature and the pulse oximeter reading.

Q. Is there any similar type of data for the end title CO2?

MS. HENRY: That you can print out?

Q. That you can get.

A. I believe what that can give you is a trend at the time, a trend. You can push a button that will give you a trend in graphical terms, but I don't know how it -- it may not give you the figure, but it will give you a trend. It is a graph from the mask spectrometer.

Q. Can that be printed out?

A. No.

Q. It just shows up on your screen?

A. Yes, if you want to see the trend during the case.

Q. Okay. Looking at your anesthesia record here, I am going to try to get us oriented to time. It appears to start at 9:00?

A. Yes.

Q. And that starting point, is that the point that he comes into the OR?

A. Yes.

Q. Okay. And at what point is he induced, pursuant to this chart?

A. I took the first blood pressure around 9:05, so I -- right after that, we had started induction.

Q. Okay. And your note says that he is moved to the OR bed in prone position at 9:25.

A. Yes.

Q. Let me just ask you about that remark section. Are you making those notes as the case is going on?

A. Yes. Most of them, except for the 9:27, that I put after the 10:00, I put that later.

Q. Why is that?

A. As you are doing things, you may leave out something, so after I put the 10:00, I put down the 18 gauge IV in the right arm.

Q. Why did you do that, put another IV in?

A. Because as you can see, the patient's blood pressure is down, is low. The patient, I presumed, was septic and needed more fluid resuscitation, so I felt the one IV was not adequate.

Q. Okay. So at 9:27, you add another IV, correct?

A. Yes. Yes.

Q. And did you get the response you were looking for in terms of his blood pressure?

A. It hovered around the same area with anatrope and more fluid. It was hovering around the same area, lower than I wanted it to be. And the heart rate was high. But to me, I presumed it is because the patient was septic.

Q. That was your presumption?

A. Yes.

Q. Did you discuss that with anybody during this procedure?

A. Not at the beginning. Not yet, no. That was for me to take care of. That is my job, so I don't need to discuss with anybody else in the room.

Q. Do you know what his BP readings had been since he had been admitted to the hospital?

A. When he was admitted, the day he was admitted, his systolic was about 145, 148. Okay?

Sometimes you see people in the emergency room who have had trauma, been injured, definitely their blood pressure may be -- unless they have lost a lot of blood, their blood pressure will be higher than normal.

On the floor, he has been between 110 to 130, 120, 130. And his preop blood pressure that was taken on the floor before he was brought down was 110 over 60.

Q. When did you get all of that information about his BP?

A. They do a form. They take his vitals just before they bring them down. During the week, we do that in the preop holding, but on the weekends, for emergency, the nurses on the floor do it just before they bring the patient down. And if you look at this one --

Q. What is it called?

MS. HENRY: Says nursing department preoperative checklist. Sandra Harold or something like that.

A. May I go to the ladies room?

Q. Sure.

(PAUSE)

Q. Okay. I was asking you about the blood pressures. And you referred me to the nursing department preoperative checklist.

A. Yes.

Q. What is it about that checklist that told you about the blood pressure? What are you looking

at?

A. It says BP 110 over 60.

Q. Okay. That was the BP they did up on the floor, right?

A. Yes, just before the preoperative vitals.

Q. Right. But you were talking before about his BP on admission and so forth, up to the 15th.

A. No. You were asking me what his BP has been. And I was just giving you an idea, the chronology.

Q. Right. And my question is when did you learn of the BP trend from the time of admission, up to the time of the operation that you were involved in?

A. When did I learn of it?

Q. Right.

A. I reviewed the chart briefly before the surgery. And I knew of -- the previous preop had said BP is 148 over 70, but that was for the first surgery.

Q. Right. I mean, did you go through and look at the BP's all the way through?

A. I looked at the nurse's chart.

Q. The graphic?

A. Yes. Yes. I just looked at a trend. I

didn't look at individual values.

Q. Were you concerned at all about the blood pressure being what it was at the time of your -- the surgery you were going to perform anesthesia on?

A. No, I was not concerned with 110 over 60.

Q. Were you aware that there had been a drop in BP that was noted up on the floor earlier in the evening or early morning?

A. Blood pressures can vary.

Q. My question is were you aware, Doctor? Were you aware of that at the time of the surgery, that there had been a drop in his BP up on the floor that Dr. Ghanma had been notified about?

A. That Dr. Ghanma had been -- Dr. Ghanma was notified about his temperature.

Q. All I really want to know is whether you were aware of that drop in his blood pressure at the time of your surgery -- not your surgery, the time of the surgery you were going to be involved with?

A. I knew it was different. But in the hospital, sometimes you see the patient comes into the office at a time the blood pressure may be high. When the patient relaxes -- so blood pressures can differ with times.

As long as it is not -- it doesn't raise a flag like very low. The blood pressure can vary. The first one, 145, was when the patient was injured, in pain, in the emergency room.

Q. Did you discuss with anyone, prior to inducing Mr. Porter, the blood pressure trend that he displayed since his admission?

A. No, I didn't discuss with anyone.

Q. Let me ask you about on your anesthesia record, the end title C02. The first entry you have for that is a 38.

A. Yes.

Q. What time does that relate to?

A. That was after the intubation.

Q. Is that the first ETCO2 that you took?

A. That was the first one I wrote down.

Q. I know that. But is that the first one that you -- is that the one that you check marked ETCO2 present up in the airway management box?

A. I don't know if it says the same value, but as soon as I intubate, 1 mask manually and look at the monitor to make sure I have a tracing right, entire amount to confirm to placement. So at that time, 1 am not recording. So I cannot say if it is that amount. That one is just checking, confirming

my tube placement.

Q. Okay. This 38, can you tell me what time period that relates to? Sometime in between 9:15 and 9:30?

A. Yes.

Q. Or is it 9:15 or is it 9:30?

A. All I can tell you right now is sometime between 9:15 and 9:30.

Q. And the 36, that is the next one, that relates to sometime in between 9:30 and 9:45?

A. Yes.

Q. And the next 36 that is recorded there relates to sometime between 9:45 and 10:00?

A. Uh-huh.

Q. You have to say yes.

A. Yes.

Q. There is a drop in blood pressure that you have recorded at 10:00.

A. Yes.

Q. A drop in systolic blood pressure, right?

A. Yes.

Q. There was a drop in end title C02 at the same time as the drop in the blood pressure, correct?

A. Yes.

Q. So that would have been at 10:00, the ETCO2 dropped?
A. Yes.
Q. From 36 to 10 to 15?
A. Yes.
Q. What did you attribute that drop in the ETCO2 to?
A. It can imply a low cardiac output state with the blood pressure drop and end title C02 drop.
Q. What else can it be a sign of?
A. Going through differential diagnosis, without saying exactly what happened to this patient, I can say that it can be -- a pulmonary embolism can give you a drop in end title CO2, but I am not saying this is -- I don't know what happened.
Q. I understand. We are talking now just generally about what a drop in end title CO2 can signify, correct?
A. Yes.
Q. That is what you were responding to?
A. Yes.
Q. And you said one of them -- one would be low cardiac output?
A. Uh-huh.
Q. You have to answer yes.

