

State of South Carolina)
) Court of Common Pleas
County of York)
2009-CP-46-05195

Angela Patton)
vs.) Transcript of Record
)
Dr. Gregory A. Miller, et al)
)
Defendant)

January 4-14, 2022
York, South Carolina

B E F O R E:

Honorable William McKinnon, Judge

A P P E A R A N C E S:

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Proceedings Recorded by DCRP
Transcribed by Joy Holston

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(PW) - Denotes Defense Witness
(DW) - Denotes State's Witness

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1 THE COURT: Counsel, I understand we had an issue
2 with voir dire.

3 MR. GRAHAM: Would you like to go first.

4 THE COURT: Yes, sir. That will be fine.

5 MR. DAVIS: It will take me a moment because I just
6 got an email. I have re-emailed you my email a week or so
7 ago and copied to and Mr. Graham asking the Court --

8 THE COURT: Mr. Graham, go ahead. Is this from the
9 paper you gave me or is this off what I just got emailed.
10 Has any member of the jury panel or a member of their
11 immediate ever experienced an unforeseen traumatic birth
12 event. What is the objection.

13 MR. GRAHAM: The unforeseen. Unforeseen traumatic,
14 just seems to -- for the Defense.

15 THE COURT: Your objection is asking for the word,
16 unforeseen, if we took that out you would be okay with it?

17 MR. GRAHAM: I would prefer to change the event as
18 well.

19 THE COURT: The big picture is a fair question to
20 ask, has anyone ever had an adverse outcome in a birth or
21 pregnancy. But I will be happy to work on the wording
22 with you.

23 MR. GRAHAM: That is fine.

24 THE COURT: Mr. Davis, is that okay?

25 MR. DAVIS: Your Honor, that is fine.

1 THE COURT: Okay. All right.

2 MR. GRAHAM: Number 11.

3 THE COURT: This is, ever had a child suffer from
4 shoulder dystocia and permanent injury result. Is that
5 correct?

6 MR. GRAHAM: That's correct.

7 THE COURT: I understand, Mr. Davis is entitled to
8 ask the voir dire, why is it improper to ask only about
9 permanent injury?

10 MR. GRAHAM: Well, it just seems to me that in terms
11 in exercising peremptory strikes, if someone has had a
12 temporary injury, that they attribute the transient part
13 nature of that injury to care of a doctor, something to
14 that effect, it would be potentially prejudicial to us.

15 THE COURT: I will ask a second question about
16 temporary injury. Would that satisfy you?

17 MR. DAVIS: Yes, sir.

18 THE COURT: Mr. Graham?

19 MR. GRAHAM: Yes, sir.

20 THE COURT: Okay. Let me put an 11b here. Okay.
21 All right.

22 MR. GRAHAM: I don't like the language of convince or
23 persuaded. It modifies the burden of proof. It is almost
24 like clear and convincing.

25 THE COURT: I am not inclined to ask number 18. I

1 don't normally ask questions that are basically saying,
2 are you going to follow the Court's instructions.
3 Obviously, the Court's instructions would be, in that
4 situation they should render a verdict for the doctor and
5 I don't like questions that presume they are not going to
6 follow my instructions. Same on number 19. The questions
7 that basically say, the law is X. If you don't think you
8 can follow the law raise your paddle. I do not normally
9 allow those questions.

10 MR. GRAHAM: As opposed to (inaudible).

11 THE COURT: Or even, if the Plaintiff does not prove
12 their case can you render a verdict for the doctor.
13 That's okay. But the questions that are like, the law
14 says this, can you do that. I don't allow those. I agree
15 on number 20.

16 MR. GRAHAM: The same with 21.

17 THE COURT: I agree. Those are perfectly legitimate
18 things to say in opening court. But as a voir dire
19 question I am not going to allow it.

20 MR. GRAHAM: Similarly number 22.

21 THE COURT: I agree on number 22.

22 MR. GRAHAM: 23.

23 THE COURT: I agree on number 23. That is completely
24 fair game for number 23, opening statement but not as voir
25 dire in the Court's opinion.

1 MR. GRAHAM: We object to the rest of those.

2 THE COURT: I was, my Law Clerk just brought me my
3 iPad. I was working off the printed copy Mr. Davis gave
4 me. Should I look at --

5 MR. DAVIS: That is fine.

6 THE COURT: Mr. Davis.

7 MR. DAVIS: Your Honor, I didn't have a chance to
8 read these until this morning. So it is very difficult
9 for me to go through, there is a lot. I didn't get a
10 chance, earlier this morning before we went downstairs.
11 Honestly, I don't have any strong objection to any of
12 them. I think they are pretty generic.

13 THE COURT: I do have a question, Mr. Graham, about
14 number 2f. What it is, convicted by felony, punishable by
15 imprisonment in Angola, like in, I don't know what that
16 means.

17 MR. GRAHAM: It may be an auto-correct.

18 THE COURT: Okay. Angola is a prison in Louisiana.
19 I mean, Mr. Graham, if you feel the need to rehash the
20 qualification questions, I am not going to tell you you
21 can't. But you have only got 30 minutes. I, as the
22 Court, are not going to reask the qualification questions.

23 MR. GRAHAM: If Your Honor, please. We have got two
24 sets here. This is the one that we were asking Your
25 Honor, and perhaps this is redundant.

1 THE COURT: Okay. Do I, okay, is the one you handed
2 up, is this the one that you want me to ask?

3 MR. GRAHAM: That's right.

4 THE COURT: I would not be inclined to ask number 2
5 at all. If you want to use your time to reask
6 qualification questions but I am not going to ask them
7 again.

8 MR. DAVIS: And, Your Honor, the questions that I
9 intend to ask is on the power point for now.

10 THE COURT: I am looking at what you would like me to
11 ask. Okay. Number 3 is not really a question, it is
12 generally commentary. I am not going to do that. Not
13 going to ask number 7. Mr. Graham, is your law firm the
14 law office of Ed Graham. How do you want me to refer to
15 your firm.

16 MR. GRAHAM: Graham Law Firm, PA.

17 THE COURT: And, Mr. Jordan, what is yours?

18 MR. JORDAN: Jordan Law Firm, PC.

19 THE COURT: Okay. Mr. Davis, what is the former name
20 of your firm?

21 MR. DAVIS: It is Davis and Snyder.

22 THE COURT: And other than the three attorneys I just
23 spoke to, is there anyone else that is going to have a
24 speaking role on the trial. Yes sir, tell me your name.

25 MR. TRAYLOR: Drew Traylor.

1 THE COURT: Anyone else from the Plaintiff's side?

2 MR. GRAHAM: No, Your Honor.

3 THE COURT: It is Mr. Traylor?

4 MR. TRAYLOR: Yes, sir.

5 THE COURT: And, Mr. Traylor, have you filed the
6 application with the South Carolina Supreme Court and paid
7 all of the fees and everything?

8 MR. TRAYLOR: Yes, sir.

9 THE COURT: Go ahead and pass that up and we will
10 rule on that while we are sitting here.

11 MR. DAVIS: Your Honor, Mr. Traylor has been with us
12 since August. He is a member of the Alabama Bar and he
13 has, the end of September filed all of his application
14 requirements to be admitted. Everything is done. We are
15 just waiting on --

16 THE COURT: Waiting on character and fitness.

17 MR. DAVIS: Yes, sir.

18 THE COURT: Okay. All right. Thank you. Mr.
19 Traylor, the only thing I don't see in this packet is your
20 certificate of good standing. Do you have that available?

21 MR. TRAYLOR: I can email it to you, if that works.

22 THE COURT: If you don't mind, can you email it to my
23 Law Clerk. It will be wmckinnonlc@sccourts.org. Did you
24 see that, if y'all have seen it I will go ahead and grant
25 the motion.

1 MR. GRAHAM: I have not, Your Honor. When I said no
2 objection, it was based on my understanding that all of
3 the requirements --

4 THE COURT: I am sure everything is okay.

5 MR. TRAYLOR: Over the Holidays they haven't been
6 responding to any phone calls or emails.

7 THE COURT: If you can send it to my Law Clerk and we
8 will check that box. And, Counsel, number 20, I meant to
9 ask you about already. Typically I ask the jury if they
10 have any information about the case, what is kind of a
11 neutral one sentence summary of what the case is about.

12 MR. GRAHAM: This child suffered a permanent brachial
13 plexus nerve injury that affects the use of her arm. We
14 assert that Dr. Miller was negligent.

15 THE COURT: I am typically, way -- generic than that.
16 Something like, alleged, it was during the delivery would
17 be the alleged negligence.

18 MR. GRAHAM: During the delivery.

19 THE COURT: So alleged negligence during delivery and
20 what was the date of the delivery?

21 MR. GRAHAM: It was in 2007, April 5 of 2007.

22 THE COURT: And delivery was at Piedmont Medical
23 Center?

24 MR. GRAHAM: It was.

25 THE COURT: Okay. That, I will tell them that the

1 alleged negligence occurred during the delivery of a baby
2 on April 5th of 2007 at Piedmont Medical Center. Any
3 objection from the Plaintiff?

4 MR. GRAHAM: No, Your Honor.

5 THE COURT: Mr. Davis?

6 MR. DAVIS: Fine, thank you, Your Honor.

7 THE COURT: Yes, sir.

8 MR. DAVIS: May it please the Court, Your Honor. I
9 was trying to take notes, I want to be sure, I know the
10 questions, my voir dire questions, that I will be not
11 asking direct voir dire. I wrote down 18, 19, 20, 21, 22,
12 23 and 24.

13 THE COURT: 18 through 26. Thank you, Mr. Davis, I
14 appreciate you clarifying. I am not inclined to ask
15 Plaintiff's question 28. It is the same issue with the
16 Defense voir dire questions about can you follow the law.
17 The same with number 27. Number 29 I am not going to ask.
18 Mr. Graham, number 30, as it is on my sheet, have you, any
19 of you had any injuries in the past. If I ask that,
20 probably everyone on the jury panel is going to stand up.
21 Can we narrow it down a little bit?

22 MR. GRAHAM: Absolutely, Your Honor. One way to be
23 permanent injury and it would still be fairly generic. We
24 could also say nerve injuries, we could say --

25 THE COURT: Mr. Davis, is there any objection to me

1 asking, has any Plaintiff have any nerve injury in the
2 past, any juror.

3 MR. DAVIS: I don't have any objection to that.

4 THE COURT: Okay. I will ask that. I am not going,
5 31 is the same reason, it is asking are they going to
6 follow the law, as I explained it.

7 MR. GRAHAM: I will revisit that one point if Your
8 Honor has not --

9 THE COURT: Sure.

10 MR. GRAHAM: And that is, when you ask nerve
11 injuries. Nerves are one of those things that some people
12 think you are referring to anxiety. So could we just say,
13 permanent, traumatic nerve injury or something to that
14 effect.

15 THE COURT: Permanent nerve injury. Would that be
16 acceptable, Mr. Davis?

17 MR. DAVIS: Yes, sir.

18 THE COURT: That is what we will ask. I am not going
19 to ask 33, about the case trial length. Mr. Graham, the
20 intent of number 34, is that to ask the panel if they have
21 been contacted by one of the lawyers in the case? I am
22 not inclined to ask that unless you have reason to believe
23 that occurred which would not shock me.

24 MR. GRAHAM: We withdraw that, Your Honor.

25 THE COURT: Okay. Let me just look through, Mr.

1 Jordan, what you propose to ask in your 30 minutes and
2 make sure -- I will say in the past with medical
3 malpractice cases, I had typically excluded patients of
4 the Defendant, physician. In this case though, my
5 understanding, there are two major obstetrical
6 gynecological practices in Rock Hill. This is one of the
7 two. And if we excluded everyone who has been a patient
8 at this practice, I think, that is not going to work. I
9 am happy to hear from the Plaintiff on that issue.

10 MR. GRAHAM: Your Honor, at the very least we would
11 ask permission to explore the specifics.

12 THE COURT: I will give you that lead way. Normally
13 my rule is, we would just, those folks are just excluded
14 because we have a big enough panel. But in this case, am
15 I correct, Mr. Davis; there is just two practices in Rock
16 Hill that basically deliver all the babies?

17 MR. DAVIS: That's it, Your Honor. And it has been
18 11 years, there has been a lot of patients coming and
19 going through.

20 THE COURT: In this case, I am, my inclination is to
21 part from my normal practice, most families have children.
22 If we exclude everybody who is a patient of that practice,
23 we are going to exclude a very large percentage of the
24 jury pool.

25 MR. GRAHAM: Yes, sir. A couple of points. Number

1 one, we believe there are 12 jurors.

2 THE COURT: Twelve jurors that were themselves
3 patients or are you counting men whose wives were treated
4 when they were pregnant?

5 MR. GRAHAM: Eight that are female patients or that
6 are presumably husband's married to female patients.

7 THE COURT: Okay.

8 MR. GRAHAM: But, certainly we would like to explore
9 it for peremptory strikes.

10 THE COURT: Absolutely. You can ask questions during
11 your 30 minutes, and normally we don't get to that because
12 I typically exclude them. But in this case I just don't
13 think I can do a blanket rule with that many prospective
14 jurors at issue.

15 MR. GRAHAM: Not even with respect to the eight that
16 are actual patients.

17 THE COURT: I mean, I am not telling you I am going
18 to deny a for cause motion in every case. I mean, I will
19 hear what they say, how long it was, all that kind of
20 thing. I am just saying, I am not going to issue a
21 blanket ruling at the start that anybody who has been a
22 patient cannot serve.

23 MR. GRAHAM: I understand. Thank you, Your Honor.

24 THE COURT: Yes, sir. Mr. Jordan, the first one, I
25 think I have got an issue with. There is one that says,

1 starts out some people believe a medical doctor should not
2 be held responsible for treating a patient in an
3 emergency. I think that is one of those, can you follow
4 the law as the Judge explains it.

5 MR. JORDAN: Well, Your Honor, it ask about, I
6 believe, about training. It is different from the
7 statute. We have got a legal issue that we plan to raise
8 about, what general emergency is as compared to emergents.

9 THE COURT: Right. My only point is, for voir dire
10 purposes. I mean this is getting into what the law is in
11 South Carolina which is not something I typically allow.
12 I understand, you can make your argument. I am not
13 saying, for voir dire I don't typically allow attorneys to
14 get into the points, you can do it in opening as long as
15 you are correct. And the same with the question after
16 that, do you feel a medical doctor should only be
17 responsible if there was intentional harm. So, Mr.
18 Jordan, I am going to say no on those two.

19 MR. JORDAN: I want to mark through those. I want to
20 make sure I have those right, I want to remove those from
21 the power point, Your Honor.

22 THE COURT: Thank you. Mr. Jordan, I am near the
23 end. There is one that says, members of the health care
24 community including your treating physician, show up for
25 trial and sit behind the Defendant, is that something that

1 you anticipate happening?

2 MR. JORDAN: Your Honor, it is something that I have
3 had occurred before in these types of cases and I think
4 Mr. Graham can speak to that as well.

5 MR. GRAHAM: Your Honor, I can't remember a case
6 where we didn't have.

7 MR. JORDAN: This is a case that he can remember that
8 it is not going to happen.

9 THE COURT: You are, just to make sure I understand.
10 You are speaking of physicians that are not involved in
11 the matter that are sitting behind the Defendant to kind
12 of a show for support?

13 MR. DAVIS: Your Honor, I can affirm that that is not
14 going to happen in this case.

15 THE COURT: Okay. I have never seen that before. I
16 am sure that y'all have seen it. Mr. Davis says no one is
17 going to be --

18 MR. GRAHAM: Maybe that is more of the low country.

19 THE COURT: I don't think I am going to allow that
20 question. I mean, your client has family members sitting
21 behind them. I mean, sitting, has family there. I mean,
22 I don't even think, if somebody was sitting behind Dr.
23 Miller, they are not going to come in in a white coat and,
24 I mean I assume, wearing a stethoscope -- that I would not
25 permit. I am not going to permit someone in scrubs to sit

1 behind.

2 MR. GRAHAM: Also I have seen physicians show up in
3 the courtroom sitting behind the Defendant, physician, who
4 are treaters of various members of the jury. I mean, it
5 is just a prejudicial attempt to influence the jury by
6 making them think that the medical community stands
7 together. And if you rule against this doctor then there
8 may be adverse consequences.

9 THE COURT: Mr. Davis, you said that there is not
10 going to be anyone coming to, in this case?

11 MR. DAVIS: Your Honor, the long and somewhat
12 tortured history of -- in this case. At the time of this
13 delivery in 2007 Dr. Miller was a partner in the group, in
14 the practice there, a named Defendant. It has been
15 several years since the group has sold the practice to
16 Healthcare System. I know a lot of the doctors there,
17 obviously Dr. Miller knows them well. I have had no
18 contact with anybody at the practice about this case. I
19 have no idea that they even know about it, that it is
20 going to trial. There has been no communication. And I
21 know the doctors well. I mean, I have represented them in
22 the past. But I have no contact with them for years. But
23 it is a public trial.

