The State of Ohio,)
County of Ashtabula.) SS:
IN THE COURT OF COMMON PLEAS
Sara McKee, a Minor,)
et al.,)
Plaintiffs,)Case No.
-vs-)2001CV129
Ashtabula County Medical)
Center, et al.,)
Defendants.)

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Videotaped deposition of GEORGE KINGSLEY, D.O., a Defendant herein, called by the Plaintiffs as if upon cross-examination under the statute, and taken before Luanne Stone, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Thursday, the 13th day of June, 2002 at 11:00 o'clock A.M. at the offices of Joseph Farchione, Esq., Erieview Towers, the City of Cleveland, the County of Cuyahoga and the State of Ohio.

APPEARANCES:

On behalf of the Plaintiffs:
Becker & Mishkind, by:
Michael Becker, Esq.

On behalf of the Defendants,
George Kingsley, D.O. and
Ashtabula Clinic:
Sutter, O'Connell, Mannion &
Farchione, by:
Joseph Farchione, Esq.

On behalf of the Defendant,
Ashtabula County Medical Center:
Bonezzi, Switzer, Murphy & Polito,
by:
Donald Switzer, Esq.

ALSO PRESENT:
Mr. & Mrs. McKee

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P R O C E E D I N G S

GEORGE KINGSLEY, D.O., being of lawful age, having been first duly sworn according to law, deposes and says as follows:

CROSS-EXAMINATION OF GEORGE KINGSLEY, D.O.

BY MR. BECKER:

Q Good morning, Doctor. Would you tell us your full name, please?

A George M. Kingsley, III.

Q And what is your current business address?

A 524 West 24th Street, Ashtabula, Ohio 44004.

Q Who is your current employer?

A The Ashtabula Clinic.

Q Is that also known as ACMC?

A It is a subsidiary of ACMC.

Q So, it's -- your employer is actually, quote, "the Ashtabula Clinic"?

A Correct.

Q Company or --

A The Ashtabula Clinic is the name of the corporation.

Q How long have you been so employed there?

A Since November of 1996.
Q All right. Let's work backwards a little bit. You went to medical school where?
A University of North Texas, Texas College of Osteopathic Medicine, Fort Worth, Texas.
Q And you graduated what year?
A In 1990.
Q Thereafter, you were engaged in an internship as well as a residency?
A Correct.
Q Where was your OB/GYN residency at?
A My categorical OB/GYN internship and residency were at the William Beaumont Army Medical Center in El Paso, Texas.
Q Were you in the service at that time?
A Yes, I was.
Q In what capacity?
A I was a commissioned officer.
Q What year did you finish your residency?
A 1994.
Q Was it a three or four-year OB/GYN residency?
A It was internship plus three years of

residency.
Q From 1994 until you joined the Ashtabula Clinic in November of '96, how were you employed?
A I was still a commissioned officer in the United States Army, stationed overseas in Heidelberg, Germany at the 95th Combat Support Hospital.
Q Doing obstetrics?
A Yes.
Q And you did your service to the country, and then you left and started private practice in 1996?
A That's correct.
Q How did you happen to come to Ashtabula?
A My -- I had served with my former partner in Heidelberg, Dr. Paul Jones. He and I were both originally from Ohio. He had moved his family back to The States prior to my leaving the service and had engaged in negotiations with the Ashtabula Clinic to start an OB group. He contacted me to join -- to join that group.
Q So, Dr. Jones, a colleague of yours, had already been employed at the time you

joined Ashtabula Clinic?
A He was not an employee yet but was in negotiations to start this group practice.
Q Okay, and to your knowledge, do you know how it was that he went to Ashtabula for his practice?
A I believe that while he was stationed at Fort Knox, Kentucky, he was doing locum tenens work and found out through a recruiter that the Ashtabula Clinic was looking to start an OB program.
Q Now, is it fair for me to conclude that when you and Dr. Jones joined the Ashtabula Clinic, you were the first obstetricians?
A I was the first one there.
Q Okay, and then Dr. Jones followed you by a few months?
A Followed me, yes, sir.
Q I understand Dr. Jones has left the Ashtabula Clinic.
A That's correct.
Q And when did he leave?
A In July of '99.
Q Why did he leave, to your knowledge?
A He was discharged from the Ashtabula

Clinic for cause.
Q Do you know where he currently is practicing?
A He's employed at Lake Obstetrics in Painesville.
Q Was there a formal hearing within the hospital for his -- I'm not asking you what happened. I just want to know if there was --
A I don't have any knowledge.
Q That's it. Do you have any plans of leaving the Ashtabula Clinic?
A Yes, I do.
Q When do you plan on leaving?
A My termination date is June 16th.
Q Of?
A This year.
Q This year?
A (At this time the witness nodded his head.)
Q Within a few days, you're going to be leaving?
A Three days from now is my last day as an employee.
Q Okay. When did you give notice of your

intent to leave?
A Ninety days ago.
Q What was -- what's the reason you're leaving?
MR. FARCHIONE: Well, we're not going to get into the reason why. He is going stay in the area, Mike, and open his own private practice, but I'm not going to get into his private business reasons for why he's opening his own practice.
It has nothing to do with this lawsuit, if you want to ask him that question, but --
BY MR. BECKER:
Q Well, I mean, you can answer in a general form. Is it for business reasons that you're starting your own practice?
A It's --
MR. FARCHIONE: It's not --
THE WITNESS: Everything is for business reasons. It's a general question which -- yes, for business reasons.
BY MR. BECKER:
Q Okay. You're going to essentially be staying within the same city?

A I don't know. I have -- I have no specific plans at this point in time.
Q Your counsel has indicated that he's going to be -- you're going to be staying in the general area. So, is that true?
A I am -- my -- my current intent is to establish a private practice in Ashtabula County. Whether I will be able to accomplish that goal is yet to be determined.
Q Well, have you started a business plan as to where you're going to open your office and how you're going to obtain clients?
MR. FARCHIONE: Now we're done with it, Mike. We're not going to get into his personal business.
BY MR. BECKER:
Q Well, do you have any idea if you're going to be employed 60 days from now?
A I anticipate that I will not be employed 60 days from now.
Q Do you have an idea whether or not you're going to be -- do you anticipate being employed six months from now?
A I would hope so, but I have no specific plans.

Q This departure from Ashtabula -- when I say "ACMC," was it voluntary on your part?
A Yes.
Q You were not asked to leave?
A No.
Q Once you leave, what obstetricians will be remaining at ACMC?
A There are --
MR. FARCHIONE: At the hospital or at the clinic?
THE WITNESS: There are several physicians that have privileges.
BY MR. BECKER:
Q Okay, at the -- at the clinic.
A At the Ashtabula Clinic?
Q Yes.
A My two existing colleagues, Dr. Murray and Dr. Slotta.
Q Are they OBs, or are they family doctors that do obstetrics?
A Only OBs do OB at ACMC.
Q Okay.
A So, they are OBs.
Q So, there will be some obstetricians there after you leave?

A (At this time the witness nodded his head.)
Q You're going to have to answer verbally.
A Yes, sir.
Q I forgot my caveats here. This is a question-and-answer session under oath. It's important you understand the question that I ask.
A Yes, sir.
Q If you don't understand the question, you tell me so, and I will attempt to rephrase or restate the question, fair enough?
A Yes, sir.
Q However, unless you indicate otherwise to me, I'm going to assume that you fully understood the question that I've posed and that you're giving me your best and most complete answer today, fair enough?
A I understand.
Q One other caveat; it's important that you answer verbally and avoid head nods. Fair enough?
A Correct.

Q Is this the first time you've ever been deposed?
A Yes.
Q What have you reviewed in preparation for this deposition?
A The antepartum and intrapartum chart on the admission for Robin and the birth of baby Sara.
Q Did you bring with you your original chart?
A No.
Q Any reason why not?
A I don't have custody of the original chart.
Q Did you review anything else?
A No.
Q Did you do any research in preparation for this deposition?
A Not specific to this cause.
Q Do you have -- did you generate any notes as a result of this particular induction at any time that would not be included in either your prenatal chart or the ACMC records?
A No.