A. Yes.
Q. One would be a pulmonary embolism?
A. Yeah.
Q. And another one would be tube displacement?
A. No. Tube displacement, you will use the end title C02.
Q. You will lose it all together?
A. Yes.
Q. And you didn't lose it all together?
A. No, because as soon as I treat it, it came right back up.
Q. You treated it after 10:00 or at 10:00?
A. I treated the blood pressure.
Q. By giving?
A. Epinephrin.
Q. And the blood pressure came right back?
A. Yes. So was the end title C02.
Q. When the end title C02 dropped, did you check the placement of the endotracheal tube?
A. I treated the blood pressure right away. The end title C02 came up. I listened to the lungs and that was it.
Q. You listened to the lungs?
A. Yes.

Q. What did the end title C02 come up to?
A. It came up to previously in the 30's.
Q. You don't have any end title C02 charted after 10:00 --
A. At the time I was busy --
Q. Let me finish my question, Doctor, You don't have any end title C02 charted after 10:00, correct?
A. Yes.
Q. So after the point that it dropped, you never charted it again, correct?
A. I was busy --
Q. Answer my -- Doctor, I understand your --
A. -- looking and taking care of the patient, and I didn't want to go back and do it when I didn't do it at the time.
Q. I just want to know -- I don't know whether it is in some other part of the chart, so that is why I am asking the question.
A. No, I didn't.
Q. So after the end title C02 dropped, you didn't chart it after that point, correct?
A. Yes.
Q. You did chart the blood pressure, correct?

A. Yes. The blood pressure -- from the time this happened, I was taking care of the patient, I didn't do a charting from that time on. The blood pressure for that time interval and the saturation I got from the Hewlett Packard machine.

Q. I am not sure I understand what you are saying, but let me try. You do have after 10:00 on this anesthesia record, blood pressures charted, correct?

A. Yes.

Q. And you have pulse charted?

A. Yes.

Q. And you have O2 saturation charted?

A. Yes.

Q. And you have temperature charted?

A. Yes.

Q. And you have EKG charted?

A. Yes.

Q. Now, when did you write that in the chart?

A. Those were after the code.

Q. After the code?

A. Yes.

Q. And you got those off of the --

A. Off of the monitor.

Q. Off the machine?
A. Yes.
Q. All that data we were talking about before?
A. Yes.
Q. So you sat with the chart, looked at the machine after Mr. Porter is dead, correct?
A. Uh-huh.
Q. Answer yes, please.
A. Yes.
Q. And wrote in his chart, right?
A. Yeah.
Q. On his anesthesia record, correct?
A. Yeah, just that portion.
Q. Everything after 10:00?
A. Uh-huh.
Q. Correct?
A. Yes.
Q. You have to answer yes. I am sorry I have to keep reminding you.
A. Yes.
Q. But a year from now -- why didn't you write anything for the end title CO2?
A. Because that does not show up in the Hewlett Packard machine.

Q. But it shows on that other machine, that trend, right?

A. It doesn't say the values. I do not want to put down something that I know -- it was in the 30's. I don't have the exact amount, okay, so I could not just put it down.

Q. But it shows a trend, doesn't it?

A. Yeah, it does.

Q. After 10:00?

A. Uh-huh.

Q. Yes?

A. Yes.

Q. Did you look at that trend?

A. I was looking at the machine throughout the entire data back up to where it was.

Q. Did you discuss with anyone that you were going to put these notes or marks on the anesthesia record after the code?

A. No, I didn't discuss. These are facts on the machine, so I thought that was okay. The machine keeps the values.

Q. Was the patient moved at all during the procedure?

A. Not during the procedure, no.

Q. Just moved on the table and then flipped

later?

A. Yes.

Q. You did when the blood pressure dropped at 10:00 inform Dr. Ghanma, correct?

A. Yes.

Q. What did you tell him?

A. 1 told him that I have a problem with the blood pressure. That was a pretty high drop, so I felt the surgeon had to know that 1 ham having problem with the blood pressure.

Q. Did he ask you about terminating the procedure?

A. Not that I recall.

Q. What did he say when you told him?

A. They turned around and looked at me. And then I was treating the patient and the blood pressure came back. End title C02 came back.

In my opinion, that surgery wasn't necessary for this patient's life. The patient had sepsis, has an infected leg, has been in Lake Eerie.

So as soon as the blood pressure came back, I told him it is corrected, and he finished, but he was aware that he needed to finish quickly, and he finished quickly.

Q. When did you first notice there was something wrong a second time?

A. As soon as the surgery was over. I realized the blood pressure started cycling again. I lost the pulse oximeter reading.

Q. You lost the pulse oximeter reading?

A. So I felt for the pulse. And that is when I didn't feel any pulse. And the machine, the EKG was showing a V tach, ventricular tachycardia.

Q. And what else? What else did you notice?

A. The end title was down again.

Q. Down to what?

A. He wasn't breathing.

Q. It was down to zero?

A. Almost, not quite zero, but it was real low on the screen.

Q. What about the BP?

A. It was cycling, because it needed a pulse to get a BP. It was just cycling.

Q. I don't know what that is, cycling.

A. The machine could not take a blood pressure.

Q. Couldn't get one?

A. Yes.

Q. So the ETCO2 was lower than it had been

the previous time when it fell, correct?

A. Yeah.

Q. Was it two? Was it five? What was it? Do you have a recollection?

A. At that time, I knew the patient had arrested, and my attention was on the patient.

Q. Okay. What time was this?

A. As soon as they finished the case, according to the note, it was 10:28.

Q. That is according to whose note?

A. According to the nurse's note, the case was done at 10:28.

Q. So what did you do when this happened?

A. I just told them, bring the bed. I give epinephrin. The patient had arrested in a prone position.

Q. Do you have to return that call, Doctor?

A. No. I turned it off.

Q. All right. I asked you what did you do when you noticed at the end of this procedure, what you have told us is the absence of blood pressure?