24 THE COURT: Yes.

25 MR. DAVIS: They are parties to the lawsuit. And if

1 one of the managing partners, whoever it is, I don't know,
2 or if they even have one; Norm Taylor or one of the
3 doctors wants to come and watch part of the trial, he
4 can't prevent him from coming in. Number one, they are a
5 defendant. Their practice is still named. And number
6 two, it is without my pre-knowledge, I have had no
7 contact.

8 THE COURT: I just, if you think that that may occur,
9 just tell them that they can't come in scrubs or the white
10 coat.

11 MR. DAVIS: Any indication whatsoever, and I am happy
12 to make a preemptive call. I almost don't want to stir
13 the pot.

14 THE COURT: I think what I am going to say, Mr.
15 Graham, let's just change this, take out the reference to
16 the health care community. And just say, if supporters
17 showed up for trial and sat behind the Defendants, I am
18 okay with that. But I think we are opening a can of
19 worms, signaling out where doctors are going to come. I
20 would rather not go down that road.

21 MR. GRAHAM: I understand your ruling. And I respect
22 what Ashby just said to the Court. But if anyone shows up
23 to have a prejudicial, coercive attempt on the jury by
24 coming in scrubs --

25 THE COURT: I would not permit that, no, coming in

1 scrubs. But Mr. Davis is correct, they may be, if there
2 is a verdict in your client's favor they may be
3 financially impacted and I can't tell them that they can't
4 come and watch the trial. But I will tell them that they
5 can't wear scrubs or white coats or anything.

6 MR. GRAHAM: And my point was extended beyond the
7 members of that firm, you know, particularly anyone
8 associated with a treater of someone on the jury. Even
9 though a courtroom is a public forum, still there are
10 reasonable limits within Your Honor's discretion. And I
11 just respectfully suggest that if someone on the jury goes
12 to the other OB practice and the other OB's sit behind
13 this OB it would be, it would be very troubling to my
14 client and to myself because there is an implied coercive
15 nature to that.

16 THE COURT: I have never personally seen that. I did
17 not try too many med mal cases but I, as a Judge I have
18 never seen it. But, again, I think you can ask the
19 question, just don't single out the health care community.
20 Just say, if supporters show up for trial and sit behind
21 the Defendants. Is that satisfactory?

22 MR. GRAHAM: Yes and we have the right to come back
23 --

24 THE COURT: Sure. If one of the juror's primary care
25 physicians happens to hear about the case, we can address

1 that if it happens. But I don't think I want to go down
2 that road unless --

3 MR. GRAHAM: Thank you, Your Honor.

4 MR. DAVIS: Your Honor, not at all arguing at any, at
5 all with what you just ruled. Just for clarification, in
6 the event that one of the physicians in Greenville GYNOB,
7 chooses to hear about the case, chooses to come in and
8 listen as a representative of the practice, it is a named
9 Defendant in the case. And I don't know about it--

10 THE COURT: It is absolutely permissible for them,
11 they are named Defendants in the case. They can't dress
12 in a way that identifies them as physicians.

13 MR. DAVIS: Perfect and that is wrote down here.
14 Cannot come in scrubs or white coats if they show up. If
15 I know about it ahead of time I will absolutely instruct
16 them accordingly.

17 THE COURT: Thank you.

18 MR. DAVIS: Thank you, Your Honor.

19 THE COURT: Thank you, Mr. Davis.

20 MR. GRAHAM: Your Honor, that is another reason why
21 we have concerns about the patients of that practice
22 sitting on the jury.

23 THE COURT: I mean, again, Mr. Graham, I will hear
24 from you if you have motions to strike for cause. I am
25 not saying I am not going to grant any of them. I am just

1 saying is, my normal rule, like when you have like an
2 oncology case. I just say, I typically will exclude any
3 patients of that oncologist. But I think in this case you
4 are talking about one of two practices in town. I am not
5 going to do a blanket ruling. But I will be happy to hear
6 from you as to any particular jurors.

7 MR. GRAHAM: Thank you, Your Honor.

8 THE COURT: Yes, sir. And, Mr. Jordan, I am say --
9 the two questions. One of them says money should not be
10 awarded to compensate for pain and suffering. And the
11 next one talking about loss of enjoyment of life and
12 hedonic damages. That is, again, I will charge them on
13 what the proper elements of damages to be considered. I
14 prefer not to get into that. And the same, the last
15 question that says, does any member of the jury think that
16 the burden of proof should be higher. All right.
17 Anything else we need to take up, from the Plaintiff?
18 And, I see, I think we have got your, we have got
19 certificate of good standing. So the motion to appear pro
20 hac vice is granted. Yes sir, Mr. Graham.

21 MR. GRAHAM: There is one thing we would like for
22 your Honor to clarify. I have had different Judges call
23 for motions to strike for cause at different times.

24 THE COURT: Okay.

25 MR. GRAHAM: Would you like us to do it after the

1 jurors names are called so we are only asking about,
2 however many jurors are coming.

3 THE COURT: I would prefer after voir dire, before we
4 actually select the panel. Any objection to that
5 procedure, Mr. Davis?

6 MR. DAVIS: No, sir. I think that is much more
7 efficient.

8 THE COURT: So I think otherwise you risk having to
9 redo the panel, if I do grant any motions.

10 MR. DAVIS: All right.

11 MR. GRAHAM: Thank you, Your Honor.

12 THE COURT: Anything else from the Plaintiff?

13 MR. GRAHAM: No, sir.

14 THE COURT: Anything from the Defense?

15 MR. DAVIS: No, thank you, Your Honor.

16 THE COURT: All right. Counsel, the Clerk tells me
17 she needs about a ten minute break to turn on the
18 equipment and make sure it is all working. We will take a
19 ten minute recess. Oh my, gosh, it is 12:15. I am
20 inclined to go ahead and take a lunch break rather than
21 start this process now. Any objection. I had no idea it
22 was this late.

23 MR. DAVIS: It sounds like a fine idea, Judge.

24 THE COURT: Let's take an hour and fifteen minute
25 break then. We will tell the jurors, if you ask the

1 jurors to be back at 1:45. They can bring them straight
2 up here when they get back at 1:45. Thank you, Counsel,
3 see you at 1:45.

4 MR. GRAHAM: Thank you, Your Honor.

5 (Whereupon, a lunch break was taken.)

6 THE COURT: We don't know if the name has changed.
7 Dr. Miller, do you happen to know if the practice has
8 changed its name?

9 DR. MILLER: No, sir. I will take a look and see if
10 I can figure that out.

11 THE COURT: Thank you. If it is okay, I will
12 describe at the practice behind Hardees on Herlong Avenue.
13 Any objection from the Plaintiff?

14 MR. GRAHAM: No, Your Honor.

15 THE COURT: From the Defense?

16 MR. DAVIS: That is fine, Your Honor.

17 THE COURT: Go ahead and bring everyone they have
18 got. Prior hearing, but one of the physician's at this
19 practice, Dr. Fran Bailey is a friend, I would not say a
20 close friend but we go to Sunday School together. Mr.
21 Graham?

22 MR. GRAHAM: We have no problem with that.

23 THE COURT: Thank you, sir.

24 (Whereupon, the jury came into open court at
25 approximately 1:56 p.m.)

1 THE COURT: Are all jurors present?

2 CLERK OF COURT: Yes, sir.

3 THE COURT: All right, ladies and gentlemen, thank
4 you for your patience. As I said, this is going to be the
5 jury selection process now. We are going to pick 16
6 jurors and you may be wondering why 16. Don't we have 12
7 jurors. We are going to have four alternate jurors and
8 those are jurors that are available to step in if one of
9 the main jurors, there is a family emergency or get sick
10 or something like that. That is why we pick 16 and you
11 won't know from the 16 that are picked, you will not know
12 whether you are an alternate or a primary juror until the
13 end of the case, when it gets time to deliberate we will
14 tell you who that, the principle 12 are that will vote.
15 If you are selected for the jury and you find out that you
16 have been exposed to COVID, a close contact or if you
17 have, I am not going to ask if you are vaccinated or not.
18 But if anyone has symptoms that may be COVID or you get a
19 diagnosis of COVID, please let the Bailiffs know so they
20 can let me know as soon as possible. All right. So,
21 ladies and gentlemen, what is going to happen now, is I am
22 going to ask you some questions, we will talk a little
23 about this case and then each side, the Plaintiff and the
24 Defense will have up to 30 minutes they can ask you
25 questions themselves. Okay. So, again, it is very

1 important that you answer these questions honestly. And
2 then for the record, this is Angela Patton, as Next Friend
3 of Alexia Lumpkin, a minor child, versus Gregory A.
4 Miller, MD and Rock Hill Gynecological and Obstetrical
5 Associates, P.A.; case number 2009-CP-46-5195. And,
6 ladies and gentlemen, you may have just caught that case
7 number as a 2009 case number. The events involved in this
8 case generally occurred in 2007. The case was filed
9 promptly in 2009. And the reason it has taken 12 years is
10 due to procedural quirks of the court system and it is not
11 the fault of any of these lawyers, when we talk about
12 things that a lot happened in 2007, in court in 2022. So
13 please don't hold that against either side. So, ladies
14 and gentlemen, the first thing is, this case involves
15 alleged negligence during the delivery of a baby on April
16 the 5th of 2007 at Piedmont Medical Center. And the baby
17 involved is Alexia Lumpkin. So my first question is, does
18 anyone know anything about this case. Do you know, have
19 you heard anything, read anything, have any outside
20 information at all about this case. If so please stand.
21 Yes sir, juror number 134. If you can stand up.

22 JUROR 134: Does the internet count. Because the
23 names were in the questionnaire packets.

24 THE COURT: You mean the questionnaire you got. That
25 is a great question.

1 JUROR 134: I read the whole --

2 THE COURT: You read the pleadings in the matter?

3 JUROR 134: Yes.

4 THE COURT: I think we are going to have to excuse
5 that juror. Any objection from the Plaintiff?

6 MR. GRAHAM: No, Your Honor.

7 THE COURT: From the Defense?

8 MR. DAVIS: No, sir.

9 THE COURT: Sir, you are excused. And you may get
10 called for a case later in the week. Tell me your number
11 one more time.

12 JUROR 134: 134.

13 THE COURT: And your jury service, it is possible but
14 unlikely a second case will be called for trial. The
15 Clerk's office will tell you how to call in and check on
16 that. But you are excused from service in this case.

17 JUROR 134: Thank you.

18 THE COURT: Yes sir, juror 26.

19 JUROR 26: I don't know if I can say the information
20 out loud. I am aware that --

21 THE COURT: Will you approach the bench, please.

22 (Whereupon, a bench conference was held with the
23 Court, Attorneys and Juror 26.)

24 THE COURT: Juror 26 is excused. The same thing, you
25 are excused from service in this case. You may be called

1 for a case later in the week.

2 Ladies and gentlemen, I am next going to introduce
3 the Plaintiffs in this case. The person bringing the
4 lawsuit, Ms. Patton, if you will stand, please. Face the
5 jury. And, Ms. Lumpkin, if you don't mind standing,
6 please.

7 Ladies and gentlemen, is there any member of the jury
8 panel related to either Ms. Patton or Ms. Lumpkin by blood
9 or marriage or do you have a close, personal or social
10 relationship with either of them. If so, please stand.
11 Yes sir, juror 227.

12 JUROR 227: We go to the same church.

13 THE COURT: You still go to the same church?

14 JUROR 227: Yes.

15 THE COURT: Would you describe it as a close
16 relationship?

17 JUROR 227: My grandma, since I was a child.

18 THE COURT: I am inclined to excuse, any on either
19 side --

20 MR. GRAHAM: Your Honor, I wasn't clear that he
21 wasn't saying, if he was close or their grandmothers were
22 close.

23 THE COURT: When you described it as a close
24 relationship, were you saying you personally or your
25 grandfather was close to them?

1 JUROR 227: I don't know --

2 THE COURT: Have you ever spent time with them
3 outside of church, gone to their house or had a meal with
4 them or anything? You, personally, say you have a close
5 relationship with them?

6 JUROR 227: (Inaudible.)

7 THE COURT: Could you still be fair and impartial to
8 both sides in this case?

9 CLERK OF COURT: Yes, sir.

10 THE COURT: Thank you, sir. Dr. Miller, if you could
11 stand, please. Ladies and gentlemen, this is Dr. Gregory
12 Miller, the same question. Is there any member of the
13 jury panel related to Dr. Miller by blood or marriage or
14 have a close, personal or social relationship with him.
15 If so, please stand.

16 (No response.)

17 THE COURT: Ladies and gentlemen, I am now going to
18 introduce the attorneys. For the Plaintiff, Mr. Ed
19 Graham, of the Graham Law Firm, P.A.; and Mr. Brad Jordan
20 of the Jordan Law Firm, P.C. My first question is, is
21 there any member of the jury panel related to either of
22 these two attorneys by blood or marriage or have a close,
23 personal or social relationship with either of them. If
24 so, please stand.

25 (No response.)

1 THE COURT: Is there any member of the jury panel
2 been represented by the Davis and Snyder Law Firm. If so,
3 please stand.

4 (No response.)

5 THE COURT: Ladies and gentlemen, I am now going to
6 read you a list of possible witnesses. It doesn't mean
7 that all of these witnesses will be called into court but
8 some of them will be. So, it is the same question. If
9 anybody, when I read the witness' name, if you have close,
10 personal or social relationship or you are related to this
11 person by blood or marriage, please stand. Shemica
12 Degraffenreid; Dr. Susan Lupo; Julie Bibb, B-I-B-B; Antwan
13 Lumpkin; Dr. John Grossman; Dr. Trevor Resnick; Oliver
14 Wood who is an economist; Margaret Greer Simmons; Dr.
15 Maureen Nelson; Darlene Carruthers; George Lumpkin; Kim
16 Coker; Michelle Dalton; Dr. Fred Duboe; Dr. Edith
17 Gurewitsch; Dr. Suneet Chauhan, C-H-A-U-H-A-N; Dr. Joseph
18 Earnest.

19 (No response.)

20 THE COURT: Ladies and gentlemen, next question, any
21 member of the jury panel been a Plaintiff, meaning you
22 sued someone in court or a Defendant, meaning someone sued
23 you in a lawsuit, not including Family Court. So I am not
24 including if you had a divorce or child custody case. But
25 if you have had any other kind of lawsuit or you were the

1 Plaintiff and you brought a lawsuit or you were the
2 Defendant and someone sued you, please stand.

3 Sir, please hold up your juror number. And were you
4 the plaintiff where you brought the lawsuit or were you
5 the Defendant?

6 JUROR: I was the Plaintiff.

7 THE COURT: And you can be fair and impartial to both
8 sides in this case?

9 JUROR: Yes.

10 THE COURT: Thank you, sir. Has any member of the
11 jury panel previously served on a jury. If so, please
12 stand. Juror number 22, was it a lawsuit or was it a
13 criminal case?

14 JUROR: Criminal.

15 THE COURT: Can you still be fair and impartial to
16 both sides in this case?

17 JUROR: Yes, sir.

18 THE COURT: Juror 179. What kind of case was it?

19 JUROR: Lawsuit.

20 THE COURT: Can you be fair and impartial to both
21 sides in this case?

22 JUROR: Yes, sir.

23 THE COURT: Juror 141. What kind of case?

24 JUROR: Grand Jury, criminal case.

25 THE COURT: Can you still be fair and impartial to

1 both sides in this case?

2 JUROR: Yes, sir.

3 THE COURT: Juror 196.

4 JUROR: Criminal.

5 THE COURT: Can you still be fair and impartial to
6 both sides?

7 JUROR: Yes, sir.

8 THE COURT: Juror 216.

9 JUROR: Criminal.

10 THE COURT: And can you be fair and impartial to both
11 sides in this case?

12 JUROR: Yes.

13 THE COURT: Juror 219.

14 JUROR: Criminal.

15 THE COURT: Can you still be fair and impartial to
16 both sides in this case?

17 JUROR: Yes.

18 THE COURT: Juror 286.

19 JUROR: Criminal.

20 THE COURT: Can you still be fair and impartial to
21 both sides in this case?

22 JUROR: Yes.

23 THE COURT: Juror 95.

24 JUROR: Lawsuit.

25 THE COURT: Can you be fair and impartial to both

1 sides in this case?

2 JUROR: Yes.

3 THE COURT: Ladies and gentlemen, do any members of
4 the jury panel know each other outside of court. Meaning
5 that there is someone else in the jury pool that you know
6 them from work, from school, you are friends with someone
7 in the jury panel. Juror 104.

8 JUROR: I am friends with 284.

9 THE COURT: You are friends with juror 284. Can you
10 still be fair and impartial to both sides in this case?

11 JUROR: Yes.

12 THE COURT: And juror, 284, can you still be fair and
13 impartial to both sides in this case?

14 JUROR: Yes.

15 THE COURT: And juror 72. Who do you know, Ma'am.
16 What juror number is the person you know. Juror 289 and
17 juror 72. Could you still be fair and impartial to both
18 sides in this case?