Q You are a general obstetrician?
A Yes.
Q You're Board certified?
A Yes.
Q When did you become Board certified?
A 1996.
Q So, as soon as you became eligible, you took the test, and you passed it?
A The first time.
Q Can you give me a sense as to how many babies you were delivering at the time that Sara McKee was born?
A I would say our average delivery at the Ashtabula Clinic was 25 deliveries per month.
Q You said "we." How about you personally? How many would you deliver?
A Well, since Dr. Jones left during the course of Robin's pregnancy, it switched from a "we" to a "me." So, Dr. Jones and I previously did about 25 deliveries a month. When he left, I began doing all the deliveries.
Q Doctor, I want you to know that at any time during this deposition, you're more

than free to look at the chart, either the prenatal chart or the hospital chart, before answering my questions.
A Okay.
Q How was it that, to your knowledge, that Robin McKee came to you for obstetrical care?
A I believe she was referred by two of her friends that were patients of mine.
Q Is that reflected in the prenatal chart?
A It is.
Q All right. Who were the friends?
A I noted on the first page of the ACOG form that she was referred by Sandy Amsdell and the Kipharts.
Q When -- what -- what was the date of your first hands-on care?
A My first visit with Robin was on April 2nd, 1999.
THE VIDEOGRAPHER: Off the record.
(At this time a short recess was had.)
THE VIDEOGRAPHER: Back on the record.

BY MR. BECKER:
Q Doctor, I just want to make sure that we've covered everything you reviewed in -- in this -- before this deposition. You did -- you did not engage in any research, correct?
A No.
Q You merely looked at the prenatal chart and the hospital chart, correct?
A Correct.
Q Okay. You did not look at any package inserts of the drug, Cytotec, correct?
A Not in relevance to this case.
Q Could I ask you: when was the last time you looked at a package insert of Cytotec?
A Probably in 2001.
Q I'm going to go through the prenatal chart, Doctor, and ask you a few questions. It says "G 2, P 0." Do you see that at the top?
A Correct.
Q G2, that's her second pregnancy?
A Second pregnancy.
Q Okay, and she has no living children?

A No children.
Q Okay. Under "occupation," could you tell me what that says? I see it says "KeyBank -- KeyBank."
A It says "Outside work, KeyBank computer programmer."
Q Was there any question about her dates when this pregnancy started?
A At the first visit, we had inconclusive dates. An ultrasound was performed at the second visit that confirmed her EDC dating.
Q And what was her EDC once that ultrasound was completed?
A November 13th, 1999.
Q Under "Past Medical History," we have "FOB." What does that mean?
A Father of baby.
Q Okay. So, does this mean that the father of the baby and the grandfather have diabetes?
A No, it means that the paternal grandfather, in this case paternal great grandfather to be, has diabetes.
Q And further down, number 12, "History of blood transfusions," the father of the

baby had transfusions as a newborn?
A Correct.
Q Did you make any inquiry as to what the reason was?
A No.
Q On the right-hand side, talking about breast cancer, do you see that?
A Yes.
Q And it looks like "GYN surgery." That's for the patient, correct?
A Correct.
Q Any abnormalities in the initial labs?
A No.
Q Any abnormality in any of the labs that appear on that lab sheet form?
A No, all results were normative.
Q Under "Problems and Plans," it says "History of cervical dysplasia, height in normal path."
A Correct.
Q Correct? Underneath that, what does it say?
A "Bicornate uterus, ultrasound 5/3," and I can't read the date for the year. That was Dr. Jones's handwriting.

Q Okay, and what does that mean, "bicornate uterus"?
A It's a Mullerian fusion defect where, as the two halves of the uterus are formed in the embryonic phase, the two halves don't meet properly in the midline and create a heart-shaped uterus.
Q Does that create any risk factors?
A It can.
Q What type?
A The greatest risk with a bicornate uterus are for second trimester pregnancy loss, preterm delivery, preterm labor, malpresentation.
Q And -- and did you counsel Robin McKee on all those risk factors?
A I noted at the bottom of the comments that the risks were identified.
Q And was that relayed to the patient?
A That's my usual practice.
Q I'm assuming you don't have a specific recollection of that.
A I don't have a specific recollection.
Q All right. Let's look at the prenatal chart. I don't have -- I'm not going to go

through it line-by-line. I just want to know if there is -- just bring me to a date when you find any abnormality.
A No, all of her visits were scheduled visits, no particular problems identified.
Q Under "Comments," it says, "Does not want to know." Is that the sex of the baby?
A The sex of the baby.
Q What do the numbers under "Comments," like 3 over 4, what does that mean?
A The plus 3 over 4 means she gained only three-quarters of a pound between those two interval visits.
Q So, this is weight gain?
A Weight gain comments.
Q Okay, and why are there some weight gains noted and some aren't?
A If there's a decreased amount or an increased amount of expected weight gain, sometimes the nurse will note it off to the side just to bring our attention to it.
Q Turning the page --
A I don't have copies of that.
MR. BECKER: Joe, do you have this?

MR. FARCHIONE: I don't have it with me. It's the ultrasound copy?
MR. BECKER: Right.
THE WITNESS: All I have is the ACOG face sheets for the prenatal record.
BY MR. BECKER:
Q Let me take a look at what you have, your prenatal record.
MR. FARCHIONE: It's just the four sheets?
THE WITNESS: It's just the four ACOG sheets.
BY MR. BECKER:
Q I mean, you don't have your office notes?
A I don't.
Q You don't have a copy of it at hand?
A No.
Q Well, I'll tell you what I'm going to do, Doctor. I'm going to give you my chart, and what I'd like you to do is chronologically interpret your handwriting.
A Okay.
Q Tell me the date, and I may stop and ask you a question or two.

A That's fair.
Q Okay.
MR. FARCHIONE: Starting with the ultrasounds, Mike?
MR. BECKER: Right.
MR. FARCHIONE: Is that your handwriting?
THE WITNESS: Yes. The first entry is April 2nd. It's just a little summary note. The --
MR. FARCHIONE: He just wants you to read it.
BY MR. BECKER:
Q Verbatim.
A Verbatim?
Q Yes.
A "No risks, ultrasound questionable, ten-day change of EDC? Repeat ultrasound four weeks."
Q All right. Next entry?
A Next entry is Dr. Jones's on -- actually it's a predating note from Dr. Jones dated March 9th.
Q Is that typed?
A Yes.

Q Why are yours handwritten and his typed?
A At that moment in time, Dr. Jones was dictating his antepartum. Depending on what the reason was, most OB notes are handwritten and GYN notes are dictated just for ease of practice. I think most of the remainder of his notes will be handwritten, but if a patient presents, and it's not defined as a normal pregnancy yet, oftentimes he'll dictate a note.
Q All right, any abnormalities noted in Dr. Jones's notes?
MR. FARCHIONE: You used "notes" in the plural. Are you talking about this first ultrasound report, Mike?
MR. BECKER: Right.
THE WITNESS: His note on this March 9th ultrasound is where he defines what he feels to be a bicornate uterus, that he discussed with Robin that there's increased risk for preterm delivery; however, no specific intervention was required, and he was -- she was recommended to follow up in four weeks for her routine OB ultrasound which was when I saw her for

the first time on April 2nd.
BY MR. BECKER:
Q All right. Read me the next note.
A May 28th, "Follow-up, no complaints, size consistent with dates. Ultrasound viable, active, normal size. Use 11/13," November 13, "EDC. Follow-up four weeks, labs and triple check today."
Q Next entry?
A This is Dr. Jones's note, July 2nd.
Q Would you attempt to interpret his handwriting for me?
A "Doing well, positive fetal motion. Size equals dates." Undecipherable, I can't read two lines. "Return to clinic four weeks."
Q All right. Next entry?
A It's a date in July. I can't read the date stamp. I'll try to correlate it with the other record. It would be July 26th. "Patient without complaint, positive fetal motion. Size equal to dates. Positive Dopp tones. Follow up four weeks for 28-week check."
Q Next entry?

A August 23rd, "Patient without complaints. Positive fetal motion. Size equals dates. Positive Dopp tones. Limited ultrasound shows breech. Counseled regarding need for primary transverse Cesarean section if breech persists. Not a candidate for version. Discussed warning signs and precautions for preterm labor, preterm delivery."