A. I just told the patient has no pulse. Hurry, bring the bed. The patient is in a prone position. We cannot do CPR or anything in a prone position. So I give a dose of epinephrin. At the

same time, I scream, "Get the bed into the room." Okay. And then I told somebody to get a crash cart.

Q. And then what did you do?

A. As I said, I gave the epinephrin. They brought the bed and we turned the patient over onto his bed, onto the stretcher.

Q. Who turned him over?

A. We all -- the people in the room helped me.

Q. Did somebody call a code?

A. Yes.

Q. How does that happen? What happens?

A. There is a button in the operating room which you can push that will call it.

Q. Who pushed it?

A. I have a patient who has arrested. All I know is a code was called. I don't think -- to me, it wasn't important who called the code. My attention was all on the patient.

Q. Okay. You could just tell me that you don't know.

MS. HENRY: Just say, "I don't know."

Q. How long did it take to get the patient

from the prone position onto his back?

A. It was quick. As soon -- they rush with the bed, and we turned the patient over right away.

Q. Have any problem getting his head turned over?

A. No.

Q. None at all?

A. No.

Q. What did you observe when you got the patient back in the supine position?

A. To turn the patient over, I disconnect from the ventilator. Okay. I turned the patient over, put the Y piece back on, and try to manually ventilate the patient.

And I felt some increased resistance to ventilating the patient. To me, increased resistance can mean a kink in the tube, plugged by mucus, or herniated -- what do you call them? They just escape me. Anything can happen.

I did not have the time to troubleshoot what is going on, why I had the increased resistance. I knew the patient was easy to mask ventilate, was easy to intubate, so my decision at the time, take the tube out, mask ventilate and put the tube back in.

Q. Okay. Before you flipped the patient over, you disconnected the --

A. Y piece. The tube was still in. The Y piece to the -- we do that when we turn a patient, because that io a pull on the tube. Okay. So we disconnect. This is briefly.

Q. It takes a second?

A. Yeah.

Q. And it took a second?

A. Yeah.

Q. No problem getting the Y piece disconnected, correct?

A. No.

Q. That is correct?

A. Yes.

Q. Did you observe the patient's face?

A. Yeah. At that time, the patient had arrested.

Q. Was he blue?

A. There was -- I am sure there was a change, but I was -- was he completely blue? No. I didn't observe him to be blue.

Q. I am trying to get the sequence now again. Did you remove -- after you moved him over onto his back --

A. No. No. Right away, after we moved him, the patient was not blue.

Q. I am asking about something else.

A. Okay.

Q. When you got him over on his back, the Y piece had been removed, correct?

A. Yes.

Q. Was the tape still in place?

A. Yes.

Q. Had it been -- had the tape been moved at all?

A. Not that I recall.

Q. Was the tube -- did the tube appear to be in place?

A. It did, but I had a problem with ventilating. It could be endobronchial. There could be a kink. There could be blockage by mucus clot. It could be anything. It could be a decreased compliance of the lungs from any sort of disease, like --

MS. HENRY: He just wants to know, Doctor, was the tube in place, from what you could see?

A. Oh, yes.

Q. From what you could see?

A. Yes.

Q. One of the things you could -- that could be a reason why you had difficulty in pressure -- let me ask it this way.

One of the things that can cause extra resistance in bagging is that the tube is not in place, correct?

A. Yeah. It is possible. From the moving, you know, moving the patient over, but it wasn't there before.

Q. What wasn't there before?

A. The pressure, the ventilator pressure. Everything was fine.

Q. So you elected to remove the tube?

A. Uh-huh.

Q. And then reintubate, correct?

A. Yes.

Q. Let me jump out of sequence here and go back to when he was first intubated. Was an x-ray done to check the placement of the tube?

A. We do not do x-ray in the operating room to check placement of tube, because end title C02 is the equal for checking placement of endotracheal tube.

Q. So the answer is no then?

A. No.
Q. What happened when you reintubated?
A. What happened when I reintubated? He had breath sounds, but we still could not get end title c02.
Q. He did have breath sounds?
A. From squeezing.
Q. From squeezing?
A. Uh-huh.
Q. But no end title CO2, which would indicate no real exchange of gas?
A. Yeah.
Q. I don't know if under the circumstances you can give any kind of time sequence, but if we start at 10:28 as being the time when the procedure ended, and this is the point at which you noticed the problems, correct?
A. Uh-huh.
Q. You have to answer yes.
A. Yes.
Q. At what point did you -- how long was it before you extubated the patient?
A. Right after we turned the patient over and I realized the increased resistance in bagging him, I just took out the air and then took the tube

out. And we have the mask sitting right there, because I used that and put the mask on and started bagging the patient.

Q. How many minutes?

A. It is not minutes. In ventilating the patient, it was just right after I removed the tube, put the mask on. But I need to get enough oxygen in the patient's system before I do a laryngoscopy to put the tube back in. That is what I did.

Q. I mean, can you say that -- let's go to the point that you intubated him. What time was it when you intubate -- reintubated him? Do you have any idea?

A. I can't tell you the exact minute, but the patient was being ventilated all the time before the intubation.

Q. Would it be within a matter of minutes of the time of the noticed arrest? Within minutes of 10:28 a.m.?

A. Yeah.

Q. Did you say anything to anybody in the room about, "I am going to extubate him now"?

A. No.

Q. When you decided to extubate him, was one of the things you were thinking, that the tube might

not be in place?

A. I knew there was something causing the increased resistance, and I didn't know what, so I just took the tube out, I was thinking a plug or a kink or anything, so I just took the tube out.

And I usually have two tubes on the machine. So I took that tube out and took the other one for the intubation.

Q. My specific question was, when you extubated him, was one of the things that you considered the possibility that that tube was not in an appropriate place?

A. I said it is possible, but what was higher on my mind was there may be a kink or a plug or anything in the tube.

Q. The reintubation, how did that go? Was it an easy reintubation?

A. Uh-huh.

Q. You have to answer yes.

A. Yes.

Q. First attempt?

A. Yes.

Q. And then you put the bag on, correct?

A. Connected it to the Y piece and manually ventilate with the bag. And that is what I was

doing with the mask also.

Q. What was the result when you were manually bagging after you had reintubated? Was the pressure relieved?

A. Yeah.

Q. And you were getting breath sounds?

A. Uh-huh. Yes.

Q. What did you in your mind consider to be the problem at that point?

A. All I know is that there has been a catastrophic event to cause an arrest. What caused the patient to arrest, I can't tell you.