19 JUROR: Yes.

20 THE COURT: And juror 289, can you be fair and
21 impartial to both sides in this case?

22 JUROR: Yes.

23 THE COURT: Juror 46, do y'all know each other. So,
24 juror 46, you know juror 22. Could you still be fair and
25 impartial to both sides in this case?

1 JUROR: Yes.

2 THE COURT: And juror 22, can you still be fair and
3 impartial to both sides in this case?

4 JUROR: Yes, sir.

5 THE COURT: Thank you, sir. Ladies and gentlemen,
6 the other Defendant in the case is the medical practice,
7 Rock Hill Gynecological and Obstetrical Associates. Is
8 any member of the jury panel have any kind of financial
9 interest or ownership of this medical practice; or you or
10 a close family member works at that medical office. If so
11 please stand.

12 JUROR: My mother used to work there, she retired.

13 THE COURT: She retired but she used to work there.

14 JUROR: Yes.

15 THE COURT: How long ago was that? Before this case
16 happened?

17 JUROR: Yes.

18 THE COURT: Could you still be fair and impartial to
19 both sides in this case?

20 JUROR: Yes.

21 THE COURT: Thank you, sir. Ladies and gentlemen, I
22 have already asked you about lawsuits. But I am going to
23 ask, has anyone brought a claim against you for damages of
24 some kind, car wreck, something else; that didn't go to a
25 lawsuit but somebody claimed that you did something and

1 you owed them money as a result. Not including lawsuits
2 because I have already asked you about that. So if that
3 applies to you please stand. Juror 106. And could you
4 still be fair and impartial to both sides in this case?

5 JUROR: Depends on the aspect of the case. I was a
6 party to on a claim and there were injuries.

7 THE COURT: You were the Defendant in that case?

8 JUROR: Yes, I was.

9 THE COURT: This is a medical case. Nothing to do
10 with an auto accident. Could you still be fair and
11 impartial to both sides?

12 JUROR: Yes.

13 THE COURT: Just one second. I am pulling up another
14 set of questions on my iPad here. Ladies and gentlemen,
15 is there any member of the jury panel know of any reason
16 whatsoever why you could not be fair and impartial to both
17 sides, the Plaintiff and the Defense in this case. If so
18 please stand.

19 (No response.)

20 THE COURT: Mr. Graham, any further questions you
21 would like the Court to ask?

22 MR. GRAHAM: No, Your Honor.

23 THE COURT: Mr. Davis, is there any questions you
24 would like the Court to ask?

25 MR. DAVIS: No, thank you very much, Your Honor. All

1 right. Ladies and gentlemen, I am now going to turn this
2 over to the lawyers. They each have up to 30 minutes and
3 they will ask questions they think are appropriate and
4 they may ask follow-up questions. And once 30 minutes are
5 up we will move to the other side. In a Plaintiff in a
6 case like this has the burden of proof. So they go first.
7 Ladies and gentlemen, because the lawyers and me, as the
8 Judge, we have to talk during the trial. Some of us don't
9 wear masks. It is up to the lawyers, Mr. Jordan, it is up
10 to you. You will be speaking. It can be hard to speak
11 with a mask on, it is up to you.

12 MR. JORDAN: Good afternoon. Can everyone hear me.
13 We, throughout this process, we have been learning about
14 you. So I will introduce myself again. My name is Brad
15 Jordan. I am an attorney, my office is in Rock Hill,
16 South Carolina. And I, along with Ed Graham, represent
17 the Plaintiffs in this case. My wife is a retired
18 teacher. I have three kids, my youngest, we are looking
19 to try to find a college for now. So part of this process
20 and want to find out a little bit more about you and about
21 your thinking on some issues related to this case. The
22 first question here, who on the jury knows or has been
23 treated by any doctor at Rock Hill GYNOB; or knows any
24 person who works for or is affiliated with Rock Hill
25 GYNOB. Quite a number of you raised your hand. And I am

1 going to have to take them one at a time, if I could. I
2 want to follow-up questions with you, starting over here
3 with number 22. You have a family member that was treated
4 by them?

5 JUROR: My wife.

6 MR. JORDAN: Did she work for them or was treated?

7 JUROR: They delivered our second child. And my mom
8 worked there.

9 MR. JORDAN: Which doctor?

10 JUROR: (Inaudible.)

11 MR. JORDAN: And how long ago was that?

12 JUROR: (Inaudible.)

13 MR. JORDAN: Do you still have a family member that
14 is a patient there?

15 JUROR: I am not sure if my wife goes there or not.
16 Sorry.

17 MR. JORDAN: Do you have, know anyone in that
18 practice outside of the, relationship there?

19 JUROR: I have got a cousin that is married to, I
20 think works in the office.

21 MR. JORDAN: Okay. And number 165, the same
22 question. What connection do you have with Rock Hill
23 GYNOB?

24 JUROR: I was a patient there in 2008. I am not sure
25 of the doctor, I don't remember which doctor I saw there.

1 MR. JORDAN: Are you currently a patient now?

2 JUROR: No.

3 MR. JORDAN: And do you have any type of relationship
4 with anyone of that practice, doctors or staff outside of.

5 THE COURT: Let me interrupt just one second. There
6 are two medical practices in Rock Hill that have kind of
7 similar names. The one we are discussing today is the one
8 on Herlong Avenue, kind of behind the Hardees.

9 MR. JORDAN: And 238.

10 THE COURT: I believe I was at the Fort Mills office
11 in 2011.

12 MR. JORDAN: Do you have an ongoing doctor/patient
13 relationship?

14 JUROR: No.

15 THE COURT: Any outside connection with anyone from
16 that practice?

17 JUROR: No.

18 MR. JORDAN: Juror number 90?

19 JUROR: I was at the Fort Mill practice. The
20 physician I saw also had a practice at Rock Hill.

21 MR. JORDAN: And how long have you been a patient?

22 JUROR: Two years.

23 MR. JORDAN: And have any type of outside
24 relationship with that practice?

25 JUROR: (Inaudible.)

1 THE COURT: Hold one second. The Court Reporter, Mr.
2 Jordan, is saying she is having trouble hearing the juror
3 responses. Is there anyway, can we grab that one. The
4 courtroom mics are wireless so I think we can grab that
5 one off the bench and pass around to jurors to speak. If
6 the Bailiffs can help get that microphone to the jurors
7 who are talking.

8 MR. JORDAN: The next person, juror number 72.

9 JUROR: I attend both the Fort Mill and the Rock Hill
10 locations for a doctor there.

11 MR. JORDAN: And are you still a patient there?

12 JUROR: Annually, yes.

13 MR. JORDAN: How long have you been a patient?

14 JUROR: Three years.

15 MR. JORDAN: Do you have any type of outside
16 relationship with anyone from that practice?

17 JUROR: No, sir.

18 MR. JORDAN: Thank you very much. Next person, I am
19 sorry, juror number 149. The far right.

20 JUROR: I have three children that were born through
21 Rock Hill.

22 MR. JORDAN: Three children that were born?

23 JUROR: Yes. The youngest is 12.

24 MR. JORDAN: Youngest is 12. So over what time
25 period, how long has that been?

1 JUROR: 2003 is the oldest; and 2009 is the youngest.

2 MR. JORDAN: Very good. Are you still a patient
3 there?

4 JUROR: No.

5 MR. JORDAN: Okay. And do you know anyone in that
6 group outside of the patient, doctor/patient relationship?

7 JUROR: No.

8 MR. JORDAN: Very good. Thank you so much. The next
9 person, number 173.

10 JUROR: I believe I went to one appointment there in
11 2010, from what I can remember.

12 MR. JORDAN: Have you, you had any type of
13 doctor/patient relationship there since?

14 JUROR: No.

15 MR. JORDAN: Do you know anyone who works there?

16 JUROR: No.

17 MR. JORDAN: Do you know anyone who works there or
18 have any type of outside relationship with anyone there?

19 JUROR: No.

20 MR. JORDAN: Thank you. I see juror number 3.

21 JUROR: My mother currently goes there.

22 MR. JORDAN: Your mother currently goes there. And
23 do you know how long your mother has been a patient there?

24 JUROR: I believe more than a year.

25 MR. JORDAN: You said?

1 JUROR: More than a year.

2 MR. JORDAN: And do you know which doctor she sees
3 there?

4 JUROR: No.

5 MR. JORDAN: Does your mother or anyone in your
6 family have any type of outside relationship other than
7 doctor/patient?

8 JUROR: No.

9 MR. JORDAN: Thank you. Did I miss anyone from this
10 side. Juror number 210.

11 JUROR: My wife used to go in 2014.

12 MR. JORDAN: Your wife used to go there?

13 JUROR: My wife used to go there.

14 MR. JORDAN: And how long ago has that been?

15 JUROR: '14 and '15.

16 MR. JORDAN: Do you have anyone in your family that
17 currently uses this group?

18 JUROR: No, sir.

19 MR. JORDAN: Do you have anyone in your family that
20 knows anyone from the group outside of the patient/doctor
21 relationship?

22 JUROR: No, sir.

23 MR. JORDAN: Thank you. We are coming over to, did I
24 miss anyone over here. I want to make sure I didn't miss
25 anyone. Okay. Coming over to this side, since the

1 Bailiff has the microphone in the back let's start there.

2 Juror number 46.

3 JUROR: I am currently a patient there.

4 MR. JORDAN: And which doctor do you see there?

5 JUROR: Dr. Robinson.

6 MR. JORDAN: And how long have you been a patient?

7 JUROR: 30 years.

8 MR. JORDAN: And you have anyone else in your family
9 that is a patient there.

10 JUROR: My whole family is a patient there.

11 MR. JORDAN: Your whole family. How many people in
12 your family?

13 JUROR: I have two sisters.

14 MR. JORDAN: Do you know anyone that works there or
15 from there outside of the doctor/patient relationship?

16 JUROR: No, sir.

17 MR. JORDAN: Thank you. Coming on up next, I believe
18 it would be juror number 76.

19 JUROR: I was a patient of Dr. Rowland's from 2009 to
20 2020.

21 MR. JORDAN: And you are no longer a patient there?

22 JUROR: No, sir.

23 MR. JORDAN: Do you know anyone or have a
24 relationship outside of the doctor/patient relationship
25 with anyone from that group?

1 JUROR: I know someone who used to work in medical
2 records, I don't know if she does or not.

3 MR. JORDAN: Was that a close, personal friend?

4 JUROR: Friend of my daughter, her mother.

5 MR. JORDAN: Very good. Thank you. Coming on up,
6 the next row would be 252.

7 JUROR: I was a patient there for eight years.

8 MR. JORDAN: And what years?

9 JUROR: After the birth of my son three years ago.

10 MR. JORDAN: And you are no longer a patient there?

11 JUROR: No.

12 MR. JORDAN: Do you have any type of relationship
13 outside doctor/patient with anyone from that group?

14 JUROR: No.

15 MR. JORDAN: Thank you very much. And next would be
16 juror number 27.

17 JUROR: I was a patient there for 10 years, 11 years.

18 MR. JORDAN: And when was that?

19 JUROR: I think 2007 until 2019.

20 MR. JORDAN: You are no longer a patient?

21 JUROR: Correct.

22 MR. JORDAN: Do you have any type of relationship
23 with anyone from that practice, outside of the
24 doctor/patient relation?

25 JUROR: No, sir.

1 MR. JORDAN: Thank you. Juror number 289.

2 JUROR: Dr. Miller delivered all three of my
3 children.

4 MR. JORDAN: Over what time period.

5 JUROR: 2001 to 2008.

6 MR. JORDAN: Are you still a patient there?

7 JUROR: I am.

8 MR. JORDAN: And do you have any type of outside
9 relationship with anyone from that practice?

10 JUROR: I have been acquaintance on Facebook but we
11 are not really friends, that works at the front desk.

12 MR. JORDAN: And who is that?

13 JUROR: Julie Martin. She has gotten married again,
14 I don't even know her new name. She works at the Fort
15 Mill office and I go to the Rock Hill office.

16 MR. JORDAN: Thank you. Juror 196.

17 JUROR: My wife is still, still goes there.

18 MR. JORDAN: What is your wife's name?

19 JUROR: Her name is Allison.

20 MR. JORDAN: And how long has she been a patient
21 there?

22 JUROR: Since 2016.

23 MR. JORDAN: Do you know which doctor she sees?

24 JUROR: I don't but Dr. Miller delivered our baby.

25 MR. JORDAN: And how long ago was that?

1 JUROR: 2008.

2 MR. JORDAN: Okay. And do you or anyone in your
3 family, any family member have an outside relationship
4 with anyone from that group?

5 JUROR: No.

6 MR. JORDAN: Thank you. Juror 259.

7 JUROR: Dr. Taylor is currently and has been my
8 doctor for the last ten years.

9 MR. JORDAN: You are a current patient.

10 JUROR: Yes.

11 MR. JORDAN: Is there anyone else in your family a
12 patient there?

13 JUROR: No.

14 MR. JORDAN: Do you have any outside relationship?

15 JUROR: No.

16 MR. JORDAN: Thank you very much. Did I miss anyone.
17 Unfortunately the next set of questions -- are you
18 satisfied with treatment at Rock Hill OBGYN.

19 If you were if you can just raise, you or your family
20 member satisfied with the -- Juror 22, 165, 238, 90, 72,
21 149, 46, 289, 196 and 259. Okay.

22 For the same group. Would you recommend this group
23 to a neighbor. If you would raise your paddle up please.
24 Juror 22, 165, 90, 72, 149, 46, 289, 196 and 259.

25 And would you or your family member go back to see

1 them if you need a treatment from an OBGYN. If you would
2 raise your paddle. 22, 90, 72, 149, 46, 289, 196 and 259.

3 And would any of you who are treated there or know
4 any of the doctor and staff have any hesitation, even just
5 a little, with finding against the doctor that you are
6 still seeing. If you would have just a little bit of
7 hesitation raise that paddle for me. 252. Thank you.
8 Juror 130. Okay. Anyone else that would have a
9 hesitation, even just a little, in finding against the
10 doctor that you are still seeing.

11 Next question, would you feel totally comfortable
12 going back to the practice of Rock Hill GYN if you set on
13 a jury and found for the Plaintiff, that is Alexia
14 Lumpkin, the young lady sitting over here. Would you feel
15 totally comfortable going back to that practice.

16 THE COURT: Mr. Jordan, these are, these questions
17 are directed to people who are current patients right now?

18 MR. JORDAN: Yes, Your Honor. If you would feel
19 totally comfortable going back to the practice and sitting
20 on this jury and finding for the Plaintiff, Alexia
21 Lumpkin. If you would raise your paddle. Okay, 72, 46,
22 289, 259.

23 For those of you, are seeing Rock Hill GYN but did
24 not raise their paddle, if you would raise your paddle now
25 if you would feel a little bit uncomfortable going back to

1 that practice if you had to sit on the jury and find for
2 the Plaintiff. If you would raise your paddle. 149,
3 anyone else?

4 The next question. Would anyone feel a little bit
5 embarrassment if you went back to the practice and you had
6 sat on a jury and found for the Plaintiff against the
7 practice. Would anyone feel a little bit of embarrassment
8 if you had to go back to the practice after sitting on a
9 jury and finding for Plaintiff, against the practice. If
10 you would raise your paddle for me. Thank you very much.

11 Some people are suspicious lawyers and clients who
12 bring lawsuits against doctors alleging medical
13 negligence. Other people think that medical negligence
14 should not go unchecked. The question is, I tend to be
15 suspicious of lawyers and their clients who sue a medical
16 doctor.

17 A. I strongly agree. I am suspicious of lawyers and
18 clients and sue a medical doctor. If you strongly agree
19 with that statement raise your paddle.

20 B. I agree.

21 C. I disagree.

22 D. Strongly disagree.

23 For those who strongly disagree, if you could raise your
24 number again. 235, 70, 117, 12, 130, 116, 207, 104, 165.
25 Did I miss someone over here. Okay, very good.

1 And for those who raised their paddle on number C., raise
2 that paddle again. I will call out the numbers briefly.
3 95, 259, you can put them down, if you don't mind, once I
4 call them out. 27, 220, 289, 60, 252, 286, 219, 287, 48,
5 122, 216, 258, 150, 76, 46, 246, 61, 64, 22, 288, 19, 100,
6 238, 90, 120, 31, 72, 21, 290, 149, 173, 185, 179, 47, 57,
7 96, 106, 5, 141, 284 and 254. Did I miss anyone. Thank
8 you.