Q Why wasn't she a candidate for conversion?

A A bicornate uterus is a contraindication to external cephalic version.

Q Okay, next entry?

A September, and I can't read the date stamp. That would be September 8th, "Patient without complaint. Positive fetal motion. Size equals dates. Positive Dopp tones. Palpates vertex. Follow-up two weeks."

Q Next entry?

A September 20th, "Patient without complaint, positive fetal motion, size equal to dates, positive Dopp tones. Follow up

two weeks."

Q Next entry?

A There's an entry by Dr. O'Maleaus. She was a family practitioner working in my office at that time. "No contractions. No vaginal bleeding. Positive fetal motion. No discharge. No edema. Breast feeding," which I assume means plans to breast feed. "Natural childbirth. Assessment and plan: IUP 34 weeks, vertex by limited ultrasound, Group B strep next visit."

Q That was by which doctor?

A Kelly O'Maleaus.

Q Why would she be seeing this patient?

A She was a family practitioner that had been hired by the clinic that summer to start a new practice in Orwell, and the facilities were not ready in Orwell at the time that she was hired, and she needed an office to practice out of, and we developed a cooperative relationship where she saw patients in my office, both family practice and some well women and routine OB. It's a practice she continued when she moved to Orwell. She provided some antepartum care

for patients that lived that far from Ashtabula.

Q Next entry?

A October 15th, 1999, "Patient without complaints. Positive fetal motion. Size equal to dates. Positive Dopp tones. Group B strep culture done. Cervix was closed 25 percent. Vertex. Follow up weekly. Labor precautions explained."

Q Next entry?

A October 25th, 1999, "Patient without complaints. Positive fetal motion. Size equal to dates. Positive Dopp tones. Cervix closed 50 percent. Follow up one week."

Q Next entry?

A November 1st, "Patient without complaint, other than being tired. Positive fetal motion, size equal to dates, positive Dopp tones, cervix still closed 50 percent. Follow up one week."

Q What were you attributing the fatigue to?

A Well, on November 1st, she would have been 38 weeks. It's a common complaint at

38 weeks.

Q Next entry?

A November 8th, "Patient without complaints. Positive fetal motion. Size equal to dates." I noted that I appreciated that the baby had maybe dropped some. "Follow-up positive Dopp tones. Cervix was closed 80 percent. Vertex. Recommendation to follow up in one week."

Q Next entry?

A November 15th, "Patient without complaint. Positive fetal motion. Size equal to dates. Positive Dopp tones. Cervix closed 70 percent, vertex. Follow up one week," crossed out. "Follow-up labor and delivery November 19th."

Q Next entry?

A There are no additional entries.

Q So, what was the date of the last entry you just gave me?

A November 15th.

Q Did you develop a plan at that time for induction?

A We had discussed induction at 41 weeks which would have been around November 20th,

and I think we picked November 19th as the last working date that week, if I'm not mistaken.
Q What was the reason for the discussion of an induction?
A We discussed that, at 41 weeks, that the risks of continuing the pregnancy outweighed the risks of induction.
Q Did you explain to the McKees what an induction meant or what it would consist of?
A We talked about the fact that there were several agents available for use with induction, and that my preferred agent at the time was Cytotec.
Q Okay. What did you tell them relative to Cytotec, if anything other than that?
A That it was a prostaglandin that had the capability of both ripening the cervix, making the Pitocin inductions later more feasible, as well as oftentimes being the only agent needed, that it was highly effective and usually resulted in short inductions.
Q Did you tell them that it wasn't FDA-approved for obstetricians to use in an

induction?
A I wouldn't have discussed that.
Q To your knowledge, at that time was it FDA-approved for use by obstetricians as an induction?
A It was not FDA-approved for that indication.
Q All right. How did you come about starting to use Cytotec?
A Dr. Jones actually had been using it at Fort Knox when we started the practice, and did some literature search and review on its current use in practice at that point in time, and when he came and started working at ACMC, we started using it fairly routinely.
Q Do you actually have a specific recollection of ever reading the package insert for Cytotec?
A Not in -- not at that point in time. The package insert would have no bearing on our use for it.
Q All right. So, here's my question. Do you have any recollection whether you actually did bother to read the package

insert for Cytotec?
A Before using it?
Q Yes.
A I do have a recollection that the medication came with a warning label on the bottle saying "Not for use in pregnancy," meaning that it was not meant to be taken orally for the indication that it was FDA-approved.
Q Say that again, please.
A That Cytotec was not meant to be used by pregnant patients for its FDA-approved indication.
Q Okay. That was on the bottle that the drug contained?
A Right.
Q Anything else you recall on the bottle of the drug, Cytotec?
A Not specifically.
Q So, I'm not sure that you answered my question. Do you think it's likely you ever bothered to study and read the package insert?
MR. FARCHIONE: Objection to the "bothered to read" it. Go ahead, Doctor.

THE WITNESS: I have read the package insert for Cytotec. I have read it several times. Whether I had read it front to back, cover to cover before this particular induction, I have no recollection.
BY MR. BECKER:
Q Okay. You may have read it for the first time after this induction?
A I believe the first time I read it cover to cover was after Searle came out with its letter.
Q And what -- what year was that?
A I don't -- I don't recall.
Q What was the substance of the letter from Searle?
A The substance of the letter from Searle was that the manufacturer objected to its off-label use by obstetricians in this regard.
Q As a result of receiving that letter, did you change any of your practices?
MR. FARCHIONE: Objection.
BY MR. BECKER:
Q For use of Cytotec?

MR. FARCHIONE: You know what, Mike? Subsequent actions --
MR. BECKER: This is -- this is all subsequent?
THE WITNESS: This is many -- many months.
MR. FARCHIONE: Searle came out with this a little while ago.
MR. BECKER: Okay.
THE WITNESS: I would say that was in 2001, early 2001.
BY MR. BECKER:
Q Well, I mean, I think it's fair game. Do you use Cytotec today?
A Yes.
Q Okay. Explain to me what Cytotec is.
A It's a prostaglandin analog, synthetic prostaglandin.
Q Okay. Does it come -- is it a paste? Is it on a --
A It's a one hundred microgram tablet.
Q Is it a tablet that you actually place on the cervix?
A It's a scored tablet that we use -- it's a scored tablet.

Q What does that mean?
A It means that there's a precut line on one side of the tablet that's used for dividing the tablet, and it comes in a 100 microgram tablet, and we would break the tablet along the score line and use a 50 microgram dose intravaginally usually in the posterior fornix between the vaginal wall and the cervix.
Q So, you would generally insert it not on the cervix but between the posterior wall of the cervix within the uterus?
A No.
Q Or within the vaginal cavity?
A In the vaginal fornix.
Q Do they recommend a certain location, to your knowledge, as to where to place it?
MR. FARCHIONE: Who is "they"?
THE WITNESS: I don't know.
BY MR. BECKER:
Q ACOG obstetricians, other people that you read literature --
A The literature supports using intrarectal and intravaginal placement.
Q All right, and how -- how often are you

supposed to place it during an induction?
A Specifically what was our practice at the time?
Q What was your practice at the time?
A That we did a 50-microgram dose every three to four hours until adequate labor was established.
Q And jumping ahead to Robin's induction, how many doses did you utilize?
A She received three doses.
Q What's the maximum number of doses you've ever done, placed in a patient?
A I would say three or four would likely be it. I don't recall.
Q But you're not supposed to place it any sooner than every four hours?
A Our practice was to dose every three to four hours until an adequate labor pattern was established.
Q Was there any policy and procedure ever drafted within the ACMC's records to your knowledge about use of Cytotec?
A During what time frame?
Q How about by the time of Robin's induction?