Q. Why do you think that you were getting pressure with the tube -- the original tube and not getting pressure with the reintubation?

A. I feel it is possible when we turned him over that the tube may have been endobronchial. But let me tell you. Sometimes when the tube is dislodged, what you get is decreased pressure. You don't always get increased pressure. Most of the time it is decreased resistance when the tube is dislodged.

Q. So what does that mean? I don't know what you are alluding to.

A. What I mean is that the tube was possibly

in, may have been kinked, may have been endobronchial, but it possibly -- possibly it wasn't out of place.

It was a decision I had to make at the time, knowing the patient could be ventilated by mask all right. The patient can be tubed easily. And that was an instant decision I made at the time.

Q. For --

A. I had to make a decision on how to treat the patient. And that was the best thing to me. That was a good decision to make.

Q. When you extubated him, did you notice a kink in the tube?

A. I just took out the tube and started masking him.

Q. Did you notice a kink in the tube?

A. I did not observe.

Q. A kink?

A. No. I did not observe a kink.

Q. Did you observe a mucus plug?

A. I did not observe.

Q. Do you know if anybody checked those tubes to see whether -- that tube, I mean, to see whether it had a kink in it?

A. No, not as far as I know.

Q. Do you know if anyone checked it to see if there was a mucus -- evidence of a mucus plug?

A. Not as far as I know.

Q. For a period of time after you extubated him, you just directly ventilated him with a mask, correct?

A. Yes, sir.

Q. What did you get when you did that?

A. I get rise in chest, you know, the air was going in, because I was busy ventilating. My one hand was on the mask, one hand was manually bagging the patient.

Q. Were you getting any exchange of gas, or at that point you wouldn't know --

A. I know I was ventilating him. I was -- I know I was ventilating him. But at the time, I don't think there was any circulation.

Q. But at that point, when you are doing it just with the mask and the bag --

A. We were also treating him. I told you a V tach and the patient was without pulse. I called for the crash cart. We just -- we defibrillated him once, and then it was more like EMD systole, so that wasn't indicated anymore, and we were doing CPR and giving him epinephrin. All of this was going on.

Q. How long did you ventilate him before -- after the extubation, before you intubated him?

A. As long as I felt it was necessary to get some oxygen in before I take the time to do a laryngoscopy.

Q. After you reintubated him, was a chest x-ray taken?

A. That was later on in the code.

Q. Were you still there at that point?

A. Yes, I was.

Q. Did you participate throughout the code?

A. Uh-huh. I was participating in the room.

Q. Did there come a point in the resuscitation efforts that you -- other people took over for you?

A. Yes.

Q. When was that?

A. Somebody took over the manual ventilation after I had done it -- I took it about an hour and a half. Sometimes we take turns to do things when a person has been doing it for a long time. You need fresh hands to come in and continue doing it.

Q. Did you remain in the OR until the code was over?

A. Yes, sir.

Q. Why was the chest x-ray taken?

A. I do not know who ordered the chest x-ray. Dr. Sacka was running the code --

MS. HENRY: Do you know why? Who ordered it or why it was taken? Yes or no?

A. No.

Q. You don't know why it was taken?

A. No.

Q. While the resuscitation was going on, were people asking you questions about what had happened?

A. Yes, sir.

Q. Was blood drawn from the patient during the resuscitation efforts?

A. Uh-huh. Yes.

Q. Do you know who drew the blood?

A. No.

Q. Do you know if there was any difficulty drawing the blood?

A. To get a blood gas, you have -- yes, because to get a blood gas, you have to feel a pulse. And when the patient is pulseless, it is difficult to draw a blood gas.

Q. Were they able to draw blood?

A. Yes.

Q. Arterial blood?

A. We don't know.
Q. Why don't you know?
A. It is not clear. The blood was dark. It is not clear if it is venous or arterial.
Q. Was this like a med technician or something that was drawing his blood, or a nurse?
A. I don't know who drew the blood.
Q. What was the purpose of drawing the blood?
A. To check the blood gases, oxygenation, pH and all of that.
Q. How many times was blood drawn?
MS. HENRY: Do you know?
A. I don't know, but from the values, it looks like I see one blood gas. Whether more was drawn, I don't know.
Q. There is two blood gas readings.
A. Okay. Then two was done.
Q. Well, I have seen situations where one sample is run twice, and they list two readings. Do you know --
MS. HENRY: How many draws there was?
A. I don't know.
Q. Were the results of the blood gas called back up to the room while you were there?

A. They usually do, but there was so much going on.

Q. Do you recall anyone discussing the blood gases during the resuscitation?

A. I don't recall.

Q. You know the results that were recorded now. When did you learn of those results?

A. After the code.

Q. What was your conclusion regarding those results?

A. There wasn't oxygenation. There wasn't anything exchange. PO2 was very low.

Q. Did you discuss those blood gas results with anyone?

A. No.

Q. Aside from anything that may have been said in your quality assurance meeting, did you discuss those at any time with anybody?

A. No.

Q. Doctor, do you have an explanation for the PO2 results that were reported for Mr. Porter at 10:45 and 11:08 on the 15th?

MS. HENRY: What do you mean by an explanation? She said earlier there wasn't much exchange of gas.

Q. I am asking whether you can explain how Mr. Porter got to those levels.

A. 10:45 is almost 20 minutes after the patient arrested, and there was no exchange, not much exchange.

Q. According to your anesthesia note, the patient was getting 100 percent O2 saturation --

A. No. No. Sorry. Go on.

Q. Between 10:15 and 10 -- between 10:00 and 10:15, correct?

A. Yes, sir.

Q. Do you think it is feasible that a patient could go from getting 100 percent 02 saturation, down to a PO2 of 9 at 10:45?

A. The patient has arrested. He is not perfusing. The patient is not perfusing.

Q. My question is do you think it is possible to get from the 02 saturation level that you have charted between 10:00 and 10:15, down to a level of 9 at 10:45?

A. All I can tell you is what happened.

Q. I understand you are telling me what happened, but as a physician, do you think that is possible?

A. The patient has arrested for 20 minutes

-- almost 20 minutes.

Q. So you think it is possible?

A. Yeah.

Q. If it was venous blood instead of arterial blood, how would this affect these readings?

A. The PO2 would be much lower, because a normal PO2 in venous blood is 40. In arterial blood it can be anywhere from 97 to 100, so it is also possible it was venous blood.

Q. Would the standard difference in readings be -- is there a standard difference in readings between venous and arterial?