9 THE COURT: Mr. Jordan, you have got about ten
10 minutes.

11 MR. JORDAN: I do not feel comfortable sitting in
12 judgment of a medical doctor.

13 A. Strongly agree.

14 B. Agree.

15 C. Disagree.

16 D. Strongly disagree.

17 First A's. 207,

18 B's. 106, 210, 120.

19 C. Disagree which is the majority. Let me do it
20 this way.

21 D. Strongly disagree. And that would be 235, 220,
22 267, 117, 165 and 284. Thank you.

23 Some people think that bad stuff just happens to good
24 people and it is no one's fault. Others think people
25 should be held accountable for the harm they cause. Do

1 you believe that people should not require to take
2 responsibility for the harm that they caused. Should not
3 be required to take responsibility.

4 Strongly. Anyone with A.

5 B. Agree.

6 C. Disagree. It looks like that is the majority.

7 D. So let me ask, D. Strongly disagree. Let me call
8 the numbers out briefly. 259, 235, 220, 267, 252, 70,
9 117, 116, 76, 150, 46, 246, 288, 165, 100, 207, 284, 141,
10 254 and 210. Thank you.

11 Do you believe it is wrong to bring a lawsuit against
12 doctors seeking money for an alleged injury.

13 A. Strongly agree that it is wrong to bring a
14 lawsuit against a doctor seeking money. Any A's. 76.

15 B. Any B's. Agree.

16 C. Disagree. Looks like the majority.

17 D. Strongly disagree. 235, 117, 254 and 210.

18 Does anybody believe it is wrong to bring a lawsuit
19 against a doctor during coronavirus pandemic.

20 A. Strongly agree. A's. 48, 76.

21 B. Agree. 210, 141.

22 C. Disagree. It looks like that is the majority so
23 let me ask.

24 D. Strongly disagree. 235, 117, 164, 216, 130 and
25 254.

1 Do you feel that awarding a verdict against a
2 physician would result in less doctors practicing in our
3 community. Less doctors practicing in our community if
4 there is a verdict against a doctor.

5 A. Strongly agree. Any A's.

6 B. Agree. 196, 27, 286, 258, 210, 3, 5 and 106.

7 C. Disagree. That looks like the majority so let me
8 ask about.

9 D. Strongly disagree. 16, 220, 254, 207. Did I
10 miss anyone.

11 Do you feel like that there are too many lawsuits
12 filed against doctors. Too many lawsuits filed against
13 doctors.

14 A. Strongly agree. 76.

15 B. Agree. 246, 150, 130, 284, 141, 210, 3, 96, 5,
16 106, 21, 120, 90, and 258.

17 C. Disagree. Looks like the majority.

18 D. What about strongly disagree. 216.

19 Do you feel like there are too many runaway jury
20 verdicts.

21 A. Strongly agree. 106, 210.

22 THE COURT: Mr. Jordan, can you bring the mic a
23 little closer to your mouth. It is sometimes not picking
24 you up.

25 MR. JORDAN: Runaway jury verdicts where a jury

1 awards excessive amounts of money.

2 A. Strongly agree.

3 B. Agree. 216, 252, 150, 76, 130, 141, 3, 5, 21 and
4 120. Did I miss anyone.

5 C. Disagree. Looks like the majority. So I won't
6 call those out.

7 D. Strongly disagree. 207, 117. Did I miss anyone
8 there.

9 In a contest regarding what was said between a doctor
10 and a patient, it would be easier to believe the doctor.

11 A. Strongly agree.

12 B. Agree. 207, 96, 210, 57, 106, 21, 117, 48, 27.

13 C. Disagree. Looks like the majority. So let's
14 call out a D.

15 D. Strongly disagree. 165, 288.

16 If supporters show up for trial and sit behind the
17 defendants, would that affect your analysis of the case or
18 your consideration of the facts and issues. Would it
19 affect you as a juror.

20 A. Strongly agree.

21 B. Agree.

22 C. Disagree. Looks like the majority.

23 D. Strongly disagree. 235, 196, 289, 220, 60, 252,
24 70, 76, 130, 152, 141, 57, 179, 31, 120 and 290. Did I
25 miss anyone.

1 People who bring lawsuits for personal injuries tend
2 to exaggerate their injuries.

3 A. Strongly agree. 106, 76, 164.

4 B. Agree. 286, 219, 157, 216, 246, 254, 141, 152,
5 210, 3 and 5.

6 C. Disagree. Looks like the majority.

7 D. Strongly disagree. 19. Anyone else.

8 THE COURT: Mr. Jordan, you have got about 90
9 seconds.

10 MR. JORDAN: In a case you may hear about rules that
11 doctors have to follow. How many rules in your work place
12 that you have to follow. Pretty much everyone. And are
13 there consequences for not following those rules. Pretty
14 much everyone. And do you believe that rules should be
15 followed in the work place. And the rules are there for
16 the protection of the employee or the customer. I beg the
17 Court's indulgence.

18 THE COURT: Certainly.

19 MR. JORDAN: Thank you, Your Honor.

20 THE COURT: Thank you, Mr. Jordan. Ladies and
21 gentlemen, it is now the Defense's term. I would like to
22 give you a restroom break in a half an hour after the
23 Defense has their turn. However, I don't want to torture
24 anyone. Is there anyone that really needs a bathroom
25 break right now and can't wait a half an hour. It is okay

1 if you say, yes, it is okay. We can take care of it.

2 (No response.)

3 THE COURT: Mr. Davis.

4 MR. DAVIS: I don't I think I will have as many
5 questions. I hope that I don't take my entire 30 minutes.
6 My name is Ashby Davis, I represent Dr. Miller and his
7 practice group, Rock Hill GYNOB here in Rock Hill. Is
8 there any member of the jury or jury panel are a close
9 friend or immediate family member, close friend, ever been
10 represented by or had any dealings with Mr. Graham or Mr.
11 Jordan, the attorneys for the Plaintiffs.

12 (No response.)

13 MR. DAVIS: Is there any member of the jury panel or
14 any member of their immediate family or close friend ever
15 been a party, someone sued or someone suing that would be
16 a party to a medical malpractice lawsuit.

17 (No response.)

18 MR. DAVIS: Is there any member of the jury panel or
19 a member of their immediate family or close friend ever
20 had a claim against a physician for any reason.

21 (No response.)

22 MR. DAVIS: Any member of the jury panel or a member
23 of their immediate family or close friend ever made any
24 other claim for damages against a physician or health care
25 provider in which it was alleged that the physician or

1 health care provider did something wrong that caused
2 injury to them or to a member of their immediate family.
3 Number 48.

4 JUROR: It never ended up going to court or anything.
5 But it was my father.

6 MR. DAVIS: Thank you, sir. Is there any member of
7 the jury panel or any member of their immediate family or
8 close friend ever been a party to any other kind of
9 lawsuit, unless you have already answered this question
10 before, you don't have to answer it again; for any claim
11 for money damages. I think there was a gentleman that was
12 named as a Defendant earlier. I can't remember his name.

13 (No response.)

14 MR. DAVIS: Is there any member of the jury panel or
15 any member of their immediate family ever served on a
16 civil jury. I think you have already answered that
17 question so let me skip by that one. I have got that. Is
18 there any member of the jury panel or a member of their
19 immediate family, I have asked that too. We will get done
20 real quick. Is there any member of the jury panel or a
21 member of their immediate family or close personal friend
22 ever suffered an injury as result of a medical procedure
23 or medical care. I will just call the numbers out.
24 Number 185, number 48, number 219, number 117, number 216,
25 number 60.

1 The fact that you may have suffered or a family
2 member or close personal friend suffered some injury as a
3 result of a medical procedure or medical care, would that
4 cause you to not be fair and impartial to Dr. Miller and
5 his practice and to the Plaintiffs in this case. If so
6 would you raise your paddle.

7 (No response.)

8 MR. DAVIS: Is there any member of the jury panel
9 feel that simply because of a lawsuit has been brought
10 against a physician, a doctor, that the doctor is likely
11 negligent.

12 (No response.)

13 MR. DAVIS: Have you recently read or heard about any
14 recent medical malpractice verdicts or settlements.

15 (No response.)

16 MR. DAVIS: At the conclusion of this trial and it
17 will be over one day, I promise; His Honor, Judge
18 McKinnon, has the sole responsibility as a law giver in
19 the case to charge you on the law, to give you the law
20 that you are to apply to the facts as you find them to be,
21 from the evidence presented in the trial of the case. Is
22 there any member of the jury panel know of any reason why
23 it might be difficult for you to follow and apply and
24 adhere to the law that the Judge, whatever the Judge gives
25 you as the law in this case, at the end of the case, as

1 you render your verdict, as you deliberate and reach a
2 decision in this case. Any problem with being able to
3 follow whatever the law is in this case that the Judge
4 gives you.

5 (No response.)

6 MR. DAVIS: Does anybody know of any reason why you
7 cannot give both parties, both Dr. Miller and his practice
8 group and the Plaintiff and this family, a fair and
9 impartial trial and listen to the evidence in the case and
10 apply the law as the Judge gives it to you to those facts
11 as you find them and render a verdict that speaks the
12 truth.

13 (No response.)

14 MR. DAVIS: Thank you.

15 THE COURT: Thank you, Mr. Davis. Ladies and
16 gentlemen, since that was, we are going to move. Counsel,
17 if y'all can approach with any for cause requests.

18 MR. GRAHAM: Your Honor, with this information, is
19 this time to take a break.

20 THE COURT: Sounds like a good idea. Ladies and
21 gentlemen, the attorneys have asked y'all a lot of
22 questions and they need to think through now. We are
23 about to do the actual juror selection process. We will
24 pick 16 of you that will serve as jurors on this case.
25 The attorneys need a little bit of time to think about

1 what they have learned from their questions. So y'all
2 take 15 minutes. You can use the restroom, do whatever
3 the Bailiffs tell you you can do.

4 (Whereupon, the jury was excused from open court for
5 a break.)

6 THE COURT: The attorneys need about ten minutes to
7 read through it and see who is what in order and that kind
8 of thing. You are welcome to talk among yourselves. If
9 you have a book you can read it, just relax for ten
10 minutes and then we will start up again.

11 (Whereupon, a short break while attorneys look over
12 jury sheet.)

13 THE COURT: Ladies and gentlemen, if I can get your
14 attention. I have a few follow-up questions for some of
15 you based on responses you gave earlier today or based on
16 the written questionnaire that you filled out. So my
17 first one is, Juror 207, if you don't mind standing up.
18 And, Ma'am, would you be able to follow the law as I
19 explained it to you?

20 JUROR: Yes.

21 THE COURT: And could render a verdict based on the
22 evidence that you heard in court?

23 JUROR: Yes, sir.

24 THE COURT: And could you be fair and impartial to
25 both sides in this case?

1 JUROR: Yes, sir.

2 THE COURT: Thank you, Ma'am. All right. Juror 76.
3 Ma'am, I just want to make sure my notes are correct. I
4 have you were a patient of this Defendant practice for 18
5 years. Is that correct? Could the bailiffs bring
6 microphones. So, Ma'am, you were a patient for 18 years
7 and are you a current patient?

8 JUROR: No.

9 THE COURT: And was Dr. Miller your doctor?

10 JUROR: No, might have saw him once.

11 THE COURT: Could you still be fair and impartial to
12 both sides in this case?

13 JUROR: Yes.

14 THE COURT: And could you follow the evidence as you
15 hear it in court and the law as I explain it to you?

16 JUROR: Yes.

17 THE COURT: Thank you, Ma'am. All right. Juror 149.
18 I want to double check my notes. I understand Dr. Miller
19 delivered three of your children?

20 JUROR: Yes, (inaudible.)

21 THE COURT: Someone at the practice did?

22 JUROR: Yes.

23 THE COURT: Okay. Ma'am, could you follow the law as
24 I explain to you and the evidence that you hear in court?

25 JUROR: Yes.

1 THE COURT: Could you be fair and impartial to both
2 sides in this case?

3 JUROR: Yes.

4 THE COURT: Thank you, Ma'am. Juror 289. And,
5 Ma'am, I also have a similar, that Dr. Miller delivered
6 three of your kids. Is that correct?

7 JUROR: Yes.

8 THE COURT: And would still be able to be fair and
9 impartial to both sides in this case?

10 JUROR: Yes.

11 THE COURT: And can you follow the law as I explain
12 to you and the evidence that you hear in court?

13 JUROR: Yes.

14 THE COURT: Okay. Juror number 3. Sir, I
15 understand, your mother was a patient and was also
16 employed by the practice. Is that correct?

17 JUROR: A patient.

18 THE COURT: Just a patient. Okay. Was someone else
19 in your family employed by the practice?

20 JUROR: No.

21 THE COURT: So your mother was a patient. So could
22 you follow the law as I explain it to you and the evidence
23 that you hear in court?

24 JUROR: Yes.

25 THE COURT: You could still be fair and impartial to

1 both sides in this case?

2 JUROR: Yes.

3 THE COURT: Thank you, sir. Juror 210. Yes, sir.
4 Sir, could you follow the law as I explain to you and the
5 evidence that you hear in court?

6 JUROR: Yes.

7 THE COURT: And could you be fair and impartial to
8 both sides in this case?

9 JUROR: Yes.

10 THE COURT: Juror 120. Can you base your verdict on
11 the law as I explain it to you and the evidence you hear
12 in court?

13 JUROR: Yes.

14 THE COURT: Could you be fair and impartial to both
15 sides in this case?

16 JUROR: Yes, sir.

17 THE COURT: Thank you, sir. Juror 57. Ma'am, you
18 are a current patient of the practice?

19 JUROR: No sir, I think my sister was.

20 THE COURT: Your sister was. Did she see Dr. Miller
21 or do you know who her doctor was?

22 JUROR: I don't know who her doctor was but I don't
23 think it was Dr. Miller.

24 THE COURT: Could you base your verdict on the law as
25 I explain it to you and the evidence you hear in court?

1 JUROR: Yes, sir.

2 THE COURT: And could you be fair and impartial to
3 both sides in this case?

4 JUROR: Yes, sir.

5 THE COURT: Juror 259. Ma'am, I understand you have
6 been a patient of the practice for approximately 10 years?

7 JUROR: Yes.

8 THE COURT: Could you base your verdict, I am sorry,
9 are you currently still a patient?

10 JUROR: Yes.

11 THE COURT: Have you ever seen Dr. Miller?

12 JUROR: I have not.

13 THE COURT: Could you follow the law as I explain it
14 to you and base your verdict on the evidence you hear in
15 court?

16 JUROR: Yes, sir.

17 THE COURT: Could you still be fair and impartial to
18 both sides?

19 JUROR: Yes, sir.

20 THE COURT: Juror 27. Ma'am, my notes is that you
21 were a patient of the practice for about 10 years.

22 JUROR: Yes, sir.

23 THE COURT: Are you currently a patient.

24 JUROR: No, sir.

25 THE COURT: Have you ever seen Dr. Miller?

1 JUROR: No, sir.

2 THE COURT: Could you base your verdict on the law as
3 I explain to you and the evidence you hear in court?

4 JUROR: Yes, sir.

5 THE COURT: Could you be fair and impartial to both
6 sides in the case?

7 JUROR: Yes, sir.

8 THE COURT: Juror 165. Ma'am, could you base your
9 verdict on the law as I explain to you and the evidence
10 that you hear in court?

11 JUROR: Yes.

12 THE COURT: Would you be fair and impartial to both
13 sides in this case?

14 JUROR: Yes, sir.

15 THE COURT: Thank you, Ma'am. Juror 46. Ma'am, I
16 understand you have been a patient for approximately 30
17 years in the practice?

18 JUROR: Yes, sir.

19 THE COURT: And have you ever seen Dr. Miller?

20 JUROR: Yes, sir.

21 THE COURT: Okay. Could you still be fair and
22 impartial to both sides in this case?

23 JUROR: Yes, sir.

24 THE COURT: And would you base your verdict on the
25 law as I explain it and the evidence in the case?

1 JUROR: Yes, sir.

2 THE COURT: Juror 90. Ma'am, I understand, you are a
3 current patient in the practice?

4 JUROR: Yes, sir.

5 THE COURT: Have you ever seen Dr. Miller?

6 JUROR: No, sir.

7 THE COURT: Can you be fair and impartial to both
8 sides in this case?

9 JUROR: Yes.

10 THE COURT: And base your verdict on the law as I
11 explain it to you and the evidence you hear in court?

12 JUROR: Yes.

13 THE COURT: Juror 106. Ma'am, would you base your
14 verdict on the law as I explain it to you, the evidence
15 you hear in court?

16 JUROR: Yes.

17 THE COURT: And could you be fair and impartial to
18 both sides in the case?

19 JUROR: Yes.

20 THE COURT: Juror 238. Ma'am, are you a current
21 patient, former patient?

22 JUROR: Former.

23 THE COURT: And have you ever seen Dr. Miller?

24 JUROR: No, sir.

25 THE COURT: Would you be able to follow the law and

1 base your verdict on the evidence as you hear it in court?