A My understanding was there was no written protocol on Cytotec at the time of Robin's induction.
Q Were other people using a drug called Cervidil?
A Yes.
Q You weren't using Cervidil?
A No.
Q Why not?
A I found it to be very expensive and ineffective.
Q Prior to Robin McKee's induction, had you experienced hyperstimulation with other patients when you were utilizing Cytotec?
A There were certainly times when the patients would develop a hyperstimulus pattern, but there was never any ill effect.
Q When you -- prior to Robin McKee, when you, in fact, have, in fact, utilized Cytotec, correct?
A Correct.
Q Do you have -- did you have standing orders as to what nurses should do in the event that they appreciate hyperstimulation?
A We did not have standing orders

specific to Cytotec use, but our standing orders for labor included orders for what patients should do if the nurse felt it was a problem with the fetal heart rate tracing.
Q And does it fall under the category of what a nurse is supposed to do with nonreassuring fetal heart rate strips?
A Correct.
Q All right, but as to your knowledge, by the time of Sara McKee's induction, there was no standing order that specifically dealt with either Cytotec or hyperstimulation secondary to drugs?
A No.
MR. FARCHIONE: Drugs -- you changed it. You've asked two questions, Mike.
BY MR. BECKER:
Q I'm sorry. At the time of Robin McKee's induction, is it true that there was not any policy or procedure within ACMC relative to use and management of a patient who is induced with Cytotec, correct?
A Correct.
Q Next question: at the time of Robin

McKee's induction, was there any policy and procedures within ACMC's promulgated records that speak to hyperstimulation, specifically hyperstimulation?
MR. FARCHIONE: If you know.
THE WITNESS: In terms of Pitocin, in terms of Cervidil, any medication?
BY MR. BECKER:
Q Any medication. I'm more interested in the -- in the concept of the term, hyperstimulation.
A I believe that there were references in both the Pitocin and the Cervidil policy regarding steps to take for hyperstimulation.
Q Okay. Would you, as an obstetrician, expect the obstetrical nurses to simply follow the same guidelines for a Cervidil induction when they were, in fact, utilizing Cytotec?
A I don't -- I don't --
MR. FARCHIONE: When you say "guidelines," Mike, are you talking about written guidelines, or are you talking about

orders that may have been given?
BY MR. BECKER:
Q I'm talking about written guidelines, policies and procedures.
A I would not expect nurses to translate one protocol for another.
MR. BECKER: Go ahead and mark them. Joe, I'm going to help myself when we're off the record.
(At this time Plaintiff's Exhibits 1 to 3 were marked for identification purposes.)
THE VIDEOGRAPHER: Back on the record.
MR. FARCHIONE: I'm just going to put a general objection to Exhibits 1 and 3 which post-date this delivery. We do not know what they said at the time of the delivery in question.
BY MR. BECKER:
Q Okay. Doctor, handing you what's been marked as Plaintiff's Exhibit 1, which appears to be a policy and procedure for the Department of Nursing at ACMC on use of the drug, Cervidil; is that accurate?

A Yes.
Q To your knowledge, was such a policy in existence at the time of Sara McKee's induction?
A I believe there was a policy. I don't have a specific recollection of what the differences between this policy and that policy would be.
Q Here.
A And this is your book.
Q Under the side effects of Cervidil, number three, would you read what that says, sir, on the record?
A Side effects number three, "Hyperstimulation," in parentheses, "(remove insert end and have terbutaline 0.25 milligrams subcu available.)"
Q What does that mean?
A The Cervidil comes basically as a medication impregnated tape. The end of the tape has the medication. It's wrapped around the cervix, and that it has a long shoelace type appearance that's left outside the entrance of the vagina. If hyperstimulation occurs, the tape is

removed.
Q And that's one of the differences that -- that is, that tape is one of the differences or distinctions between Cytotec and Cervidil?
A Correct.
Q If -- if one was utilized in Cytotec, and you wanted to remove it, how would you do it?
A It cannot be effectively removed because, for the most part, the tablet dissolves in the acid pH of the vagina.
Q In what period of time?
A Usually no pill fragments can be found after an hour.
Q Whereas Cervidil, you can pull it out to reduce the effect of -- of the drug?
A It's more easily reversible in that nature.
Q What does this reference mean to terbutaline?
A Terbutaline is a beta II agonist that is FDA-approved for the use of causing bronchodilation in patients with asthma. It is also frequently used as a smooth muscle

relaxant for the uterus in case of hyperstimulation.
Q So, what is a nurse supposed to do under this Plaintiff's Exhibit 1 in the event of hyperstimulation relative to the drug of terbutaline?
A If she feels that an intervention is required based on the hyperstimulation, then she will administer 0.25 milligrams of terbutaline subcu.
Q Without any doctor's orders?
A I don't know. The doctor would have to substantiate that order, but she might take it as a standard order. This is not a standing order. It is a policy.
Q Have you used yourself terbutaline in response to hyperstimulation when a patient has been given Cytotec?
A Yes.
Q How do you administer terbutaline?
A Subcutaneously.
Q By injection?
A Injection just below the level of the skin.
Q In what part of the body? Does it

matter?
A It can be given anywhere.
Q Plaintiff's Exhibit 2, would you identify what that is, please?
A It says "Ashtabula County Medical Center, Department of Nursing, Department of Obstetrics, Management of patient with nonreassuring fetal heart rate trace -- fetal heart rate pattern," excuse me. "The purpose is to help ensure optimal maternal and fetal well being. Personnel permitted to perform, registered nurse."
Q And to your knowledge, was that policy and procedure in existence at the time of Robin McKee's birth?
A This appears to be dated June of '98. So, this would most likely be the policy in place.
Q Take a moment and look at that, Doctor, and tell me if there's anything within that particular policy and procedures that speaks to either Cytotec or hyperstimulation.
A There's no reference to any specific medications in terms of stimulating labor, and the only documentation, the only area of

documentation regarding uterine activity is frequency of contractions, duration of contractions, intensity and strength. There's no specific protocol for hyperstimulation noted.
Q Well, let's start with your definition of hyperstimulation. What does it mean?
A Hyperstimulation is when there is no appreciable break between the end of one contraction and the beginning of the next, or if you have an intrauterine pressure catheter in place, that the uterus does not return to its baseline tone between contractions.
Q Do you want at least a one-minute break between each contractions or a two-minute break between each contractions?
A You'd like to see some return to normal resting tone of the uterus before another contraction begins.
Q For how long?
A (At this time the witness shrugged his shoulders.)
Q Five seconds?
A As long as it gets back to tone, back

to baseline tone, it's not hyperstimulus.
Q You've never heard of a definition where it talks about so many contractions within so many minutes of time?
A In terms of a definition, no, but there's several people that use different working definitions.
Q Back at the time of -- of this induction with Robin McKee, did you expect your nurses to utilize terbutaline if they appreciated hyperstimulation?
MR. FARCHIONE: Objection. They're not his nurses. He doesn't employ them.
BY MR. BECKER:
Q The -- with that objection, obstetrical nurses at ACMC is what I'm talking about.
A Can you repeat the question?
Q Yeah. I'm interested as to what you would have expected back at the time of Sara McKee's birth. If your nurses appreciated hyperstimulation, what would you expect them to -- to do.
MR. FARCHIONE: Objection. Go ahead, if you can answer it with that.

THE WITNESS: I would -- would expect them to utilize their judgment in assessing whether there was any evidence of untoward effect of the hyperstimulation. Hyperstimulation in and of itself is not of significant concern unless there's signs of fetal nontolerance of the hyperstimulation. There can be transient hyperstimulation of the uterus in unstimulated labors.
BY MR. BECKER:
Q Well, what intervention would you expect the ACMC obstetrical nurses to engage in if they appreciated hyperstimulation?
A Without any evidence of any change in fetal status, I would expect them to do nothing other than closely observe.
Q Okay. So, as far as you're concerned, unless there's evidence of nonreassuring fetal monitoring strips, the nurses are free to disregard hyperstimulation?
A Not disregard.
THE VIDEOGRAPHER: Off the record.
(At this time a short recess was had.)