A. Oh, yes.

Q. I mean, I know there is a difference, but can you say well, it is five -- the difference is five?

A. It depends on how much oxygen you are giving to the patient, but normal -- the standard PO2 is about 40. Arterial blood is anywhere from 90, 97 to 100 for breathing room air.

Q. After the resuscitation efforts ceased, Mr. Porter was declared dead3

A. Yes.

Q. It was at that point that you got some of

these values that you put in your anesthesia record off the machine?

A. Only those I could get off the machine.

Q. And I noticed that your values after 10:00 go up to 10:15 and stop on your anesthesia record, correct?

A. On the record that I did, yes.

Q. Why does it stop at 10:15?

A. Sometimes the time -- I don't know why I stopped at 10:15, but I am sure the values were there after the time we turned the patient over.

Q. Because the procedure --

A. I may not have recorded everything, because after the patient was pronounced, there was just so much going on, I put some of it down, but the patient was okay until the patient coded.

Q. Well, here is my problem, Doctor. You go back after the procedure, after the patient is pronounced dead, and you put in values from 10:00 to 10:15, and then you stop. And the procedure went on to 10:28, correct?

A. As I remember, I don't know if that is what happened. I was told I had a call from the assistant coroner, so I left the room while I was doing this to answer the phone call.

I do not know if that was the time I stopped doing the recording, but I got on the phone and was talking to the assistant coroner, and I didn't go back again to do anything.

Q. Are you just speculating that this may have been what interrupted you --

A. Yes.

Q. -- or do you know that?

A. It is possible.

Q. Okay.

A. You should note my frame of mind. I was working on this, I got a call. I had to come out and pick up the phone and talk to the assistant coroner on the phone. He wanted to know what had happened. So I left the room, and then I didn't go back to my recording.

Q. Who is the assistant coroner? Dr. Madis? Who is the coroner?

A. No. It is not Dr. Madis. It wasn't Dr. Madis. This guy was also a family physician at the hospital. I don't remember his name. If I get some names, I can become familiar.

Q. There were values on the machine leading up to the arrest at 10:28, correct?

A. Yes.

Q. And for some reason, either you got interrupted, or we don't know, for some reason you didn't record those values after 10:15, correct?

A. Uh-huh.

Q. You have to answer yes.

A. Oh, boy. Yes.

Q. Well, did anyone ask you, "Hey, Dr. Quansah, what happened between 10:15 and 10:28?" Anyone ever ask you that?

A. No.

Q. When did you write your note in the progress notes that is dated 7-15-95?

A. After the whole event.

Q. Was that before or after you made the notes in the anesthesia record that we talked about after 10:00?

A. After 1 came back -- after I left the room to talk to the assistant coroner, and then I went and sat in the doctor's lounge and wrote the note.

Q. Okay. Was anyone with you when you wrote this note?

A. No.

Q. Did you discuss your note with anybody?

A. No.

Q. When did you write your addendum?
A. Right away. After I signed the note and read over it, I realized that I hadn't added anything on taking the tube out, so I put the addendum right away.
Q. Did you have a discussion with the risk manager about that addendum?
A. No, sir.
Q. Did you have a discussion with the risk manager about the placement of the tube at all?
A. No.
Q. How long did you talk to the assistant coroner?
A. I was on the phone -- he was asking me what had happened. And I told him I didn't -- I can't tell you exactly how many minutes. He just was asking me questions.
Q. And do you know, was he taking notes of this? Do you know?
A. I don't know. He was on the phone.
Q. Was he recording it? Do you know?
A. I don't know.
Q. What did you tell him?
A. I just told him what has happened in the operating room.

Q. And after your discussion with the coroner, you went back into the operating room?

A. I went to the doctor's lounge and sat down and wrote my notes.

Q. I thought before you said that you went back in. Okay. Did you have the whole chart with you when you wrote this note?

A. No.

Q. What did you have? Just three blank sheets of paper?

A. No. I had the preop report and the preop -- the nurse's sheets. Things were not put together. I didn't have the code note. I didn't have anything. I just had my preop.

Q. You had your preop note, correct?

A. Yes.

Q. And that is all?

A. That is what I recall I had.

Q. What about your anesthesia note? Where was that when you were writing your --

A. Yeah, I had my anesthesia record.

Q. Did you have any conversation with the risk manager in the operating room?

A. All I recall was her mentioning that we should not use the room.

Q. That conversation you told us about before?
A. Yes.
Q. And when did that conversation take place?
A. After the code, in front of the OR room.
Q. Do you know how the risk manager was called up to this operating room?
A. I think --
MS. HENRY: Do you know?
A. I don't know.
Q. Has anyone told you how she got up there?
A. No.
Q. Was there a procedure in place for the risk manager to respond to something like this?
A. Maybe --
MS. HENRY: Do you know?
A. I don't know.
Q. Did the risk manager tell you anything about another case involving an endotracheal tube at this hospital?
A. That was later when 1 went up to her and wanted a copy of the patient's chart. Some few days later. But I had -- okay.
Q. When did you go? A couple of days --

MS. HENRY: When did you go?
A. This happened Saturday. Probably Tuesday.
Q. You went up to her office?
A. Yes.
Q. What did you go up to her office for?
A. I wanted a copy of the patient's chart.
Q. Why did you want a copy of the patient's chart?
A. Some event has happened and I needed to have a chart for my record.
Q. Okay. What did she tell you about this other case?
MR. TREU: Objection.
Q. Go ahead.
A. Just what happened, and that the patient passed in the OR, and there was a lawsuit. That was about it.
Q. It involved questions about an endotracheal tube?
MR. TREU: Objection.
A. No. There was no mention of endotracheal tube.
Q. She just said, "We have got another case where somebody died in the OR"?

A. Uh-huh.

MR. TREU: Objection.

Q. You have to say yes.

A. Yes.

Q. Did she tell you anything about your charting?

A. No.

MR. TREU: Objection.

Q. Did anyone discuss with you prior to your writing your note, your anesthesia note that is in the progress notes, that this death could be attributed to extubation?

A. No.

Q. Has anyone ever discussed that with you?

A. No.

Q. You have obviously gone over these events in your mind many times, haven't you?

A. Yes, sir.

Q. And you have gone over the records?

A. Yes, sir.

Q. You have a copy of the complete chart with you, don't you?

A. Yeah.

Q. I mean, all the -- you have it in your office or something?

A. In my home,

Q. Is it possible, Doctor, that the endotracheal tube came out of place while Mr. Porter was in the prone position?

A. No, sir. If it had, the patient would have -- something would have happened. The patient was paralyzed. If the tube had come out of place, this would have happened long before.