2 JUROR: Yes.

3 THE COURT: Could you still be fair and impartial to
4 both sides?

5 JUROR: Yes.

6 THE COURT: Juror 22. Sir, I understand that your
7 wife and mother are patients and someone in your family
8 worked there as well?

9 JUROR: (Inaudible.)

10 THE COURT: Do you believe you could be fair and
11 impartial to both sides in this case?

12 JUROR: (Inaudible.)

13 THE COURT: And can you base your verdict on the
14 evidence you hear in court and the law as I explain it to
15 you?

16 JUROR: (Inaudible.)

17 THE COURT: And juror 252. Ma'am, I understand you
18 are a patient for eight years?

19 JUROR: Yes.

20 THE COURT: Are you currently a patient?

21 JUROR: No.

22 THE COURT: Did you ever see Dr. Miller?

23 JUROR: Yes.

24 THE COURT: And could you still be fair and impartial
25 to both sides in this case?

1 JUROR: Yes.

2 THE COURT: And would you base your verdict on the
3 law as I explain it to you and the evidence you hear in
4 court?

5 JUROR: Yes.

6 THE COURT: Thank you, ma'am. Juror 64. Ma'am,
7 would you still be, would you be fair and impartial to
8 both sides in this case?

9 JUROR: Yes, I can try.

10 THE COURT: When you say you can try, that concerns
11 me a little bit.

12 JUROR: I have worked with 23 doctors and --

13 THE COURT: You have doubts about whether you would
14 be able to fairly decide between a doctor and a patient?

15 JUROR: Yes. I have worked with 23 doctors and,
16 (inaudible.)

17 THE COURT: Thank you, Ma'am. Juror 106. Ma'am,
18 would you be able to be fair and impartial to both sides
19 in the case?

20 JUROR: Yes.

21 THE COURT: And would you base your verdict on the
22 law as I explain it to you and the evidence you hear in
23 court?

24 JUROR: Yes.

25 THE COURT: Thank you, Ma'am. And juror 157. And,

1 sir, would you be fair and impartial to both sides in this
2 case?

3 JUROR: Yes.

4 THE COURT: And would you base your verdict on the
5 law as I explain it to you and the evidence that you hear
6 in court?

7 JUROR: Yes.

8 THE COURT: Counsel, can y'all approach one more
9 time, please.

10 (Whereupon, a bench conference was held in the
11 presence of the jury but out of the hearing of the
12 jury.)

13 THE COURT: Juror 196. Would you be able to follow
14 the evidence as you hear it in court and follow the law as
15 I explain it?

16 JUROR: Yes.

17 THE COURT: Could you still be fair and impartial to
18 both sides?

19 JUROR: Yes.

20 THE COURT: Thank you. These are the Court's strikes
21 and they are using the numbers on the left, not the juror
22 numbers. Court strikes number 6, number 8, number 9,
23 number 24, number 28, number 44 and number 47.

24 I will do it one more time. The last one was 47.
25 Number 6, number 8, number 9, number 24, number 28, number

1 44 and number 47.

2 Is the Plaintiff prepared to proceed with the strike?

3 MR. DAVIS: I beg the Court's indulgence.

4 THE COURT: Yes, sir.

5 Is the Plaintiff ready to proceed?

6 MR. GRAHAM: Yes, Your Honor.

7 THE COURT: Is the Defense ready to proceed?

8 MR. DAVIS: Yes, Your Honor.

9 THE COURT: Okay. Ladies and gentlemen, this is the
10 actual juror selection in the case. And y'all may have
11 seen this on TV or in movies. Every State does it
12 differently. Some are really dramatic and the attorneys
13 will stand up and say, I strike juror so and so. In South
14 Carolina it is very low key. This random sheet has given
15 you separate numbers. So it is not the juror number you
16 will hear called out. The Clerk of Court is going to call
17 on each attorney back and forth. They are going to read
18 numbers out. They are not your juror numbers. It is a
19 different number that has been assigned for this purpose
20 only. And at the end the Clerk of Court is going to say
21 who has got picked. Madam Clerk, whenever you are ready.

22 CLERK OF COURT: Is the Plaintiff ready?

23 MR. JORDAN: Plaintiff strikes number 2.

24 MR. DAVIS: Defense strikes number 21.

25 MR. JORDAN: Plaintiff strikes number 12.

1 MR. DAVIS: Defense strikes number 13.

2 MR. JORDAN: Plaintiff strikes number 14.

3 MR. DAVIS: Defense strikes number 19.

4 MR. JORDAN: Plaintiff strikes number 20.

5 MR. DAVIS: Defense strikes number 22.

6 CLERK OF COURT: You will have one strike each for,

7 (inaudible.)

8 THE COURT: 25 through 27.

9 MR. GRAHAM: Can you kindly read those one more time.

10 CLERK OF COURT: For your next strike will be 25
11 though 27; 29 through 31; 32 through 34; and 35 through
12 37.

13 MR. GRAHAM: Thank you.

14 MR. JORDAN: Plaintiff strikes number 25.

15 MR. DAVIS: The Defense strikes number 26.

16 MR. JORDAN: The Plaintiff strikes number 29.

17 MR. DAVIS: The Defense strikes number 30.

18 MR. JORDAN: The Plaintiff strikes number 33.

19 MR. DAVIS: The Defense strikes number 32.

20 MR. JORDAN: The Plaintiff strikes number 37.

21 MR. DAVIS: The Defense strikes number 36.

22 CLERK OF COURT: I would like to verify the strikes
23 for both sides. I have the following strikes for the
24 Plaintiff. 2, 12, 14, 20, 25, 29, 33 and 37. Is this
25 correct?

1 MR. JORDAN: That's correct.

2 CLERK OF COURT: I have the following strikes for the
3 Defendant. 21, 13, 19, 22, 26, 30, 32 and 36. Is this
4 correct?

5 MR. DAVIS: Yes, ma'am.

6 CLERK OF COURT: Thank you.

7 THE COURT: Ladies and gentlemen, at this point the
8 Clerk of Court is going to call your names and juror
9 numbers out. If you are one of the 16 names called that
10 means you have been selected to be a juror or an alternate
11 in this case. If your name is called the Bailiffs will
12 direct you to have a seat up here. You need to bring with
13 you any personal belongings, your purse, your book or
14 anything like that. And rest of you, don't leave. I
15 speak to the lawyers before I let anyone go. So those
16 folks the Clerk calls now, you are not in any particular
17 order. Again, it is a randomized sheet but the Clerk is
18 going to call you to come up here and sit where the
19 Bailiffs tell you to sit.

20 CLERK OF COURT: Ladies and gentlemen, if I call your
21 name please bring your personal belongings and move to the
22 jury box to my left, my right; the Bailiff will direct
23 you. Number 31, Kristina Breece; number 141, Sheryl
24 Johnston; number 70, Dara De Mauro; number 5, Matthew
25 Anderson; number 286, Leigh Ann Watkins Calvert; number

1 152, Scott Kodell; number 96, Daniel Fulk, Jr.; 216,
2 Steven Pesa; 173, Celeste McCain; 219, John Pinto; number
3 95, Debora Fritts; number 21, Chadwick Blackmon; number
4 60, Tracy Rosiak; number 235, Mitchell Rowe; number 122,
5 Jesse Holland; number 254, David Smathers.

6 THE COURT: Does the Plaintiff have any motions or
7 rejections regarding juror qualification or selection?

8 MR. GRAHAM: Your Honor, might we have a few minutes.
9 We believe there are grounds for that and we would like to
10 consider it carefully.

11 THE COURT: Okay. Certainly.

12 MR. GRAHAM: Can we step out, Your Honor.

13 THE COURT: Certainly. Ladies and gentlemen, the
14 attorneys have raised an issue, there may be an error in
15 the juror selection process. I am going to ask you all to
16 head back downstairs to that big room. And if you want to
17 stop to the restroom on the way down that's fine. I am
18 going to hear the attorneys argument then I will make a
19 decision as to whether or not we go forward with the 16
20 folks we have selected or we do it all over again. If we
21 have to do it all over again, it will just be the very
22 last bit. The computer will print out a new randomized
23 order. We don't have to do any of the questions again or
24 anything like that. Does that make sense to everybody.
25 Follow the Bailiffs, they will take you down to the big

1 room downstairs.

2 (Whereupon, the jury was excused from open court.)

3 THE COURT: We are back on the record. Your motion,
4 Mr. Graham.

5 MR. GRAHAM: Your Honor, we move under the case of
6 Batson to, for relief under the Batson case, on the
7 grounds that the strikes by Defense create a prima facie
8 case of peremptory based on racial discrimination. Out of
9 eight strikes, four of those were used on African
10 Americans. One of those was used on an Asian. These
11 represent the only Asian on the possible juror list and
12 all of the blacks on the potential jury list, we believe
13 it is an obvious prima facia showing of racial
14 discrimination. And so we would suggest moving to the
15 next step of, whether there is some other legitimate
16 justification for those strikes that is
17 non-discriminatory.

18 THE COURT: I think we will move on to the second
19 phase. But just for the record, you are challenging the
20 strikes of juror 267, Stover; 185, Izzard; 57, Coulter;
21 227, Redfield and 157. Is that correct?

22 MR. GRAHAM: Your Honor, I have it listed by the
23 numbers to the left.

24 THE COURT: That would be fine. So I have 13, 21,
25 26, 30 and 36.

1 MR. GRAHAM: Correct, Your Honor. Thank you.

2 THE COURT: Mr. Davis.

3 MR. DAVIS: Your Honor, I have to go back through my
4 notes. I am happy to do that and I will just try to take
5 them in order. Starting with, should I use the juror
6 number or the juror strike number?

7 THE COURT: I think to make the record clear we
8 should use the, for this purpose, the true juror number,
9 the right column.

10 MR. DAVIS: I believe the first one was 267, is that
11 right?

12 THE COURT: Yes sir, Juror Stover.

13 MR. DAVIS: 267 in my notes. This individual did not
14 fill out a questionnaire. So I had very limited ability
15 to learn anything and my notes are probably not real good.
16 She is a very young student and I think her inexperience
17 would not suit her well to this complex medical
18 malpractice case. You want me to go to the next one?

19 THE COURT: Yes, sir.

20 MR. DAVIS: Number, juror number 186, excuse me, 185.
21 Is that the next one?

22 THE COURT: Yes, sir. Izzard.

23 MR. DAVIS: In the jury questionnaire she indicated
24 that she served on a civil jury with a guilty verdict.
25 And as I look at that information, that leads me to

1 conclude for a peremptory strike, that the person may be
2 confused about the law from prior service, that a civil
3 case is a criminal case. If a verdict is for one party or
4 another it is a guilty or not guilty. And for that reason
5 I struck her. You want me to go to the next one, Judge?

6 THE COURT: Yes, sir.

7 MR. DAVIS: The next one I have is number 57, I
8 believe.

9 THE COURT: Yes, sir.

10 MR. DAVIS: This individual juror, in her
11 questionnaire indicated that her father was in a
12 motorcycle accident and had a permanent disfigurement on
13 his hand. Actually she also list that sister is a patient
14 at Rock Hill OBGYN. I focused in on the fact that her
15 father, who I assume she would be close to, even at age
16 46, I think she is; having a father with an accident with
17 a permanent disfigurement may tend to cause her sympathy,
18 more with a permanent injury, unquestionably permanently
19 injured Plaintiff. And for that reason I peremptorily
20 struck her. You want me to go to the next one?

21 THE COURT: Yes, sir.

22 MR. DAVIS: Juror number 227. And, Judge, you may
23 recall a very nice young man, very honest and candid about
24 his longterm knowledge of the Plaintiffs church. The
25 grandmother had been very close to his family. He has

1 known this family for years, I think was his quote. And
2 for that reason I struck him for cause.

3 The last one, I think, is Mr. Jack Lee.

4 THE COURT: Yes sir, 157.

5 MR. DAVIS: Let me pull his information up. Number
6 157. Your Honor, you may recall this is an individual
7 juror I request to be stricken for cause based on his
8 information that he filled out in the questionnaire which
9 revealed that he states that he cannot judge the
10 believability of Angela Patton and Dr. Miller. And I
11 think that a preconceived determination that he can't, is
12 unable to judge credibility which is essential in any
13 case, caused me to peremptorily strike Mr. Lee. Thank
14 you, Your Honor.

15 THE COURT: Yes, sir. All right. In the Court's
16 opinion the Defense has provided satisfactory race neutral
17 explanation. So any response from the Plaintiff?

18 MR. GRAHAM: Yes, sir. We believe that it is
19 pretextual. The first one, no questionnaire. And
20 questionnaire and youth, may not be able to understand a
21 medical case because of her youth. That applies to so
22 many jurors that he did not strike. A relatively small
23 number of, there are so many jurors that are young that he
24 did not strike. I don't know off the top of my head how
25 many questionnaires were not turned in. My impression is

1 that there were a significant number. And if that is
2 correct then we believe that is pretextual too because,
3 you know, there were others who did not submit a
4 questionnaire, he did not strike. Assuming that factual
5 predicate to be correct.

6 The business about number 267. I am sorry. I was
7 addressing --

8 THE COURT: I thought you were speaking about 267.

9 MR. GRAHAM: Oh, I am sorry. Yes, Your Honor, I was.
10 180, if I recall correctly, Your Honor, number 185 is the
11 one where Mr. Davis said that she had served in a criminal
12 case and because of her service on the criminal jury that
13 she might confuse the burden of proof or some other
14 aspects of a civil claim --

15 THE COURT: Mr. Graham, my recollection is, is that,
16 I haven't seen the questionnaire. Mr. Davis said that she
17 claimed that she served on a civil jury but rendered a
18 guilty verdict. That was his objection.

19 MR. GRAHAM: Well, I think a lot of lay people
20 talking that way. She hasn't gone to law school to find
21 in favor of a plaintiff in a civil lawsuit against a
22 defendant. It is analogous to finding the Defendant
23 guilty even in a civil context because those words are so
24 often used, we made a motion in limine in this case to
25 prevent the Defendants from claiming that the doctor has

1 been charged. There is often language used that derives
2 from criminal cases that is used in a civil case as a
3 defense technique to try to convince the jury that there
4 is something going on here besides just a civil judgment
5 for monetary damages.

6 THE COURT: Yes, sir. I understand that you may
7 disagree with Mr. Davis as to whether that is the kind of
8 juror you would like on your case but do you have any, do
9 you have a way to show that that was racially
10 discriminatory. I mean, is there --

11 MR. GRAHAM: Your Honor, while we are considering
12 some of the other points I would like to put on the record
13 that juror number 227, whose grandmother was close to Mr.
14 Lumpkin's, you have Mr. Lumpkin's grandmother. It was not
15 as Mr. Davis described it where they were close, he, in
16 fact, said that he and Mr. Lumpkin were not close. That
17 it was their grandmothers that were close and that he had
18 known the family just as they, you know, they were members
19 of the same church but they weren't close. There is --

20 THE COURT: Mr. Graham, I agree and that is why I
21 didn't strike them for cause. Don't you have to show that
22 there is some other person who knew the Plaintiff, who
23 knew the Plaintiff from church and didn't get struck to
24 show racial discriminating?

25 MR. GRAHAM: Yes, sir. To get past, to win the

1 pretextual argument. But, and if Your Honor would indulge
2 us just a moment.

3 THE COURT: Yes, sir.

4 MR. GRAHAM: We are dealing with a lot of different
5 facts.

6 THE COURT: I understand.

7 MR. GRAHAM: Your Honor, one of the strikes, was if I
8 recall correctly, is based on an answer about couldn't
9 make a decision between the parties or something to that
10 effect?

11 THE COURT: Right.

12 MR. GRAHAM: Just as you did with every other juror
13 out here, you ask if he could be fair and impartial and he
14 said, yes. Every single person that you asked that
15 question to answered yes except one. And I don't see why,
16 an answer on his questionnaire is not overwritten by his
17 statement that he could be fair and impartial, just like
18 all the other ones.

19 THE COURT: But, Mr. Graham, Mr. Davis is only
20 choosing between three jurors. Using the left column,
21 juror 35, 36 and 37. So you struck juror 37. So Mr.
22 Davis only has two choices. He either has to strike 35 or
23 36. And I, that is a tough rode on a Batson's motion on
24 that, choosing between those two. So you think it was, it
25 is improper under Batson for Mr. Davis to have chosen

1 juror 36 over juror 35 to strike?