(At this time the question was read back.)
THE VIDEOGRAPHER: Back on the record.
BY MR. BECKER:
Q I want to make sure I understand what you would have expected of your -- of the ACMC obstetrical nurses at the time of Sara McKee's birth, okay?
A Okay.
Q If they appreciated a hyperstimulation pattern, but there was not a concurrent evidence of nonreassuring fetal heart rate strips, you would not expect them to engage in any intervention?
A No. There would be no indication for an intervention, but I would expect them to more carefully assess for any change in fetal status. It's -- it's a warning sign, but it's not a sign that requires an immediate response.
Q Well, isn't hyperstimulation uncomfortable to the mom as well?
A With different agents, there are different degrees of strength of uterine

contractions. A woman can be contracting every 30 seconds and not even feel them. So, she could be in a hyperstimulus pattern with no pain, or she could be contracting every ten minutes with extraordinary pain. You can't correlate frequency of contractions with intensity.
Q You mentioned something earlier about an intrauterine pressure catheter. What is that?
A That is a device that's manufactured by Utah Medical. It has a pressure transducer on the tip. It is placed through the vagina, through the cervical opening into the amniotic fluid cavity, and directly measures the pressure generated by each uterine contraction, so it gives you not only a qualitative assessment of how often and how long the contractions are lasting, but an actual amplitude of the intensity of the contraction.
Q Was -- was there a standing order to -- for the nurses to place the same?
A Nurses at ACMC do not place intrauterine pressure catheters.

Q Okay.
A So, there would be no standing order.
Q When would you -- when would you as an obstetrician place one?
A You would place an IUCP if there was an indication for additional monitoring, if you felt like your external monitoring was inadequate, or you needed additional information, or the patient was not progressing despite what you thought were adequate contractions. It's another way to document whether your induction has been adequate to give the patient a chance to go into labor, but it does require ruptured membranes which was not Robin's case until later in the evening.
Q Handing you what's been marked as Plaintiff's Exhibit 3, would you identify that?
A "Ashtabula County Medical Center, Department of Nursing, Procedure: Fetal monitoring of high risk obstetric patient. Purpose: fetal surveillance technique to establish evaluation of fetal heart rate and uterine activity when high risk factors are

present."
Q This form goes on to list examples of high risk factors, correct?
A Again, this was developed after Robin's delivery. It's dated May of 2000, and it has general information regarding some factors which may attribute to a higher risk.
Q Is -- to your knowledge, was there such a policy and procedure in existence?
A I don't know. These are -- these are nursing policies and protocols.
Q To your knowledge --
A I have no input to, so --
Q Okay.
A If there was such a thing, I have not seen it.
Q To your knowledge -- well, would you have considered this induction with Cytotec such that it would fall under a category today of high risk?
MR. FARCHIONE: Objection. Go ahead.
THE WITNESS: I don't consider inductions to be inherently high risk.

Oxytocin induction and augmentation is listed on this referenced A-1 article, but in my practice, I don't consider an induction to be an inherently high risk pregnancy.
BY MR. BECKER:
Q All right. Going back to this induction, when was it scheduled to take place?
A It was originally scheduled for the 19th of November, and my recollection is that the McKees contacted us and asked if we could move up the date by two days.
Q To the 17th of November?
A To the 17th of November.
Q All right. What was the reason they wanted to move it up two days?
A I don't recall the specifics. I believe they had some family conflict or had something else planned later in the week, and they wanted to know if we could do the induction two days earlier.
Q And November -- had they gone forward with the induction on the 19th, that would have been at what gestational age?

A She would have been one day short of 41 weeks. She would have been 40 and six-sevenths.
Q As it was on November 17th, what was her gestational age?
A Forty and four-sevenths.
Q And you may have already told me this, but one more time. What was the reason that you wanted to gain the induction?
A It was our standard practice to initiate inductions at 41 weeks so that the delivery would be accomplished no later than 42 weeks.
Q What did you tell the McKees about what to expect in the induction?
A Specifically I have no recollection of what I told them, but my standard discussion with patients for inductions I could describe.
Q Okay, go ahead. This is what you generally would tell?
A This is what I would generally tell a patient undergoing induction.
Q Okay.
A That they would be placed on a

monitoring bed, that we would assess how the baby was doing. We would do a cervical examination, and in this case, recommended induction with Cytotec. That we would place one tablet and reassess, and in many cases, one tablet is all that is required. We would reassess three to four hours later. If there was no significant change, no evidence of significant uterine activity and the onset of labor, then the dose would be repeated as necessary, that the average induction with Cytotec was under 14 hours from initiation to delivery, that transitioning to Pitocin was a possibility, but in most cases was not going to be required.

Q Did you indicate to the McKees that you would be available or a physician would be available during the whole period of time of the induction?

A I would have to define what "being available" means.

Q Either in the hospital or across the street at the clinic.

A I don't recall making any declaration

as to where I would be during the course of the induction.

Q Prior to this induction of November 17th, 1999, would you routinely engage in an induction and, then, leave the hospital while the induction is going on?

A Oftentimes, I would be across the street in my office while an induction was going on.

Q And were there times when you would be engaged in an induction, and you were at home; that is, the patient being -- undergoing induction, and you would be home?

A If my plan was that the induction was proceeding, then I would usually not leave the general area of the hospital.

Q Can we agree that up until November 17th, 1999, you had every expectation of having a normal newborn for the McKees?

A Yes.

Q Can we agree that it was really essentially an uneventful pregnancy up until the time of the induction?

A We had identified some risk factors, but the bicornate uterus didn't end up

having any obvious effect on the pregnancy at the time.

Q You had every reason to believe, Doctor, that the McKees would receive a normal, healthy newborn by the end of the induction, correct?

A That's my anticipation, but obstetrics is an uncertain business. You can't promise or guarantee any outcome.

Q Okay. I'm not asking you about promises or guarantees. I'm asking about your expectation.

A My expectation was that the baby would be fine.

Q To your knowledge, you never indicated to the McKees up until the time of the induction that: I'm worried about this or that, and we may have a problem if there's an induction?

A We had no reason to anticipate a problem.

Q Okay. Now, what time did the -- and, again, feel free to look at your chart.

A Uh-huh.

Q What time did the induction begin?

A I believe the first Cytotec dose was given at approximately 8:00, but I can give you an exact time.

Q This is a.m., correct?

A It's in the nurses' flow sheet. Okay. Nursing Assessment, their entry at 0800, "Dr. Kingsley in to view strip, plan of care discussed, Cytotec 50 micrograms vaginally, Rochelle Perkio, RN."

Q Eight a.m.?

A Eight a.m.

Q All right. When -- for the next three or four hours, was there a positive response to the use of Cytotec?

A There was some evidence of increased uterine activity.

Q All right.

A But --

Q Excuse me.

A But there was no evidence of onset of labor.

Q All right, and for that reason, you ordered a second dosage of Cytotec?

A I personally placed the second Cytotec.

Q Okay. Do you recall having discussions

with the McKees at the time you placed the second dosage of Cytotec?
A I have no specific recollection regarding that discussion, but I came over to assess how the induction was progressing. There was no cervical change. Uterine contractions were still mild, and, so, the second dose was placed.
Q All right, and what time was the second dose placed?
A 11:20.
Q All right. What happened thereafter for the next three or four hours; was there any success now that we have two units or doses of Cytotec onboard?
A Is there a time in specific that you want me to look at or just in general?
Q I'm going up until the time of the next administration of Cytotec.
A Again, there was some response to the Cytotec. There was increase in the number of contractions. The nurses noted at 4:00 that she began becoming slightly uncomfortable. She was up to walk, normal process at this point.

Q All right. At some point, you applied a third dosage of Cytotec?
A Um, I believe that was at 1800. It's not marked on this record. I think it might be on the strip, on the other page. At 1755 the third dose was placed.
Q Okay, and did you place it?
A Yes.
Q Do you recall having any discussions with the McKees after placement of the third dose?
A I recall that we were a little bit discouraged that we hadn't seen any significant change in the cervical status, but I felt like things were a little bit softer. The cervix was a little bit more anterior, that I thought that there was still a chance that she would go into labor with the third Cytotec dose, but our plan was that, if she didn't go into labor with the third Cytotec dose, that we would rest her on the floor overnight and start with Pitocin in the morning as the Cytotec had proven to be ineffective.
Q Would you say that one more time, please?
A That we were going to go ahead and place a third Cytotec dose.
Q Okay.
A That it was somewhat unusual that she was not responding to the medication, and that the plan was that, if she did not enter into a regular labor pattern with the third dose of Cytotec, that we would allow her to rest overnight, and initiate a Pitocin induction in the morning.
Q All right. Then, what happened?
A Specifically, I'm not --
Q Did you -- you went home after you placed the third dosage?
A I went home at some point during the evening. I don't have a specific recollection of what time that was.
Q Can you tell from the chart what time you went home, Doctor?
A No, it's not documented.
Q How far away from the hospital do you live?
A I live in Jefferson, which is approximately 12 miles south of the hospital.