Q. What do you mean it would have happened long before?

A. It is not possible for the patient to have gone on for a while, almost one and a half hours paralyzed with endotracheal tube not in place. That is not possible, sir.

Q. No, I am not suggesting it is possible, but it wasn't in for an hour and a half. What I am asking, isn't it possible that this endotracheal tube came out of place at some point towards the end of the procedure while he was in the prone position?

A. No, sir. The end title C02 came right back. I listened to the lungs. There was a pulse oximeter reading. No, sir.

Q. You are referring to the 10:00 drop, aren't you?

A. Yes. Yes.

Q. I am referring to a time after 10:00, closer in point in time to 10:28.

A. No, sir. Nothing could have happened to have moved the tube out of place. The patient was not moved. Nothing happened. I look. I am very attentive in the operating room.

Q. I mean, for the tube to be out of place, it only has to move a small amount?

A. No. The tube was taped very securely. The end title CO2, the capnograph is sensitive. I would have noticed.

Q. What you are saying is that if it had come out, you would have noticed it, right?

A. Yes, sir. Yes.

Q. I mean, but is there anything --

A. Alarms would have buzzed. And I have a capnograph right in front of me. And with the patient, I am watching. I am watching my monitors. I am watching the patient. No, sir, nothing came out.

Q. What alarm would have gone off?

A. The ventilator alarm. You are not ventilating the patient, and the capnograph alarm will go off.

Q. What do they do when they go off? Do

they buzz or beep?

A. Yeah, they buzz. It is loud. You can hear it.

Q. Well, is there anything in the record between 10:15 and 10:28 to tell us what the status of Mr. Porter's ETCO2 was?

MS. HENRY: Is there anything in the records?

A. I said this is my anesthesia record, and that is what you see.

Q. And there is nothing on your anesthesia record to tell us what was happening with his blood pressure from 10:15 -- actually let's back up. Strike that.

With respect to the end title CO2, there is nothing in your anesthesia record to tell us anything about it after 10:00, correct?

A. Yes.

Q. And with respect to the blood pressure, there is nothing in your record to tell us what was happening with his blood pressure after 10:15, correct?

A. Yes, sir. I wish we could have gotten that printout, but nothing -- there was -- the machine would have alarmed and everybody in the room

would have known.

Q. Nothing with respect to his pulse after 10:00 -- 10:15, correct, in your records?

A. Sir, there was a pulse. I was there.

MS. HENRY: He just wants to know in your record.

A. No.

Q. When is the last time that you made any notation in Mr. Porter's chart anywhere?

A. Usually all of the anesthesia record is --

MS. HENRY: When is the last time you made any notation?

A. In the chart itself?

MS. HENRY: Which would include -- yes. You are talking about the addendum, too?

MR. LANSDOWNE: Right.

A. That was it.

Q. This would be the day after when you were in the -- or the day of his death when you were in the --

A. The doctor's lounge. I had no access to the chart after that.

Q. Did you make any notations anywhere else, outside the record, about Mr. Porter, after that

time?

A. No, sir.

Q. Did you have any other discussions with anybody from the coroner's office after July 15th?

A. Yes.

Q. Who did you have discussions with?

A. I talked to Dr. Madis.

Q. When?

A. I think the day after the autopsy.

Q. Did he call you or did you call him?

A. I called him.

Q. What did you discuss?

A. I just asked him what his findings were.

Q. Anything else?

A. No.

Q. Did you ever have any discussions with anybody from the Porter family?

A. No.

Q. Who is the chief that you mentioned? Sacka?

A. He is a cardiologist.

Q. He is the one who was -- he is one of the people that was in the room when the code was --

A. He came later.

Q. Did you have a discussion with him later

after July 15th about this patient?

A. No. Not outside.

Q. Not outside what?

A. We already mentioned it. I am not supposed to.

Q. Let me just take a few minutes here to go back over my notes.

MS. HENRY: If you want to ask anything, Don.

MR. SWITZER: No, I don't have any questions.

MS. HENRY: Kris?

EXAMINATION

BY MR. TREU:

Q. Just one or two, Doctor. First just let me ask you, do you have any criticisms of any of the other people taking care of Mr. Porter?

A. No, sir.

Q. That would include any of the doctors, any of the nurses?

A. No, sir.

Q. I wanted to ask you. When you saw Mr. Porter preoperatively, did you do any kind of an examination of him at that time?

A. Can you explain?

Q. Did you do any kind of a physical examination of him?

A. I checked his airway. That is all.

Q. You did not check the rest of his anatomy?

A. No.

Q. All right. You mentioned to us that when you tried to get him to move up on the bed, that he complained of pain in his leg?

A. Yes, sir.

Q. Did he ever complain to you of pain in the abdominal area?

A. No, sir.

Q. That is all I have. Thank you.

MS. HENRY: Dennis?

FURTHER EXAMINATION

BY MR. LANSDOWNE:

Q. Do you have to -- in a patient under anesthesia that you have got the tube taped in, do you continuously check the tape yourself?

A. Not all the time. We just check -- I don't check the tape all the time. Usually when they are supine, you can see the tape. But what

continue checking is the ears, eyes and hand position, to make sure that everything is okay, there is no unnecessary bending of the arm or anything.

Q. Does saliva loosen the tape?

A. Yes, it is possible, but only around the area you see saliva go by, but the tape is all the way and wound around.

Q. Is that one of the things that you watch for, saliva loosening the tape?

A. Yes. I see saliva when it comes out, but I don't think in this case it was saliva coming out.

Q. I am sorry again on this timing. The conversation that you had with the risk manager about not using that room, was that before or after you wrote your note?

A. Before. Just when I was passing, she was saying the room should not be used, but that was the extent of the conversation.

Q. The nurses that were involved in this procedure, did you have any discussions with them after July 15th about what had happened?

A. I don't recall.

Q. When you went to see the risk manager a

couple of days later, did you discuss with her that the room was now -- had been used?

A. No, sir. No.

Q. Did you discuss with her anything about the data being lost?

A. I don't recall discussing that.

Q. It just seems to me that this data would really clarify a lot of things about what happened, wouldn't it?

A. I wish we could have printed it. We just couldn't. We got a tape from another room, put it in the machine, tried. And as I told you, the nurses tried to use a Polaroid to get it, and we just couldn't get it. I wish the data was here, too.