2 MR. GRAHAM: Indulge me for just a moment, Your
3 Honor.

4 THE COURT: Yes, sir.

5 MR. GRAHAM: Your Honor, we will rely on our
6 comments. That is our argument, that is our position.

7 THE COURT: Okay. Let me just say, I am prepared to
8 make a ruling. I think, the last four I was satisfied
9 with Mr. Davis' argument. For juror 185, he responded in
10 his questionnaire, a civil jury with a guilty verdict.
11 Number 57, father in the motorcycle accident with
12 permanent disfigurement. 227, he knew the family of the
13 plaintiff. And 157, he said he can't judge between a
14 physician and a patient. I don't think under Batson the
15 Plaintiffs has presented me with similarly situations. So
16 I think Mr. Davis wins on those. I was not sure about the
17 first one because that was, because obviously I am not
18 suggesting that Mr. Davis has any ill-will. But that is
19 the one where he said it was a young student with no
20 questionnaire. So I asked the Clerk's office to tell me
21 how many people did not return a questionnaire. And of
22 those first 23 on the sheet there were only three that did
23 not return the questionnaire. And that was juror 289,
24 juror 152 and juror 173. And juror 289 was stricken by
25 the Court. So that means that, in that first group of 23

1 there were only two jurors that did not return the
2 questionnaire. The one that was struck by, hold on, wait
3 a minute. We are talking, wait a minute. I may have made
4 an error here. Okay. For the record, when I, if y'all
5 want to approach you can see the sheet I am talking about.
6 But the Clerk has given me a sheet showing people who
7 returned and who did not return the questionnaire. Juror
8 267 who is the juror in question is not on either column
9 and the Clerk tells me that is because she did not return
10 her postcard either. She didn't return anything. So let
11 me do a count here and, because we have 62. So by my
12 count there were two people who returned nothing at all of
13 which this juror was one of them. So there were, so there
14 are five people did not return the survey and two of those
15 five did not return anything at all. So are any of those
16 young people.

17 MR. GRAHAM: The numbers again Your Honor?

18 THE COURT: The numbers that I have of people in that
19 first group of 23 that did not return anything are juror
20 289, which was struck by the Court; juror 152, 173. And
21 let me see, and I don't know how to determine the other
22 missing one. Let me look real quick and I can do it this
23 way. I have gone through the Clerk's report. There were
24 only three jurors in that first group of 23 that did not
25 return, I am sorry, there were four. So the four jurors

1 in that first group that did not return a survey are juror
2 289, struck by the Court. She doesn't count. So the
3 remaining three are juror 152, white male, Scott Codell;
4 juror 267, the juror in question; and juror 173, a white
5 female, Celeste McCain. Those three jurors did not return
6 questionnaire's. Can you tell me how old jurors 152, and
7 173.

8 MR. GRAHAM: 173 is 37.

9 THE COURT: And then how old is the juror in
10 question, 267.

11 MR. GRAHAM: I believe she is quite young, like 18,
12 19.

13 THE COURT: She is 18. The Court's inclination is to
14 deny the motion in that case. There are only three jurors
15 in that group of 23, of the first group that did not
16 return their questionnaire. And just for the record, of
17 what I am saying, Mr. Davis is striking out of that group
18 of 1 through 23, those are his choices. Of that group
19 only three of them did not return the survey other than
20 the one the Court struck. And the ages of those three
21 are, age 37; born in 1965, so that makes him 35; and then
22 juror 267 was 18. So in the Court's opinion I think Mr.
23 Davis has satisfied his burden. But if I am missing
24 something I will be happy to hear from the Plaintiff, if I
25 am missing something.

1 MR. GRAHAM: We will stand on the earlier comments.

2 THE COURT: Okay.

3 MR. GRAHAM: Thank you, Your Honor.

4 THE COURT: I am going to deny the motion. Counsel,
5 do y'all want to just look real quick. This is what, why
6 don't y'all approach and we will make this a Court's
7 exhibit.

8 (Whereupon, Court's Exhibit 1 was marked for
9 identification only.)

10 (Whereupon, a bench conference was held.)

11 THE COURT: Ladies and gentlemen, the Bailiffs have
12 probably already told you this. My 16, take a seat where
13 you were before, please. It doesn't have to be the exact
14 same chair in the jury box. Ladies and gentlemen, thank
15 you very much for your patience. We thought there may be
16 an issue with the jury selection process but I have talked
17 with the lawyers and I am satisfied everything was done
18 the way it ought to have been done. So I am going to hold
19 y'all for just a second.

20 Those folks sitting out there on the benches that
21 were not selected as jurors in this case, I need you to
22 put your paddles on your bench and call in in the evening.
23 It is possible, unlikely but possibly that we have a trial
24 later in the week. So the Clerk's office has told y'all
25 how to call in so make sure you call in to see if we need

1 you later in the week. Jury service is for the whole
2 week. But otherwise y'all have a great week, thank you
3 for your patience and your service.

4 (Whereupon, the remaining jurors not seated on the
5 trial jury were excused.)

6 THE COURT: Ladies and gentlemen, so y'all are the 16
7 jurors and alternates for this trial. I will let you go
8 in just a second but I need to give you some rules first.
9 The first one is, you know a little bit about the case,
10 you know the names of the parties who are involved, a
11 little about what the case is about. You know the names
12 of the lawyers. Do not do any research. Don't google
13 anyone's names, don't look up the laws in South Carolina;
14 don't do anything like that on the internet. You will
15 hear all the evidence you need to hear in the courtroom
16 and I will explain the law to you so please do not do any
17 outside research. Secondly, it is going to be very
18 natural when y'all go home that your husband, wife, kids
19 are going to say, what happened in court, tell me about
20 what happened in court. All you are permitted to say is,
21 you were chosen as a juror in a civil case or a lawsuit,
22 however you want to say it. Nothing else. At the end of
23 the case you will be totally free to talk about the case
24 with whoever you want. You can talk about it to your
25 spouse, kids, you can write a book about jury service if

1 you want to. But while the case is pending you may not
2 discuss the case with anyone else. And that even includes
3 each other until it is time for deliberation. So two of
4 you may have hit it off today and decide you are going to
5 go get pizza after you leave the Court House. You can do
6 that, get a beer or whatever, y'all can hang out if you
7 want to. But you cannot talk about this case unless it is
8 time at the end of the case when you have heard all the
9 evidence and you have heard from the lawyers then it is
10 time for juror deliberation. And, of course, at that
11 point you talk to each other. But back in the jury room
12 when you are on break, if you go out for a beer tonight or
13 whatever, y'all cannot discuss the case with each other.
14 Any questions about any of those rules.

15 (No response.)

16 THE COURT: All right, ladies and gentlemen, y'all
17 have been extremely patient, I really appreciate your
18 service. Because we went late tonight, the lawyers and I
19 have some legal matters to take up. We will start early
20 tomorrow but I will ask y'all to be here at 10:30. Be
21 back tomorrow morning at 10:30. The Bailiffs will tell
22 y'all where to come. Thank you very much.

23 (Whereupon, the jury was excused from the day.)

24 THE COURT: Anything before we break for the day,
25 from the Plaintiff?

1 MR. GRAHAM: No, Your Honor.

2 THE COURT: From the Defense.

3 MR. DAVIS: No, Your Honor.

4 THE COURT: We will see y'all at 9:30 tomorrow. We
5 are recessed for the evening.

6 January 5, 2022

7 MR. JORDAN: -- Mr. Davis about it. I don't know if
8 Ed has or not.

9 MR. DAVIS: It has never been discussed. I would
10 oppose it, I don't think there is any advantage or
11 disadvantage to what --

12 THE COURT: I think that given at this point, been
13 given how long this matter has been litigated, I guess
14 there is not going to be much surprise testimony?

15 MR. DAVIS: Your Honor, I would ask for
16 sequestration.

17 THE COURT: Mr. Graham, we had just gone on the
18 record. I had forgotten to ask Counsel yesterday about
19 witness sequestration. Do you have a position on whether
20 you want witnesses sequestered or not?

21 MR. GRAHAM: We would ask for it, Your Honor.

22 THE COURT: Let me think about that. I will issue a
23 ruling.

24 MR. GRAHAM: Would you like me to go first, Your
25 Honor.

1 THE COURT: Yes sir, whenever you are ready.

2 MR. GRAHAM: I think we handed one up to you
3 yesterday.

4 THE COURT: I can't see what you are holding up.

5 MR. GRAHAM: It is our motion in limine.

6 THE COURT: I don't recall getting one. Can I read
7 it first, Mr. Graham, or do you want to go ahead --

8 MR. GRAHAM: I think I can just go through some of
9 it. I confess, it might be a hint of boilerplate in it.
10 So I think I can speed through it, Your Honor. The first
11 one, we ask that the Defense be precluded from using
12 character or reputation evidence of Defendants and their
13 employees to try enhance their, the jury's reaction to
14 them and to, and to soften the burden of proof based on
15 the idea that they are good guys, or something to that
16 effect when that is not an issue in the case.

17 THE COURT: I mean the rules of evidence cover that
18 issue. I will enforce the rules.

19 MR. GRAHAM: Thank you. Secondly, oh, I am not sure
20 if Ashby intends to get into medical records prior to the
21 birth, the labor and delivery. It is our position that
22 anything that goes back like that would be irrelevant
23 unless they can spell out some particular reason or it
24 would be relevant.

25 THE COURT: Again, on this issue, if Mr. Davis

1 attempts to introduce evidence that you think it is
2 objectionable, I will be happy to rule on it. But I don't
3 want to issue a ruling at this point.

4 MR. GRAHAM: I think item three probably falls into
5 the same on as number one. It is a bit redundant, I
6 believe. Number four, improper statements about the
7 alleged adverse effects of a verdict against Defendant
8 medical providers. I am not sure the rules takes care of
9 that. But it has been a real problem.

10 THE COURT: Are you talking about in opening or
11 closing?

12 MR. GRAHAM: Or, certainly opening and closing but
13 also through any witness.

14 THE COURT: Mr. Davis, do you have any arguments
15 along those lines?

16 MR. DAVIS: Never have and never will.

17 THE COURT: All right.

18 MR. GRAHAM: Number five, we move to preclude any
19 assertion that either Defendant is not an insurer of any
20 particular outcome. Of course, they aren't. But, and I
21 know that is a regular charge. Recently I have had some
22 trial Judges, they put in their charge because it
23 introduces insurance. And it really doesn't apply to a
24 tort case, it really applies more to a warranty case, a
25 breach of warranty or something, if somebody is going to

1 plastic surgery for a beautiful nose or something.

2 THE COURT: I think Mr. Davis is entitled to argue
3 that, you know, a physician who meets the standard of care
4 does not guarantee a good outcome.

5 MR. GRAHAM: Absolutely. My concern is any mention
6 of insurance, insurer, anything remotely like that in the
7 charge or in the --

8 THE COURT: I have never included insurance. Mr.
9 Davis, you are not going to mention insurance?

10 MR. DAVIS: I never have yet. I don't think I am
11 going to stumble across that rock.

12 MR. GRAHAM: It is in some of the standard charges
13 that have persisted for decades that I respectfully submit
14 really doesn't belong there because it introduces
15 insurance. And I don't want to run the risk that there is
16 an argument that Your Honor is going to charge you so and
17 so and have it come into --

18 MR. DAVIS: Again, in 40 years I have never made that
19 argument. I have never advanced that argument. I have
20 submitted the charge and let the Court read the charge and
21 bring it to the law. That is all I do.

22 THE COURT: All right.

23 MR. GRAHAM: Number six, unsupported and unreliable
24 standard of care, causation testimony by experts. We have
25 got some Defense experts who have indicated, we intend, we

1 have expertise in this area, say standard of care but not
2 in causation or something similar like that. So we want
3 to make sure that they don't try to slip over the line
4 there. And also one thing that concerns me, the last
5 couple of trials I have had, the Defense lawyer basically
6 bases the case on, was this reasonable without using the
7 rest of the language, you know, consistent with that of a
8 reasonably prudent physician as opposed to just reasonable
9 in the abstract, like reasonable man or reasonable person.

10 THE COURT: What are you asking me to rule for number
11 six. I am not sure I follow.

12 MR. GRAHAM: Ask that if they make points about the
13 statute, I mean about the common law and the case law in
14 this State about what standard of care means or is defined
15 as, that, well certainly we will defer to Your Honor. But
16 if there is any attempt to try to define standard of care
17 as whatever is reasonable. It is transferring what would
18 ordinarily be limited to expert testimony into what sounds
19 to the jury like a lay argument. Is it reasonable, you
20 know, and I think it is important that we stick to the
21 language of the case law just so there is not that
22 mistake, reasonable actions of a reasonably prudent
23 physician acting under the same or similar circumstances.

24 THE COURT: If you believe there is any testimony
25 that you think is objectionable I will rule on it as it

1 comes up.

2 MR. GRAHAM: Forget number seven. I withdraw that
3 one. That was from the last time we had this trial
4 scheduled.

5 THE COURT: Okay.

6 MR. GRAHAM: Number eight. Any comment that
7 implicates Plaintiff greedy or the need for tort reform,
8 further tort reform or anything along those lines.

9 THE COURT: I cannot imagine Mr. Davis making
10 arguments along, Mr. Davis?

11 MR. DAVIS: Again, I have never done that before. In
12 reading these, it does enter my mind that this is maybe
13 something I need to be thinking about I missed in the last
14 four years. But I haven't done it yet, I hadn't planned
15 on it.

16 THE COURT: I would, any comments that a Plaintiff is
17 greedy or whatever, that would not be permitted.

18 MR. GRAHAM: I just wanted to make it clear on the
19 record and to Mr. Davis. I am not casting aspersions on
20 him. I have just tried a lot of these cases and run into
21 some surprises. And I did not think that, these are
22 basically trying to learn from mistakes. Number nine,
23 comment by the Defendant which uses criminal case
24 terminology like they accused my client with this. They
25 have charged him with that. We need to find that, he is

1 proven that he is guilty again. Again, it is sort of a
2 subtle way to raise the standard of proof and I don't
3 believe criminal language is appropriate in a civil case.

4 THE COURT: I am going to deny that motion. I think
5 that is language to say, you know, my client has been
6 accused of something. I will be very clear on my charge
7 on the burden of proof. So I am going to deny that
8 motion.

9 MR. GRAHAM: Your Honor, the next one has to do with
10 any testimony about arrest and so forth.

11 THE COURT: Is there an issue, an issue in this case?

12 MR. GRAHAM: My understanding is that 18 or 19 years
13 ago there was an arrest and perhaps a conviction or a
14 guilty plea. To my knowledge it would not be considered.

15 THE COURT: Does it have any relevance to this case?

16 MR. GRAHAM: No, sir.

17 THE COURT: Mr. Davis, any intention to introduce
18 that?

19 MR. DAVIS: No, sir.

20 THE COURT: Thank you.

21 MR. GRAHAM: And then number 11, the listing
22 testimony about the credibility of another witness. And
23 just a specific context. I have experts in other cases
24 and I believe this case as well, although it might had
25 been with respect to an expert that has been withdrawn.

1 To say, to ask for an opinion on causation, you hold this
2 opinion to a reasonable degree of medical certainty and
3 have them say, not only do I not but there is no way
4 anybody in the world could. You know, that kind of thing.

5 THE COURT: Why is that, again, I --

6 MR. GRAHAM: Because it is one expert hitting against
7 another expert by saying, if he has an opinion that in and
8 of itself is a lie.

9 THE COURT: I disagree on that. Obviously you can't
10 say, Dr. Smith can't say, other expert, Dr. Jones, is an
11 idiot and you shouldn't believe him. But I think an
12 expert can say, this is not a gray area, I believe this is
13 true and I think any expert would agree with this. But,
14 of course, your expert can disagree. I don't think that
15 is impermissible testimony.

16 MR. GRAHAM: Well, it is a little bit different, Your
17 Honor. In that, the testimony from the Defense expert was
18 to the effect of this is unknowable. In my opinion nobody
19 can say that X was the proximate cause of Y. Nobody can
20 say that. So if your expert says that then he can't be
21 believed.

22 THE COURT: Obviously, if there is testimony that
23 doesn't comport with the evidence I will listen to your
24 objection and rule on it. But I, as presented there, I
25 don't think that testimony would be objectionable. If an

1 expert believes something is not, science can't determine
2 the answer, I think they are allowed to say that.

3 MR. GRAHAM: Number 12, any statement about good
4 character part, redundant to something before. Any
5 opinion related to alleged successful injuries in the
6 absence of other brachial plexus injuries. The testimony
7 is, that when a baby is born, the baby gets handed off and
8 for anybody to, for the Defendant to hear that there is a
9 brachial plexus injury, it would have to come from a third
10 party. Absent of hearing that from a third party doesn't
11 prove that there were no prior injuries. All it proves
12 that he was not informed of any prior injuries, if any
13 exist.

14 THE COURT: Mr. Graham, what would you like me to
15 rule on that. What is --

16 MR. GRAHAM: That if, in fact, the doctor's testimony
17 that he has had no prior brachial plexus injuries is based
18 on the fact that nobody told him he did, that he precluded
19 from saying that.

20 THE COURT: Isn't that just cross-examination
21 material. You can say, well doctor, what you really
22 saying is, you don't know of any.