Q At any time on the evening of the 17th, did you come back to the hospital and look at the fetal monitoring strips or examine Robin?
A No.
Q Why not?
A There was no indication that my presence was required.
Q Did you have any phone contact by any of the obstetrical nurses between six p.m. and midnight on the 17th?
A I believe there was one.
Q And what time was that phone contact?
A I'm having difficulty locating it.
THE WITNESS: Joe, do you remember when the first phone call was? I don't think it was --
MR. FARCHIONE: Here's a 2:20 in the morning. Was there one earlier?
THE WITNESS: I thought there was one earlier, because that's the delivery one. There were two phone calls.
MR. FARCHIONE: This copy is pretty difficult to read, Mike. Is yours any better to read?

THE WITNESS: If you can direct us to the time of the first phone call.
MR. SWITZER: 7:40.
THE WITNESS: There it is, okay.
BY MR. BECKER:
Q What is your recollection, independent -- if you have any independent recollection of that phone contact?
A She called to say that the -- the patient was wanting something for pain medication, and I asked if she had done a cervical exam, and she said yes, there was no change. I asked how she was contracting in response to the last Cytotec dose, and she said there was an increase in uterine activity. I asked how the baby was doing. She said there was good variability, and the baby was fine.
Q Who is "she"?
A Denise Wadowick. So, my recollection is I approved the use of pain medication despite the fact that we were not showing signs of active labor, but that it might give her some pain relief and help her to get a good night's rest so we could start

the induction again in the morning.
Q Where was the pain located?
A Lower uterine, lower abdomen.
Q So, it was just uterine cramping? Yes?
A Discomfort with labor, yes.
Q What type of pain medication did you authorize?
A We had standing orders for Nubain with Phenergan.
Q Is that an injection?
A It's an IV injection, slow IV push.
Q And was that actually administered to Robin?
A I believe it was administered at several times throughout the night.
Q What was your order; one time?
A My order was that she could go ahead and initiate pain management.
Q Meaning she could use it when she feels it's indicated?
A Right. Nurses have a standing order that allows them, with a particular dosing schedule, to use pain medication along with their nursing judgment as to how the baby's tolerating labor and what the response is to

the medication.
Q Did you have any other inductions going on that evening?
A No.
Q Did you have any other of your patients in labor that evening?
A I don't recall if any other patients came in, outpatient or not. The ACMC would have a log of that, but I have no recollection.
Q Have we covered your recollection of contact with OB nurses from ACMC for that evening?
A There was one subsequent phone call.
Q In the morning?
A At 2:00 in the morning.
Q Okay, and let's go on to the 18th, then. On the 18th, when was your next contact from ACMC obstetrical nurses?
A 2:20 in the morning.
Q And that again was by Denise?
A Yes.
Q And what did she want?
A She was concerned that there was evidence of hyperstimulation, and I asked

how the -- again about cervical status, and she said no significant change at that point, if I recall, and that the fetal variability was still good, and my recommendation was, as long as there was no change in the fetal status, that we could continue to observe and proceed with the plan.
Q So, you -- you were contacted by Denise about 2:00 in the morning on the 18th?
A 2:20 a.m. is what her notes say. I have to trust her timing.
Q Right?
A Correct.
Q But is it fair to state that what prompted the call to you was Denise's concern about hyperstimulation?
A That's why she called.
Q Okay. Why was she concerned about that?
MR. FARCHIONE: Objection, go ahead.
BY MR. BECKER:
Q If you know.
A I don't know what her concern was,

because she then went on to say that the fetal heart rate tracing was reassuring, and in the evidence of a reassuring fetal heart rate tracing and the patient's membranes are now ruptured - that was my first report that membranes were ruptured - and she was contracting more regularly, and no evidence of -- of any change in fetal status, no intervention was authorized.

Q Well, you could have told her to give terbutaline, correct?

A I could have.

Q Why didn't you?

A Because there was no report of any change in fetal well being. I had to trust her assessment that at the time that, despite what she thought was some hyperstimulation, that the baby was tolerating the labor.

Q Okay, and the concept of nonreassuring fetal heart tones, is that defined anywhere in policy and procedures, to your knowledge?

A In terms of how to interpret?

Q Right.

A Fetal heart rate tracing, all of our

nurses undergo significant training in fetal heart rate interpretation.

Q What are the categories of nonreassuring fetal heart tones?

A Nonreassuring fetal heart rate tracings can be characterized by periodic or nonperiodic changes in the fetal heart rate tracing that show decreases in variability, that show presence of uniform or variable decelerations in combination, and they have to be interpreted in context.

Q Had you worked with Denise prior to this particular induction?

A Certainly.

Q And had you ever had any problems with Denise prior to this induction relative to her ability to either appreciate nonreassuring fetal heart rate tones or to engage in appropriate intervention?

A No.

Q Never had a problem with her?

MR. FARCHIONE: He said no, he's not had a problem with her.

BY MR. BECKER:

Q When did you next -- so, did you

essentially reassure her that -- that, as long as we don't have nonreassuring fetal heart rate tones, we will tolerate the hyperstim?

A My job was not to reassure her. Her job was to reassure me. She reassured me that the baby was tolerating labor.

Q Well, she called with a concern.

A Correct.

Q And to your knowledge, did you array her concern?

A I told her that as long as there were no changes in the fetal heart rate tracing that made her feel that the baby was not tolerating labor, that we would continue to observe and see if Robin was going to enter into labor at that point.

Q And do you recall what Denise told you relative to what the strips were demonstrating by 2:20 a.m.?

A All she said was that there was no -- there was nothing that was nonreassuring.

Q You don't recall whether she spoke -- specifically spoke to variability or decels or an absence of decels?

A We discussed variability, and she said there was no problem with variability.

Q And have we covered your recollection of that conversation with Denise?

A Yeah. This -- I mean, these are two-minute conversations at 2:30 in the morning. They're not lengthy.

Q But she was an experienced nurse by that time, correct; Denise?

A I believe that she had worked at the hospital for many years.

Q And did she routinely call you in the middle of the night concerning a patient?

A It is all OB nurses' practice to call the physician when they have a patient on labor and delivery. Some will call more often than others. Some concerns are more salient than others. The relationship between an obstetrician and their OB nurse is very --

MR. FARCHIONE: You've answered.

THE WITNESS: -- complicated.

BY MR. BECKER:

Q When did you next hear from Denise or any OB nurse?

A I had no contact until 6:00 in the morning, ten minutes after six, I believe, when I was called to say that the patient was nine centimeters, and my presence was requested.
Q Who called you?
A I believe it was Denise.
Q I didn't hear that. Who called you?
A Denise. I believe she was working a 12-hour shift from seven to seven.
Q Okay. Is it your practice to generate any notes at home if you were contacted?
A No.
Q So, you get a call at six a.m. saying that she's nine centimeters, come on in?
A Come now.
Q Okay. What did you proceed to do?
A Came directly to the hospital.
Q What time did you arrive at the hospital?
A Again, this is based on her notes. It says that my presence was noted at 6:42.
Q She called you at six a.m.
A At 6:11.
Q So, really --

A I got dressed, and I drove in.
Q That's about half an hour?
A I didn't take a shower. I didn't stop and get coffee. I didn't go anywhere else. I got dressed and came directly in.
Q All right, and once you arrived at 6:42, what did you find?
A My initial assessment was that the fetal heart rate tracing, there was only a very short segment of the strip on the monitor for me to look at, but it showed absence of variability and some concerning periodic changes that I thought were nonreassuring. I ordered oxygen placement, assessed Robin, found that she was completely dilated and had her begin pushing.
Q So, when you arrived she was fully dilated, correct?
A Correct.
Q And then how long did she engage in pushing?
A My progress notes say that she pushed five times. In terms of how many minutes that was, prep was done at 6:43, and, then, on her delivery note, completely dilated at

6:42, delivered at 6:46. So, a four-minute second stage.
BY MR. BECKER:
Q What was the station when you arrived?
A My delivery notes, it says on arrival on labor and delivery the patient was complete, complete and plus three.
Q Was there a pediatrician in attendance?
A No.
Q What happened at birth?
A The baby was delivered. There was a tight nuchal cord present that could not be reduced. The cord was clamped times two, cut between the clamps. The infant was then delivered immediately with no difficulty, no shoulder dystocia. It was a female infant that showed no muscular tone and was pale, was taken directly to the warmer. Respiratory therapy was present. There was some internal meconium that was noted for the first time with the delivery of the head. The nasotracheal area was suctioned out with clear secretions, respiratory therapy, and the nurses then initiated a Code Pink.