Q. Right. I mean, I just imagine that you would have talked to somebody who said, "Why can't we preserve that data," not just printing it, why can't we prevent anybody from using those machines until we have established exactly what happened? Did you have any conversation --

A. Sir, if you have been in my position and know how I felt at that time, you know, to me, I tried as much as possible to get the data and I couldn't.

Q. When you say you tried as much as possible, what do you mean?

A. Like trying to print it and somebody using the Polaroid to try to take a picture of the data.

MS. HENRY: Come on Dennis. Don't belabor this.

Q. I know you tried really hard, but somebody is dead and we have got to find out what happened.

A. I know.

Q. This really distresses me.

MS. HENRY: She can't give you the data because she doesn't have it from the machine, the printout. I don't know what else she can tell you about this.

Q. When you had the data in front of you, you started recording it into your anesthesia note, correct?

A. Yes.

Q. And then for the last minutes of the procedure, you stopped recording it, correct? And now we have to go by your memory, right? Is that basically what we are left with as far as these critical minutes towards the end of the procedure?

A. Sir, all I know is that a patient was breathing. The patient was ventilated. Alarms would have sounded. The whole room would have heard it. The capnograph is a very sensitive indicator of what is going on. It will measure the entire C02. It alarms when it is not measuring. And everything happened as soon as they finished the case. And there were people in the room.

Q. I just want to -- so if this ever comes up. You have no opinion as to what caused Mr. Porter's death, correct?

A. No, sir.

Q. Okay. That is all I have.

MS. HENRY: We will read it, just to be sure that we have it taken down properly, if it is transcribed. Thank you.

(WITNESS EXCUSED

IN THE COURT OF COMMON PLEAS
FOR THE STATE OF OHIO
COUNTY OF LORAIN

HUBERT PORTER, ADMINISTRATOR
OF THE ESTATE OF
BRAD J. PORTER, DECEASED

VS. NO. 96 CV 115689

MANHAL A. GHANMA, M.D.,
ET AL

COURT REPORTER'S CERTIFICATE
ORAL DEPOSITION OF DR. ARABA B. QUANSAH
Taken November 16, 1996

ATTORNEYS OF RECORD:

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I, Debra D. Guthrie, Certified Shorthand Reporter for The State of Texas, do hereby certify that I am the deposition officer before whom this deposition was given; that the witness was duly sworn by me; that the transcript is a true record of the testimony given by the witness; that my charges for preparation of the completed original deposition transcript and any exhibits thereto are:

Original Deposition $ 630.65
Copying of Exhibits $ .15
Mileage $ N/A
To Be Paid By Hon. Dennis R. Lansdowne - PLF

I further certify that the original deposition was:

[X] Hand-delivered or sent via First Class Mail to Hon. Deirdre G. Henry, attorney of record, on the date shown on the bottom of this Court Reporter's Certificate, for obtaining the signature of the witness

[ ] I further certify that the witness failed to sign and return the original deposition within 20 days, and that a copy of the deposition may be used in lieu of the original.

[X] I further certify that the witness signed and returned the original deposition, and that the original deposition, along with any corrections or changes thereto, was hand-delivered or sent via First Class Mail to the attorney who asked the first question appearing in the transcript for safekeeping and use at trial.

I further certify that a copy of this Certificate was served on all parties to the lawsuit made known to me at the time of the deposition, and filed with the Clerk of the Court in which the case is pending.

Witness my hand this 3rd day of December, 1996.

Debra D. Guthrie

Debra D. Guthrie
Certified Shorthand Reporter
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THE STATE OF TEXAS)
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COUNTY OF________)

I hereby certify that I have read the foregoing deposition, and that this deposition is a true record of my testimony given at this deposition, together with any changes or corrections that I have indicated in the spaces provided below and the reasons for the changes. (DO NOT MAKE CORRECTIONS ON THE TRANSCRIPT. USE BACK SIDE OF PAGE IF NECESSARY)

PAGE	LINE	CHANGE OR CORRECTION	REASON FOR CHANGE

____
DEPONENT

SUBSCRIBED AND SWORN TO before me by the said witness on this the_____ day of___________________, 19____.

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COUNSELLORS AT LAW

February 7, **1997**

Ms. Loretta Lancaster, Office Manager
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Midland, Texas **79701**

RE: *Hubert Porter, Admin., v. Manhal Ghanma, M.D., et al.*
Our File No. 01087-17373

Dear Ms. Lancaster:

You provided Dr. Quansah with her deposition. She has had the opportunity to review this and has made the changes / corrections to the transcript. These are set forth in the three page Affidavit which has been signed and notarized.

Please do not hesitate to contact me should you have any questions.

Very truly yours,

Deirdre G. Henry

Deirdre G. Henry

DGH/ljl
Enclosure

cc: Mr. Dennis Lansdowne, w/encl.
Mr. Donald Switzer, w/encl.
Mr. Kris Treu, w/encl.

CV 115689
Plaintiff vs. Ohio

2-11-97
Let Deirdre see entire depo - gone Copy to Deirdre

STATE OF **TEXAS**)
) **ss:** **AFFIDAVIT**
COUNTY OF **DALLAS**)

I, hereby certify that I have read the foregoing deposition, and that this deposition is a true record of my testimony given at this deposition, together with any changes or corrections that I have indicated in the spaces provided below.

PAGE	LINE	CHANGE / CORRECTION
4	11	"wait" should be "waited"
4	13	"Brinmar" should be "Bryn Maw"
4	23	"Brinmar" should be "Bryn Maw"
5	22	"Michigan" should be "Miami"
6	23	"locum-tenency" should be "locum tenens"
7	8	"Compel Corn" should be "Comp Health/Kron"
8	5	"premed" should be "Premier"
9	23	"the" should be "their"
13	3	"Ghana Dominican Republic" should be "Dominican Republic"
13	22	"July" should be "August"
13	23	"middle" should be "end"
14	11	"October 18, '95" should he "October 13, '95"
15	13	"locum-tendancy" should be "locum tenens"
15	15	"opened" should be "open"
15	21	"Nation Wide" should be "Nationwide"
16	5	"locum tenancy" should be "locum tenens"
16	9	"locum tenancy" should be "locum tenens"
16	17	"locum-tenant" should be "locum tenens"
17	5	"February" should be "September"
20	8	"Hays" should be "Hazen"
23	8	"preop" should be "peri-op"
24	15	"places" should be "colleagues"
27	18	"IND" should be "I&D"
28	7	"morning test" should be "monitors"
28	18	"IND" should be "I&D"