23 MR. GRAHAM: Well, to me it is really negative
24 hearsay that would be impermissible. If somebody said,
25 you did, you know, X did have a prior injury. That would

1 be hearsay and you might get around the hearsay rule with
2 an objection. But when you have someone not making a
3 statement and the inference drawn is because there was no
4 statement that I heard, I never had one of those injuries
5 before. It just seems to me that doesn't get past --

6 THE COURT: The objection is, instead of phrasing it,
7 I am not aware of any prior injuries, saying just there
8 aren't any.

9 MR. GRAHAM: I believe that would handle it, Your
10 Honor.

11 THE COURT: I just think that is a proper topic for
12 cross-examination but I am not going to say, any time
13 someone says, no, they have to qualify that by saying that
14 I know of or to the best of my understanding or I have
15 never been informed.

16 MR. GRAHAM: So he doesn't have to say, I am not
17 aware.

18 THE COURT: I think if you ask a witness, you know,
19 has anyone ever hit your car. And the witness says, no.
20 What they mean is, I don't know of anybody and it doesn't,
21 in making every witness say, to the best of my knowledge,
22 no or I have never been informed anyone has hit my car. I
23 mean, I think that goes, I don't think I can order every
24 witness to answer in that way. If that particular point a
25 question is important to you you can raise it on cross and

1 say, aren't you really saying you are not aware of such
2 injuries. But I am not blanket ruling that every witness
3 has to testify every time they are saying, no, that they
4 mean no, to the best of my knowledge.

5 MR. GRAHAM: Very well. Number 13 has to do with
6 what I consider to be a waste of the Court's time.
7 Testimony on and on and on about events prior to the
8 alleged negligence as though committing acts that we do
9 allege were negligent or somehow relevant to the
10 allegation of negligence.

11 THE COURT: And I, to be honest, I am not entirely
12 following you there. What testimony are you concerned
13 about or what possibly testimony?

14 MR. GRAHAM: Office visits, you know, did you do the
15 appropriate test on your first visit. Yes or my colleague
16 did. And your, the blood sugar reading was this. Did you
17 respond to it appropriately.

18 THE COURT: Now I understand. So your argument if
19 asking about care that happened prior to the incident is
20 bolstering the doctor's credibility by showing he did, I
21 understand your argument. But I think that is permitted.
22 Why is that not permitted. If the question is, was the
23 care what a reasonable prudent doctor would do in the same
24 circumstances. Isn't he allowed to put in testimony that
25 his care --

1 MR. GRAHAM: It really addresses his care in
2 different circumstances. And whether he's free of
3 negligence with respect to an office visit really, to me,
4 has no probative value towards he is negligent in managing
5 a delivery, labor and delivery. And I don't want to waste
6 the Court's time and it is confusing to the jury.

7 THE COURT: I will withhold the ruling on that. I
8 certainly think, I mean, Dr. Miller is entitled to say, I
9 saw the patient on this many days and we have these
10 visits. But if it gets to the point where we are going
11 through every test that was ordered and make an objection
12 and I will rule on it at the time.

13 MR. GRAHAM: 14, we probably don't need to worry
14 about collateral sources. I can't imagine that that would
15 be an issue. Correct?

16 THE COURT: Correct.

17 MR. GRAHAM: Number 15 concerns me, Your Honor. This
18 has come up repeatedly. There is some Defense oriented
19 literature on the issue of causation of brachial plexus
20 injuries. These are stretch injuries and the Defense will
21 typically contend that, the historical understanding was
22 that, excessive bending force is what causes nerve damage.
23 You know, brachial plexus affecting the arm and that they
24 will all, there is some literature out there from an
25 engineer that says, if, even if, even if the amount of

1 manipulation of the head by the doctor was not ordinarily
2 something that would be negligent or causative of damages,
3 normal traction in this case caused the injury because
4 these nerves were anomalous in some way or weaker in some
5 way. If it were true, if they had some evidence of that
6 then, you know, fine. But for them to just throw that out
7 there without evidence, I think would be prejudicial and
8 improper.

9 THE COURT: You are asking me to rule that a
10 physician cannot testify that this injury resulted from
11 normal care but weakened nerves on the babies side without
12 evidence to back that up?

13 MR. GRAHAM: Well, it is really the last part of that
14 that I don't believe they should be testified to without
15 evidence to back it up. The first part about, they didn't
16 use excessive traction, they didn't cause the injury. I
17 think that comes in. But then when they say, here is why.
18 It is because Alexia's arms and her nerves were weak.
19 They had some kind of anomalous connections or something
20 long those lines without having any evidence of that would
21 just be highly speculative and prejudicial.

22 THE COURT: Mr. Davis, do you anticipate any
23 testimony along those lines?

24 MR. DAVIS: Your Honor, this case has been going on
25 for a long time. There have been multi-hour expert

1 depositions. I can't remember at the moment every detail
2 of what my experts are going to testify to. But there is
3 literature, medical literature, peer review medical
4 literature that talks about some babies having weaker
5 nerves that can make them more susceptible to brachial
6 plexus injury. I think that is permitted for experts to
7 talk about in the medical literature. In this case, as
8 Mr. Graham in his motion eludes, he assumes that our
9 experts or Dr. Miller is going to say, oh in this case she
10 had weaker nerves and that is why it caused the injury. I
11 don't think there is any deposition testimony from any of
12 my experts or Dr. Miller that has ever offered that even
13 at a deposition. I don't anticipate some bottom line, oh,
14 this is what it was. The fact that it is known in other
15 States, not this case, that weaker nerves in some children
16 cannot be known ahead of time, can and do lead to brachial
17 plexus injuries. I think the literature and the
18 recollection of the expert's testimony establishes that
19 factor phenomenon. That doesn't mean that we can, are
20 able to prove it in this case but that is out there. And
21 I don't think that my experts are going to testify and if
22 they do, we can address it at the time. I don't think
23 they are going to testify, oh, here is what happened in
24 this case, she had weaker nerves and that is what
25 happened.

1 THE COURT: Let's leave it, let's leave it like this,
2 Mr. Davis. If you can just tell your experts, don't go
3 down that road without giving the Court a heads-up.

4 MR. DAVIS: Absolutely. I will do that and if they
5 advise me prior to testimony, I will hopefully get to meet
6 with them the night before they testify, I will bring that
7 out to them. If they indicate that, yes, I would like to
8 testify about that. Well, tell me what you want to say.
9 I will bring it up to Mr. Graham and the Court before they
10 testify and maybe we can, even before the jury comes in, I
11 can proffer that part and we can make a ruling and happy
12 to go from there. Will that work?

13 THE COURT: That sounds great.

14 MR. GRAHAM: May I be heard. It seems to me that the
15 argument that Ashby just made is analogous to saying in a
16 wreck case, don't blame the Defendant because some people
17 cause wrecks by having a seisure because they are a heroin
18 addict. I mean, some people are in wrecks because they
19 have a heart attack. Well, if this guy is not a heroin
20 addict, doesn't have a heart attack, then the only reason
21 throwing that out there is just to try to create some sort
22 of improper inference, it is just purely speculative.
23 Sure, there is evidence out there that certain children do
24 have anomalous nerves or weaker nerves. There is no
25 evidence that this applies to this child at all. And if

1 they were to say that, even the first part of what Your
2 Honor suggested, if they were allowed to say, some
3 children have weak nerves, we can't prove that this child,
4 but some children do. The whole part of the argument is
5 to confuse the jury, have them rule on an improper basis
6 and just waste the Court's time because then we get into
7 all kinds of side issues about engineering testimony.
8 About how that is calculated and what it means and how
9 much stretch can be performed on a healthy nerve person,
10 impaired nerve and how much impairment must there be, for
11 that material. We just get into all kinds of things about
12 something that is truly not relevant and it is highly
13 prejudicial.

14 THE COURT: Mr. Davis, let me expand my ruling. If
15 you can just let, tell your experts not to discuss this
16 issue of children with a greater susceptibility to nerve
17 damage without giving me a heads-up first. That would be
18 great.

19 MR. DAVIS: I will make a note to that effect. Thank
20 you, Your Honor.

21 MR. GRAHAM: Number 16. Any expression of apology or
22 suggestions that the Defendants regret the horrible
23 tragedy be precluded. I mean 14 years has passed with no
24 indication of apology or expression of sympathy for the
25 injury much less responsibility for the injury. And for

1 them to come into court now and posture themselves as nice
2 guys because they are apologizing for the fact that the
3 child was severely injured in front of the jury is just
4 gamesmanship. And it has no probative value and it's
5 potentially prejudicial.

6 THE COURT: I am going to deny the motion. I mean, I
7 don't know how much it matters to jury's whether, Counsel
8 says in their opening that they are sorry for what
9 happened. But I think that is a fair thing for Counsel to
10 say. You can obviously respond, if they were truly sorry
11 then they have had 14 years to write a check. I am not
12 going to tell Mr. Davis he can't say that Dr. Miller is
13 sorry for what happened.

14 MR. GRAHAM: I understand, Your Honor. Number 17,
15 lack of insurance. We have touched on a different aspect
16 of insurance before but I am concerned about any inference
17 that a big verdict would ruin the doctor's practice, his
18 future because they would be out-of-pocket. There is \$2
19 million dollars worth of coverage.

20 MR. DAVIS: Again, I have never traveled that road,
21 don't intend to in this case either.

22 THE COURT: All right.

23 MR. GRAHAM: 18 we have touched on before. 19, oh,
24 this is --

25 THE COURT: 18 talks about Kentucky law.

1 MR. GRAHAM: That is why I withdrew it, Your Honor.
2 That was, it got stuck in there from another case.

3 THE COURT: It is okay.

4 MR. GRAHAM: Number 19 is a very important point.
5 The only issue in the case having to do with actions with
6 Dr. Miller is whether or not he conformed to the legal
7 standard of care. Whether or not he did his best is
8 totally irrelevant if his best is less than the legal
9 standard of care. Also this business about, his clinical
10 judgment or his best clinical judgment. That has been no
11 relevance if his clinical judgment falls short of the
12 standard of care. It just confuses the jury, it changes
13 the elements of proof of a medical malpractice case if
14 they think, oh, he did his best. How can we punish him
15 now for doing his best.

16 THE COURT: I think that is something he is entitled
17 to argue. His client did his best under the
18 circumstances. You are entitled to respond he didn't and
19 here is why. But I don't think I can tell Mr. Davis he
20 can't say that Dr. Miller did his best or tried to make
21 the best judgment as possible.

22 MR. GRAHAM: Well, my desired response would not be
23 that he did not do his best, he may well have done his
24 best, I have no way to access that. My point is that
25 whether he did his best or not, if it all is short of the

1 standard of care, its totally irrelevant and immaterial
2 and confusing and prejudicial.

3 THE COURT: You can say to the jury his best isn't
4 good enough. I don't preclude Mr. Davis from saying that
5 his client did his best and in the circumstances made the
6 best judgment in his opinion.

7 MR. GRAHAM: Yes, sir. And one reason I brought that
8 to the Court's attention is, I am very sensitive about
9 arguing to the jury in a way that invades your province as
10 the Judge of the law because my response to that really
11 gets into that.

12 THE COURT: You mean as far as saying, you are
13 entitled to say to the jury, the question is not whether a
14 doctor did his best or not. It is what he did and met the
15 standard of care. That is certainly permissible argument.

16 MR. GRAHAM: Number 20. Dr. Duboe, OBGYN expert for
17 the Plaintiff who sits on the back row was recently sued
18 in a case which alleged negligence handling to the
19 shoulder dystocia resulting in a brachial plexus injury.
20 He has been instructed by Counsel not to discuss it, not
21 even a deposition has been taken yet in the very early
22 stages yet so there is not like there is a public record I
23 could present to you with a deposition where he explains
24 why he didn't even deliver the baby. So we believe that
25 would be totally improper.

1 THE COURT: Dr. Duboe is your expert or Mr. Davis'
2 expert?

3 MR. GRAHAM: Mine.

4 THE COURT: And so you don't want Mr. Davis to
5 inquire the case he has been served with but nothing has
6 been done on it?

7 MR. GRAHAM: Have you ever been sued for causing any
8 injury to a baby? No. There is allegations in a lawsuit
9 that he injured a baby but once depositions are taken, I
10 mean, I am cautious about what I say because there is
11 advice from Counsel not to talk about it. But I would
12 just say hypothetically if there were depositions already
13 then there may well be testimony that --

14 THE COURT: Mr. Davis, is that something that you
15 intend to go into?

16 MR. DAVIS: At his deposition it came up and I
17 cautioned him. I said, look, if you have, you don't
18 really have to talk about it but I could ask you some
19 questions but I don't want to go into detail. It was very
20 respectful and I have no intention of ever going into
21 that.

22 THE COURT: All right.

23 MR. GRAHAM: Very well. The next one, Your Honor,
24 is, it is closely related. At the deposition, I mean it
25 may be moot now, at the deposition Ashby had asked a

1 series of questions about deliveries by Dr. Duboe. And
2 then when he asked questions about prior suits it was
3 ambiguous about whether he was talking about babies that
4 he delivered, being sued about delivery of babies that he
5 delivered hands-on. He answered at the time, no. Then
6 when he got the deposition read and signed he realized,
7 you know, that question is ambiguous. Answered it
8 truthfully based on my understanding but if Ashby, if he
9 parsed his sentence word for word, out of context, then my
10 answer was not appropriate. So in an abundance of caution
11 he explained that at length and errata sheet. And we just
12 ask that none of that be presented and from Ashby's last
13 comment I don't think it would be.

14 MR. DAVIS: It is not on my outline. I have no
15 intention of going into that direction. If I slip into
16 that please remind me. That is not where I am going.

17 MR. GRAHAM: And, Your Honor, the next one is
18 somewhat similar. Dr. Duboe resigned from ACOG. There
19 was no sort of adverse finding of anything with respect --

20 THE COURT: Tell me, I don't understand the
21 significance of resigning from ACOG. Is it a
22 certification issue or is it just a voluntary, I mean.

23 MR. GRAHAM: He is Board Certified.

24 THE COURT: Right. So when you say resign from ACOG,
25 is it, I don't want to pay the dues any more. What does

1 it mean?

2 MR. GRAHAM: That's part of it. But some defense
3 counsel in the past have tried to make a big deal of it,
4 to create an implication. They want the jury to draw an
5 inference that there is some --

6 THE COURT: Let me ask you. What is the difference,
7 talking about among Board Certified Obstetric
8 Gynecologist, what is the difference between an ACOG
9 member and a non-member. What significance does it have.

10 MR. GRAHAM: Pay dues, get invited to conferences.

11 MR. DAVIS: Your Honor, I am not a member of the
12 American Bar Association. I gave that up years ago for
13 personal reasons. But I have been practicing law ever
14 since. I don't have any intention of going into that.

15 THE COURT: Sounds good.

16 MR. GRAHAM: Number 23. Some of the records suggest
17 that one or more, I believe it is two, cousins of one of
18 the parents. I think it is Angela but maybe Antwan?

19 A has an extra finger. And, you know, its, we believe
20 it has no relevance, it would be prejudicial.

21 THE COURT: Mr. Davis, at you intending to go into
22 that?

23 MR. DAVIS: That is the first time I have become
24 consciously aware of that in eleven years. So I don't
25 plan to go into that direction.

1 THE COURT: All right.

2 MR. GRAHAM: Your Honor, 24 is unique to this case.
3 As Your Honor knows, the birth was in '07, the suit was
4 filed in '09. Not too long after that there was a ruling
5 made by the Magistrate that pre-majority medical expenses
6 could not be recovered in this case. We filed an appeal
7 of that order. The Court of Appeals affirmed. The State
8 Supreme Court granted cert and then ruled in my favor.
9 You know, significant change in the law which I have been
10 trying to accomplish for a while. At any rate, you know
11 how long it takes to do an appeal to the Court of Appeals
12 and then petition for cert and wait for that to be, then
13 to have the Supreme Court go through the process and then
14 wait for the opinion to be decided. And then, so that
15 took a lot of years. After that we ran into problems with
16 Dr. Miller's schedule one time, with somebody being sick
17 one time; experts being diagnosed with cancer. Various
18 reasons and then COVID caused a couple of cancellations.
19 I wind up having to hire a whole bunch of experts that are
20 no longer available to testify. And I don't want, I don't
21 think it would be fair under these circumstances for Ashby
22 to go back and cross-examine witnesses that will be in
23 court with testimony of experts that were deposed prior to
24 10 years of controversial literature, for example. And,
25 well that is it. And the same thing would apply to me,

1 they had experts that they dropped. And I don't think it
2 would be fair to either side for us to cross-examine
3 current experts with what former experts that will not be
4 presented at trial, said in the distance past.