Q Was Sara taken away from the delivery room into another part of the hospital at that time?
A After an initial resuscitative period, and I'd have to look at the Code Pink notes - those aren't my notes - she was taken to the intermediate nursery. Dr. Miller, who is the pediatrician on-call for our group, came in and attended the baby.
Q Do you know who called Dr. Miller?
A There were several nurses at this change of shift. Several nurses were there. I don't know who placed the phone call.
Q What time was the actual delivery?
A Actual delivery was at 6:46. Change of shift was at seven. So, both third shift and first shift nurses would have been present.
Q What did you do for Robin after delivery?
A After delivering the placenta and repairing the episiotomy, I went and checked to see what the assessment was on the -- on the baby to see how the baby was responding to the resuscitation. Then I came back and

reported to the McKees.
Q Okay. At some time that morning, did you have an opportunity to discuss the induction with Denise?
A I had only a minimal contact with her because she was off duty and was leaving the hospital.
Q That morning, did you have an opportunity to go back and look at the strips that were generated during the night?
A Yes, I did.
Q As a result of reviewing the strips, did you have any conversations with the head of nursing --
MR. FARCHIONE: Objection.
BY MR. BECKER:
Q -- at ACMC?
MR. FARCHIONE: Don't answer that, under the peer review statute, Michael.
BY MR. BECKER:
Q What was your reaction once you had an opportunity to personally review the fetal monitoring strips?
A I had many reactions.

Q I need to know all of them.
A My first response was concern for baby Sara. I had many emotions from anger and shock to disbelief.
Q Let's take each emotion and tell me the basis for that emotion.
A Well, I've got a profoundly depressed baby at birth that was unanticipated by me. That's not a usual occurrence in my day-to-day practice. So, I had lots of emotions churning about this couple delivering a baby that clearly is in very serious trouble and not knowing what the cause of that trouble was.
Q Maybe I didn't make myself clear. I'm interested in what your reaction was after you had an opportunity to sit down and study the strips.
A Uh-huh.
MR. FARCHIONE: Wait. Are you asking him what he saw on the strips, Mike?
THE WITNESS: Do you want me to --
MR. BECKER: First I want to know what his reaction is.

BY MR. BECKER:
Q I appreciate you being concerned and sympathetic for the McKees because of the condition of their daughter, but I'm interested in, you talked about shock and anger. I want to know, is the shock and anger related to what you saw on the fetal monitoring strips?
A Yes.
Q Tell me, explain that.
A I don't feel that the communication that was provided to me as to the status of the induction correlated with what I saw on the fetal monitoring strip.
Q Would it be fair for me to state that you felt you were misled by Denise in her interpretation?
MR. FARCHIONE: Wait, wait a minute. "Misled" means intentionally.
BY MR. BECKER:
Q I'm not suggesting -- I'm not for a second suggesting intentionally. Would it be fair for me to state that, after you had an opportunity to look at these strips, that you felt that the information that was

imparted to you by Denise was inaccurate?
A The fetal monitoring strip information was incongruous with the communication I received from Denise.
Q And explain that statement.
A The two did not make any sense, comparing one to the other. You would assume that you were talking about two different patients.
Q All right. Tell me what you saw on the strips when you had an opportunity to review them.
A I saw many episodes where the fetal heart rate tracing was not reassuring, and several areas where it was specifically ominous.
Q To your knowledge, Doctor, up until the time that you actually put oxygen on Robin McKee, had she been given oxygen by anybody else during that induction?
A I believe that she was, but I had no knowledge of that at the time of delivery.
Q Did you have an opportunity to, in the next few days, have any conversations with the McKees?

A Robin was discharged soon after delivery so that she could go and be with Sara when she was transferred to Rainbow, so I had minimal contact with Robin after the delivery. She had a discharge order at 2:15 in the afternoon on the 18th.

Q Do you recall saying anything to the McKees relative to the type of job Denise did during the night, during the induction?

A No.

Q To your knowledge, were there any new policies and procedures implemented or enacted as a result of this case?

MR. FARCHIONE: Objection. Don't answer that.

MR. BECKER:I think that's a fair question, Joe. You're instructing him not to answer?

MR. FARCHIONE: Yeah. What happened after the fact is not relevant to what happened at the time.

BY MR. BECKER:

Q Well, Doctor, do you provide any input for the obstetrical nurses' policies and procedures?

A I have no direct input into those policies and procedures.

Q To your knowledge, did the hospital ever consult with you about: here are the proposed OB policies and procedures, the nurses' policies and procedures; would you like to comment on them, or do you have any criticism of them?

A The nursing policies and procedures are just that. They are their policies and procedures. The physicians develop policies and medical practices and approve standing orders, but we have no direct input into their policies and procedures.

Q Were there any policies and procedures for physicians that were developed by the OB/GYN Department at ACMC?

MR. FARCHIONE: Talking about written policies like -- similar to what you just saw in Exhibits 1, 2 and 3.

THE WITNESS: We developed departmental policies.

BY MR. BECKER:

Q To your knowledge, did the development of policies in any way speak to Cytotec or

Cervidil or induction or hyperstimulation?

A We have policies for each of those agents. We did not have a written policy for Cytotec at the time of Robin's induction.

Q What would those policies be called?

A Well, the -- the nursing policies would just be that. I think we have --

MR. FARCHIONE: So we're clear here, he's talking about physicians.

BY MR. BECKER:

Q I'm talking about physicians.

A Physicians.

MR. FARCHIONE: And is there something that's almost the same or similar to that that says "for physicians" at the top?

THE WITNESS: I don't know what -- specifically what that is called. We have -- I guess it would be a departmental guideline.

BY MR. BECKER:

Q Okay, that's good, a departmental guideline.

A (At this time the witness nodded his

head.)

Q Who -- who's the keeper of the departmental guidelines?

A I would assume they'd be on file with the departmental minutes at ACMC.

MR. FARCHIONE: Are you sure? I've never heard of this before, and that's why I'm asking. What he's talking about are things like this that, instead of saying "Department of Nursing," it would be "Obstetrical Physicians."

THE WITNESS: Well --

MR. FARCHIONE: "Procedure, purpose, general information."

BY MR. BECKER:

Q It doesn't have to be identical to that, Doctor.

MR. FARCHIONE: No, similar.

BY MR. BECKER:

Q Guidelines are guidelines.

A Well, there were many different documents that were generated during the course of the discussion about use of Cytotec significantly after this event. So, the -- the documents that went back and

forth, I don't know what they're entitled and who has ongoing copies of any drafts or anything like that, but what we tried to do was define the scope of the -- of the issue and respond as a department, so there was physician input into that, but as to whether -- whether there was a finished document that somewhere says: Department of Obstetrics and is signed by the chief of the department, I can't speak to that.

Q Is -- is there an understanding between you, or was there an understanding back in November of '99 between you and the OB nurses that the mom is ready, fully dilated and ready to push. Even though you're not in the hospital, it's okay for her to push?

A It is -- it was not my practice or my -- my expectation that patients would be pushing without my presence.

Q So, I understand that there's some kind of a reflex with women that sometimes occurs around ten centimeters, but it more has to do with the position of the baby that gives the mom an urge to push; is that right?

A Involuntary urge to push, correct.

Q Okay. Now, many times that happens at or about when the mom is ten centimeters, sometimes before.

A Sometimes before.

Q Sometimes after, right?

A Correct.

Q So, if a mom has an urge to push, and she happens to be ten centimeters, why wouldn't you want the nurses to permit her to -- to proceed to deliver the baby?