PAGE	LINE	CHANGE / CORRECTION
31	4	"Ritalin" should be "Reglan"
31	12	"Biodman" should be "Boydman"
32	25	"Biodman" should be "Boydman"
42	7	"tonsil palate" should be "tonsillar pillars"
45	17	"polarizing" should be "depolarizing"
49	10-11	"tubal curari" should be "tubocurarine"
49	14	"curari" should be "tubocurari"
49	15	"curari" should be "tubocurari"
50	14	"nitros" should be "nitrous"
51	15	"endotracheal tube" should be "y-piece"
51	17	"monoxide" should be "dioxide"
52	13	"is paralyzed" should be "is to paralyze him"
54	9	"piece" should be "tube"
59	23	"form" should be "foam"
61	2	"form" should be "foam"
63	1-2	"mask spectrum" should be "mass spectrometer"
63	2	"monoxide" should be "dioxide"
63	9	"**mask** spectrum" should be "mass spectrometer"
63	10	"title" should be "tidal"
66	2	"title" shouid be "tidal"
74	13	"mask" should be "mass"
76	5	"anatrope" should be "inotrope"
80	21	"mask" should be "bag"
82	9	"title" should be "tidal"
82	14	"title" should be "tidal"
83	6	"use" should be "lose"
83	7	"title" should be "tidal"
83	16	"epinephrin" should be "epinephrine"
83	18	"title" should be "tidal"
83	22	"title" should be "tidal"
88	17	"title" should be "tidal"
88	18	"wasn't" should be "was"
88	21	"eerie" should be "Erie"
89	11	"title" should be "tidal"
90	14	"give" should be "gave"
90	15	"epinephrin" should be "epinephrine"
90	between lines 16-17	the transcript should reflect that (the doctor's beeper went *off)*
90	25	"epinephrin" should be "epinephrine"
94	18	"clot" should be "plug"
95	22	"title" should be "tidal"
96	4	"title" should be "tidal"
101	23	"**EMD** systole" should be "**EMD**" and then "asystole"
101	25	"epinephrin" should be "epinephrine"

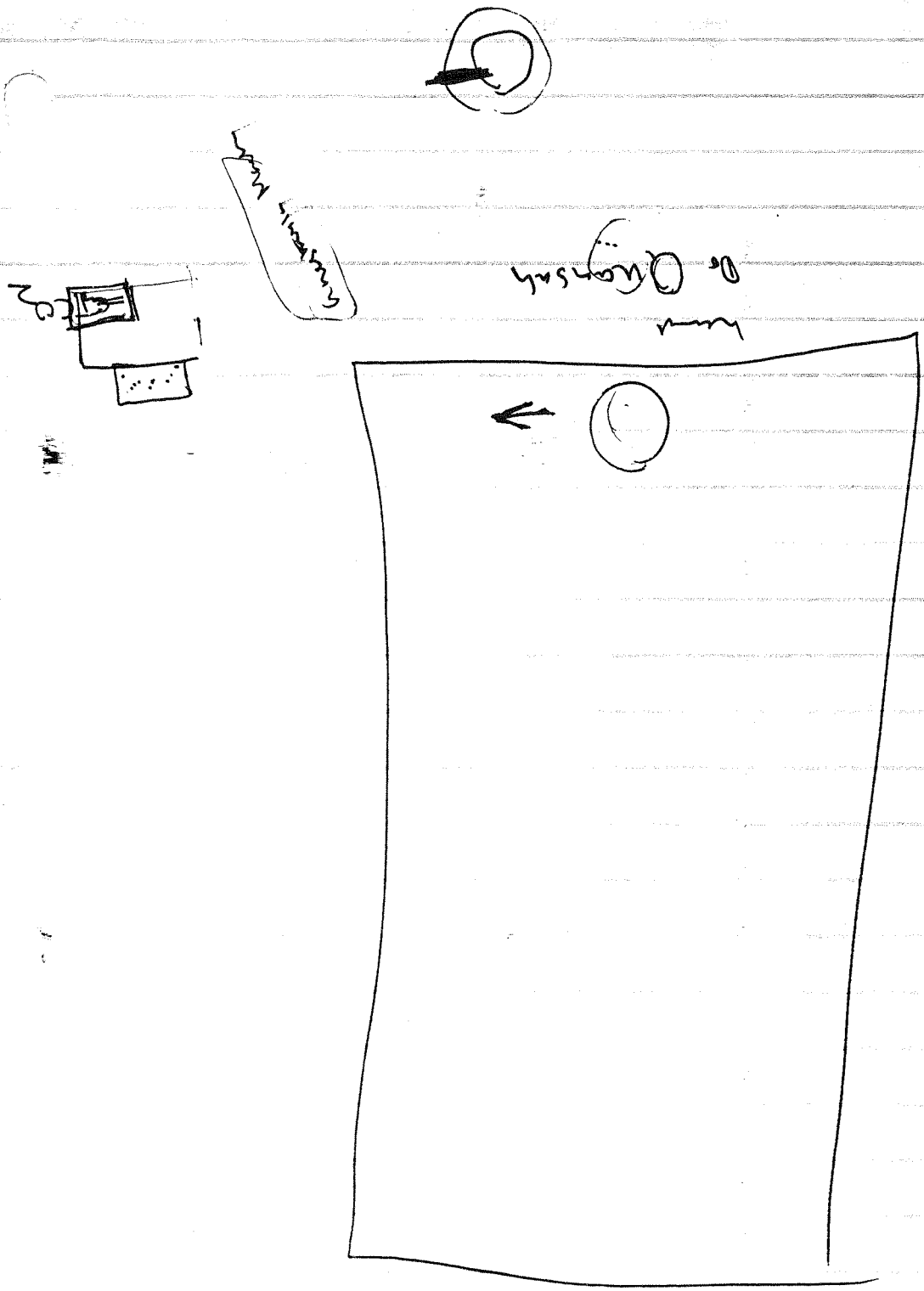
PAGE	LINE	CHANGE / CORRECTION
103	2	"Sacka" should be "Salka"
105	12	"anything" should be "any"
116	20	"title" should be "tidal"
117	10	"title" should be "tidal"
126	5	"title" should be "tidal"

ARABA QUANSAH, M.D.

SUBSCRIBED AND SWORN TO before me by the said witness on this the ___ dav of Feb 1 . 1997.

[illegible] AMINIAN
Notary Public, State of Texas
My Commission Expires 01-25-0[illegible]

Notary Public



DEPOSITION EXHIBIT
1