A Our expectation is that our deliveries will be attended by a physician, and if a patient begins pushing voluntarily or involuntarily before a physician is in the hospital, then you're increasing the chance of a delivery that's going to be unattended, and the nurses, although they can handle an uncomplicated, no typ delivery, you don't know which deliveries are going to be uncomplicated and, so, physician presence at deliveries is an expectation. So, our -- to answer your question, our intention was that we don't want moms to push either voluntarily or involuntarily until we know that a physician is immediately available,

even though some patients push for two hours.

Q Do you recall any conversations you've had with Denise since this birth?

A Regarding?

Q The McKee case.

A I've not discussed this case with Denise.

Q You never have?

A No.

Q Why not?

MR. FARCHIONE: Objection.

BY MR. BECKER:

Q Let me ask you --

MR. FARCHIONE: Peer review issues.

BY MR. BECKER:

Q Did you feel that any discussions you would have with Denise, they should be in a formal setting versus informal?

A I think that's an accurate statement.

Q At what station do you prefer to be notified or what degree of dilatation do you prefer to be notified on a patient that's being induced?

A I like to know when they're in active labor, so any time from five centimeters on, I like to be notified and aware, and in most cases I'll be in the call room which is just around the corner from labor and delivery.

Q And do they notify you -- did Denise notify you when Robin went into active labor?

A No.

Q So, that's -- that's a call that you would have expected, but you didn't receive?

A If I can just look at the labor. I'm trying to follow where she documented active labor. She was not in active labor until I was -- almost immediately before I was called. She was noted to be five centimeters at what looks to be 5:45 in the morning, and went on to completely dilate over the course of the next half hour. So, what happened was, her last check before that looked to be just before 4:00 in the morning, and she was still two. Let me make sure I'm looking at -- yeah, dilation was still one, I'm sorry, at 3:50 in the morning or so, and then the next check at 5:45, she was five, and I was called just after six.

Q Is that kind of an unusual pattern rate?
A It's very unusual for a first-time mom to go from five to complete that quickly.
Q Yes, most -- don't most PRIMIPs increase about one-and-a-half centimeters an hour?
A That's correct.
Q What do you attribute the unusual pattern in Robin to?
A I -- I don't have an opinion on that.
MR. BECKER: We're going to take a break. We're winding down. Off the record.
(At this time a short recess was had.)
THE VIDEOGRAPHER: Back on the record.
BY MR. BECKER:
Q Doctor, the McKees recall that, at the time that you were administering either the second or the third dose of Cytotec, your hand came out, and on the glove was a partially dissolved tablet. Could that be?
A Sure.
Q What is -- what is the significance, if

anything, of -- of seeing a partially dissolved tablet after four hours?
A That's a common event, that the tablet is broken down; its surface area is increased; and that's how it's absorbed and has its effect. So, the fact that there's still some particulate matter from the tablet is of no particular significance.
Q I thought we -- you indicated earlier that normally the whole tablet dissolves within one hour. Maybe I misunderstood you.
A We think that we see pretty much a peak effect within one hour. In terms of not being able to detect any additional residue from the pill, I would say it's significantly longer than that, but in terms of, you know, the -- the medication works by, you know, the pill has a limited surface area, but as the pill dissolves, the medication becomes available, and, so, the medication is absorbed. There's still some residual from the pill even after it dissolves.
Q Is there a discussion or a concept of half life of pills when we're dealing with

Cytotec?
A That -- there is the concept of half life that's documented on its FDA-approved indication but not anything that's published on its intravaginal use.
Q What is your understanding as to -- well, first of all, what does half life mean to you?
A That means the point at which half of the efficacy of the -- it has already achieved its peak effect, and it's already reduced down to half of its peak efficacy.
Q Okay, what is your understanding of what the half life was of Cytotec?
A It is probably in the two to three-hour range.
Q Is there any danger of putting three doses or giving a patient three doses within -- I'm not sure what we have here; 12 hours. What's -- what's the time period between the first dose and the third dose?
A The first dose was at eight in the morning.
Q Eight, right.
A And the third dose was --

MR. FARCHIONE: Six at night.
THE WITNESS: 6:00 at night.
BY MR. BECKER:
Q Okay. So, we have three doses within ten hours.
A Right.
Q Is there any danger of kind of a synergistic effect of -- of this drug on the patient's uterus?
A I'm not sure how you're meaning "synergistic."
Q Well, can they kind of piggyback each other and then make the second one -- adding the second one makes the total impact on the body more than just two; the third triples the impact of the second one? To your knowledge, have there been any studies along those line?
A I've not seen anything published along those lines. My experience with the medication is one dose has whatever effect it's going to have. The next dose has whatever effect it's going to have. After two doses, usually subsequent doses don't have any significant impact. Some patients

just don't respond well to it.
Q Do you have an opinion on whether it's likely that Sara McKee sustained her brain damage some time in the morning of November 18th, 1999?
MR. FARCHIONE: Objection.
MR. SWITZER: Objection.
MR. FARCHIONE: He's not a pediatric neurologist or neonatologist. If you have an opinion. My objection is you're not qualified.
THE WITNESS: If you're asking me when do I think --
BY MR. BECKER:
Q Yes.
A -- Sara suffered damage.
Q Yeah, brain damage.
A I would say it was some time after 11:00 at night.
Q Okay, and what's the basis for that opinion?
A My interpretation of the fetal heart rate monitoring strip and what the cause of it was is debatable, but when do I think the damage occurred? Some time after 11:00.

Q Okay, 11 p.m.
A Correct.
Q And do you have an opinion whether or not Denise violated the prudent standard of care of an obstetrical nurse during her management?
MR. FARCHIONE: Don't answer that question. He is not here as an expert on the standard of care for anyone other than himself.
MR. BECKER: I just -- I just asked him if he had an opinion.
MR. FARCHIONE: Yes. He's not going to --
THE WITNESS: The answer is no.
MR. FARCHIONE: He is not going to render one.
MR. BECKER: Anything else?
BY MR. BECKER:
Q Just to recap, Doctor, I'm -- I'm -- I'm not trying to pry into this, but it just seems a little unusual to me that you -- you're leaving ACMC, and you hope to practice in this same county, Ashtabula --
A Correct.

Q -- within the next three or four or five or six months, correct?
A Correct.
Q But have you -- you have not zeroed in on where you're going to have a home, whether you're going to have a private practice or join a group?
MR. FARCHIONE: Objection. We've gone through that enough, Mike. People take time off in between jobs all the time, and I'm not going to get into his personal life or his business life.
BY MR. BECKER:
Q Well, let me ask you this, Doctor.
A I don't have any problem sharing, but it's not pertinent to this case, so I don't --
MR. FARCHIONE: That's why -- you may not, but I do. I'm not opening the door into business relationships now and taking time off and -- and those issues.
BY MR. BECKER:
Q At the time of Sara's birth --
A Uh-huh.
Q -- your health was fine, correct?

A Correct.
Q Can we agree that one of the dangers of hyperstimulation and induction can be fetal hypoxia?
MR. FARCHIONE: Objection to "dangers." Go ahead.
THE WITNESS: Hyperstimulation needs to be carefully monitored because of the possibility of progression into fetal hypoxia. The presence of one doesn't cause necessarily a progression into the next. You can have hyperstimulation with no fetal compromise, or you can have hyperstimulation with fetal compromise.
Q And when you have fetal hypoxia, if prolonged enough and/or severe enough, severe enough, can it also lead to asphyxia?
A That's the cause of asphyxia.
MR. BECKER:Okay. That's all I have.
MR. FARCHIONE: He'll waive viewing the videotape. We won't waive the transcript.
MR. BECKER: You ought to give Don an opportunity.

MR. SWITZER: No questions.
THE VIDEOGRAPHER: Off the record.
(Off the videotape.)
THE VIDEOGRAPHER: Gentleman, do you waive the one-day filing requirement? I'll hold onto the custody of the original videotape.
MR. FARCHIONE: Fine.

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CERTIFICATE

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

I, Luanne Stone, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, GEORGE KINGSLEY, D.O., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed; and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio this _____ day of _____, A.D., 2001.

_____
Luanne Stone, f.k.a. Protz
Notary Public
In and for the State of Ohio
My commission expires 4/6/03