5 THE COURT: Mr. Davis, any intention to go down that
6 road?

7 MR. DAVIS: Very briefly, Your Honor. It is my
8 understanding that in terms of an expert witness
9 testifying on the witness stand, that he can, on direct
10 and cross and properly refer to anything that he has
11 reviewed that helps him to form the basis of opinion
12 including hearsay testimony, including deposition
13 testimony of even other experts. I mean, if they read the
14 depositions as part of their review of this case and they
15 want to refer back to another Defense deposition or an
16 expert's deposition or a Defendant's deposition; or a
17 Plaintiff expert deposition, whether they are coming here
18 to testify at the trial or not, I think that is a proper
19 admissible grounds for question on direct or cross, for an
20 expert. In other words, I learned for the first time
21 yesterday that Mr. Graham, of the four experts he had
22 listed, early yesterday morning I discovered he was not
23 going to be calling Dr. Gomez Carrion or Dr. Engelbert,
24 both of them have been deposed years ago. And up until
25 yesterday morning, I was fully prepared to examine them at

1 trial, subject to my motion which are moot now as far as
2 cumulative evidence. But my experts have reviewed those
3 depositions and there are things in those depositions that
4 I think they can talk about and refer back to and comment
5 on, to support their opinions, if they are asked either on
6 direct or cross to do that, as part of the basis of their
7 opinion. If they elect to do that, I don't know
8 specifically whether they will or not but I think that is
9 permissible.

10 THE COURT: I think it, I think it is a fair question
11 when you say, doctor, how did you learn about particular
12 fact X and for the doctor to reply, well, I read it into
13 the deposition of so and so. I guess my question, are you
14 intending to, as long as you go down the road of, well,
15 that person was an expert and now has been withdrawn.
16 That is the issue. The jury is going to hear doctor
17 whoever. They are not going to know if it is a treating
18 doctor, is it an expert. That is not going to mean
19 anything to them unless you point it out that it was Mr.
20 Graham's expert and no longer is coming to court.

21 MR. DAVIS: And for example, and I appreciate that
22 fine tuning and I appreciate that wisdom. For example, I
23 am just trying to think through it in real time. If I
24 have one of my Defense expert's on the witness stand and
25 say, you know, typically, tell the jury what you have

1 reviewed in this case. And they are going to give me a
2 long list of depositions which, or expert, Plaintiff
3 expert depositions.

4 THE COURT: That would be unobjectionable.

5 MR. DAVIS: And then I get into their opinions, you
6 know, for them to trip into and say, well, as Dr.
7 Gurewitsch said, who is testifying; as Dr. Engelbert said,
8 if they get into that. Would that not be an appropriate
9 reference.

10 THE COURT: I think that is okay. The expert is
11 allowed to testify based on facts argued in evidence. But
12 as long, Mr. Davis, that you don't draw attention to the
13 fact, after he says, doctor, whoever that you just quoted,
14 that in fact was Mr. Graham's expert but that person is
15 not in court today.

16 MR. DAVIS: I would never do that, I will avoid that
17 like a plague, I have no intention of doing that. And I
18 think that would be improper and I agree, I wouldn't do
19 that.

20 THE COURT: Mr. Graham, does that satisfy your
21 concern?

22 MR. GRAHAM: Not really. I mean if he is allowed to
23 talk about depositions, I think it is unfair inference on
24 the jurors part, it must be Mr. Graham's expert that was
25 deposed. Why else would there be a deposition.

1 THE COURT: I am not sure I agree with you. I think,
2 they are going to see lots of physicians names they are
3 going to hear. Experts, treating physicians,
4 pediatricians, I am assuming. And lots of them are not
5 going to be present in the courtroom. I am not sure I
6 agree that they are going to say, well, doctor A said he
7 read the deposition of doctor B. Why wasn't doctor B in
8 court. Unless Counsel draws attention to that, I don't
9 see that as a problem.

10 MR. DAVIS: Your Honor, if I may supplement my
11 earlier comments in anticipation, objections and your
12 thoughts. I have no intention of, in closing for example,
13 and get up and say, where is Dr. Gomez, where Dr. so and
14 so and where is Dr., where is Dr. Engelbert. I have no
15 intention of doing that. I don't need to do that, I am
16 not going to do that. And I think that would be improper.
17 It is his choice. I think I am permitted to do that. In
18 a criminal case, why didn't the Defendant call so and so.
19 But in a civil case there have been cases where Plaintiff
20 lawyers have said, why didn't they call so and so; where
21 is so and so. They could have called so and so. It is
22 fair game. And I think probably permitted to do that if I
23 elect to do that in closing. It is a fair comment on the
24 evidence or lack of evidence. But I have no intention of
25 doing that in this case and won't do that.

1 THE COURT: My ruling would be it is a fair comment
2 in closing for fact witnesses. I don't think I would
3 permit it for expert, experts, would say paid retained
4 experts. I think attorneys are allowed to change experts.

5 MR. DAVIS: I totally agree and again don't have any
6 intention of doing that and won't do that.

7 THE COURT: That will be my ruling. I am not going
8 to order, if a witness in fact learned about something by
9 reading the deposition of another doctor, I am going to
10 say they can't mention that but Mr. Davis says he is not
11 going to argue the absence of particular experts implies
12 that they changed their mind or where is doctor so and so.

13 MR. GRAHAM: It wouldn't be facts that would be
14 gleamed from an expert deposition. What I am worried is
15 about opinion testimony where they say something like, you
16 know, Dr. Gurewitsch has said under oath that so and so.

17 THE COURT: Your concern is that testifying experts
18 would refer to the expert testimony of another physician.
19 Mr. Davis, do you anticipate that happening.

20 MR. DAVIS: I am not sure, I am probably lost at this
21 point. I don't know what he is saying. I don't
22 understand.

23 THE COURT: I think, if I am understanding you
24 correctly. Mr. Graham is concerned about one of your
25 expert's bolstering his testimony by saying, Mr. Graham's

1 former expert agrees with me. I read in doctor so and so
2 testimony that he also agrees that X, Y Z.

3 MR. DAVIS: I hire experts. They are pretty good. I
4 don't have them on a chain, I don't make their script. I
5 don't know what they are going to say in that regard. I
6 have no indication they are, I don't plan on eliciting
7 that kind of testimony. I don't think it has ever
8 happened before.

9 THE COURT: Okay. If you don't mind, just tell your
10 experts, give the Court a heads-up, don't refer to the
11 opinion. They can refer to I learned, they can say I read
12 so and so's depo and I learned X, Y and Z facts. But
13 don't mention the opinions of the non-testifying experts
14 without notifying the Court first.

15 MR. DAVIS: I will make a note.

16 MR. GRAHAM: And that really hits to the heart of it.
17 What I foresee is Ashby cross-examining one of my expert's
18 and saying, did you know that doctor so and so, under oath
19 in a deposition testified to a different opinion. That
20 kind of a thing. But given Your Honor's ruling I am less
21 concerned about that. But one thing that I am concerned
22 about is, the procedural rights that I have that would be
23 triggered by them going into a deposition. I mean, it
24 seems to me that, a rule of completeness. They use part
25 of a deposition, I can put it in context with further --

1 THE COURT: You just asked me to prohibit them, what
2 you are saying now is, that if a witness says, well,
3 reading doctor so and so's deposition I learned that the
4 birth occurred on this date. Then that opens the door for
5 you to bring, I mean, I am not sure.

6 MR. GRAHAM: That would certainly be of no
7 consequence but if they were to say, you know, did you
8 read that doctor so and so said that, natural forces of
9 labor can significantly impact this injury. I am not
10 saying such testimony exists but as an example. If they
11 were to say something like that, do you agree or that is
12 different from your opinion. And then it seems to me that
13 I would have the right to put that in context.

14 THE COURT: I have already, Mr. Davis understands
15 that if he is going to have an expert refer or the expert
16 begins to refer to a non-testifying expert he needs to
17 give the Court a heads-up. If in fact that happens we
18 will reach that issue if we need to.

19 MR. GRAHAM: Thank you, Your Honor. Back in 2014
20 ACOG, again, gathered together some OBGYN'S, some maternal
21 fetal specialists and an engineer to sit on a task force,
22 supposedly to consolidate the learning up to that point
23 about brachial plexus injuries and potential causes of
24 those injuries. And a significant motivation for that, I
25 draw an inference that a significant motivation for that

1 is to help defend these cases. I mean, that is what they
2 were talking about at the ACOG meetings before all of this
3 got developed. Now one of the Defense experts was on that
4 task force. I feel certain that that task force report
5 will be used as a learning treatise in this case. One
6 thing that, and as long as they use it according to the
7 rules for learning treatises. I have got no problem with
8 that. But there are two things about that that I am
9 concerned about. One is, in the very beginning there is a
10 statement that says, this text has been approved or
11 endorsed by, then it list a laundry list of organizations.
12 March of Dimes is one; the rest of them are different
13 speciality groups. None of those speciality groups have
14 anything on their website about endorsing this. I have
15 never been able to find a member of those other groups
16 that were invited to vote on this or to have any clue what
17 it is. Whether there really was a vote or whether it was
18 a secret meeting where, you know, I will scratch your back
19 if you scratch mine, kind of a thing. It is hearsay that,
20 for them, for ACOG to intend that these various
21 organizations endorsed their publication, is hearsay that
22 isn't under the exception, under the learn treatise rule.

23 THE COURT: I just want to make sure. You would like
24 me to prohibit Mr. Davis from referring to the fact that
25 the ACOG bulletin or the ACOG, is bulletin the right word?

1 MR. GRAHAM: No, sir. I think it is sometimes
2 referred to as a compendium or a position paper or task
3 force paper. It is about this thick, Your Honor.

4 THE COURT: You want me to prohibit Mr. Davis from
5 referring to the ACOG compendium as endorsed by other
6 organizations outside of ACOG?

7 MR. GRAHAM: Yes, sir. Any assertion that those
8 endorsements were, in fact, actually made and who they
9 are.

10 MR. DAVIS: Hadn't had an intention, hadn't read what
11 he just talked about and I won't do it.

12 THE COURT: Mr. Graham, I am getting a little worried
13 about time.

14 MR. GRAHAM: I think we are near the, 27, improper
15 use of learn treatises. My real concern there, if it is
16 according to the rule I have got no problem. But what
17 often happens in my experience is an expert gets up there
18 and says, there is a whole list of literature that
19 supports this opinion without, I mean if they identify the
20 publication, all they are allowed to do is listen to some
21 language taken from that and say if they agree with it.
22 And for them to be allowed to say far more than that
23 without identifying the publication, to me violates the
24 learn tristesse to the hearsay rule.

25 THE COURT: The issue is a physician testifying that

1 there are many treatises that support, without identifying
2 which ones they are?

3 MR. GRAHAM: And saying whether they are reliable and
4 instead of paraphrasing what he -- to follow the learn
5 treatise exception and the rules, there is a sentence read
6 or some language read and then do you agree with that.

7 THE COURT: If this issue comes up I will rule on the
8 objection as it is made. I just, I don't feel like I can
9 make a blanket rule right now.

10 MR. GRAHAM: Okay. 28. In a lot of the literature
11 the Defense experts in this field and ACOG itself, have
12 tried to change the subject. Instead of talking about
13 what causes brachial plexus injuries when the baby comes
14 through the birth canal and the top shoulder comes down
15 behind the pubic bone slowing down delivery. And if that
16 situation is mismanaged then brachial plexus nerve damage
17 can occur. There is a huge concern on my part that most
18 of that literature does not distinguish between temporary
19 and permanent injuries. The only ones that matter are
20 permanent injuries. So that is one part that we would ask
21 that they be precluded from any sort of learn treatise
22 that does not identify the result as a permanent brachial
23 plexus injury, otherwise it is irrelevant, it is time
24 consuming, it is prejudicial, it is confusing. So we
25 would ask that that be precluded. Also to take it a step

1 further, if they are talking about, well, we have got a
2 study over here that says babies delivered by cesarean had
3 a brachial plexus. This is not a cesarean delivery so
4 that really has nothing to do with this case. There is a
5 totally different engineering principle about why those
6 babies can get injured in cesarean. It is a very small
7 percentage but if they get into that then we would have to
8 get into all of the explanations and it just leads us down
9 an alleyway of trying to get back on focus to what the
10 facts of this case are. Similarly, there is some
11 literature that says, that, usually shoulder dystocia is
12 when a baby comes down the birth canal. Ideally a baby
13 would fit through the pelvis at a diagonal because that is
14 the biggest dimension. If a baby comes down vertically
15 compared to the floor or, you know, perpendicular to the
16 floor then it is that top shoulder that gets impinged
17 behind the pubic bone and then pulling down like that
18 causes damage. Sometimes, a minority, but sometimes in
19 that same situation, if there is a precipitous delivery,
20 if the baby just shoots through the birth canal real fast,
21 there is some literature that says the bottom shoulder can
22 get injured in a precipitous delivery. Now in this case
23 it is the top injury, I mean the top side of the brachial
24 plexus that got injured and I think we would be confusing
25 things if we got into injuries to the bottom shoulder.

1 THE COURT: You want me to rule that experts can't
2 refer to parts of learn treatises that refer, that mention
3 other injury mechanisms.

4 MR. GRAHAM: That they be allowed to testify only to
5 things that are relevant to this case, not confusing, not
6 prejudicial. And in terms of prejudicial we have got
7 different engineering principles. They are going to say,
8 if you can get injured by a C-section, in a C-section
9 delivery then that means that the most common form of
10 injury by the doctor manipulating the head in a forceful
11 way, must not have caused it. And it is just, there is a
12 whole, I mean there is literature saying that that is a
13 whole different animal when there is an injury from a
14 C-section. And if they are allowed to get into that then
15 that is going to drag on this trial for a long time
16 because we are going to have to respond to that and
17 explain how, no, that is a totally different situation.
18 Babies just don't pop out, you have to lift them out and
19 sometimes it takes a lot of force, vacuum, forceps --

20 THE COURT: Given our time, if this issue comes up
21 and if someone starts to get into this issue I will rule
22 on it if I need to.

23 MR. GRAHAM: Thank you. Okay, number 29 relates to
24 well known controversy. In this task force book they talk
25 extensively about all these other things can cause

1 temporary injury and then they say, and there is a
2 suggestion that permanent injury perhaps can be caused
3 without negligent physician manipulation of the head. And
4 they cite one article. It is an article, coauthored by
5 Dr. Lerner and Dr. Salamon. It was not revealed in that
6 article that Dr. Salamon was in a lawsuit over an injured
7 brachial plexus. Dr. Lerner was her Defense expert. They
8 alleged in that article that there was, I can't remember
9 the exact word, but something like unchallengeable
10 evidence that a baby can get a permanent injury without
11 any, without shoulder dystocia and without traction. But
12 in the lawsuit the doctor, the Defendant Dr. Solomon, the
13 coauthor admitted that she uses traction in every
14 delivery. The nurse documented shoulder dystocia and its
15 just, I mean, to the best of my knowledge Dr. Lerner is no
16 longer a Defense expert because he is so easily
17 impeachable on those points. And, again, we have got
18 orders from other courts that have precluded him from
19 testifying on the basis or had precluded that part of the
20 treatise about permanent, there has been a permanent
21 injury. It is just that one and if they get into that
22 issue then we are going to have a whole slew of
23 impeachment over that issue because it is just a sham.

24 THE COURT: Mr. Davis, is that something that is
25 going to come up in this case?

1 MR. DAVIS: Not that I am aware of. If it does, I
2 would just ask the Court to indulge, or our experts
3 testimony, and make a ruling subject to whatever
4 objections he wants to make at the time. If it becomes
5 objectionable, I just would like to go ahead and start
6 trying this case.

7 THE COURT: I mean, Mr. Graham, I don't think I can
8 make the ruling you are asking me to make without a mini
9 hearing right now on what is in the compendium. And then
10 you are going to impeach the sources they used. If we
11 have to do that in trial then we have to do it. But I
12 don't want to do that now if we don't have to. If it
13 comes up make an objection and we will do everything we
14 need to do.

15 MR. GRAHAM: I don't think we need to talk about 30
16 long. I think Ashby will admit he is not going to. This
17 next one, 31, is very similar to what we just argued on
18 29. I assume the ruling would be the same?

19 THE COURT: Yes, sir. I am not ruling against you.
20 I am just saying, for me to make ruling on that issue is
21 going to take a substantial amount of time and let's not
22 spend that time if we don't have to.

23 MR. GRAHAM: I understand. 32 is something that Your
24 Honor has already addressed about, don't hold the long
25 delay against either side.

1 THE COURT: All right.

2 MR. GRAHAM: And 33 is just asking for, if you grant
3 any of their motions in limine we ask that it be
4 reciprocal. That is it, Your Honor, thank you.

5 THE COURT: Mr. Davis.

6 MR. DAVIS: Your Honor, we have two motions, two sets
7 of motions. And I will do it in chronological order. The
8 first one was filed when this case was first scheduled for
9 trial in early December of 2020. My then Associate,
10 Mitchell Applebee, prepared and filed the motion. Most of
11 those are withdrawn because Mr. Graham notifying me Monday
12 or Tuesday, that he is withdrawing some of his experts.
13 So number one, the testimony on the standard of care, that
14 is withdrawn. Number two, cumulative testimony for
15 Plaintiff witnesses. We counted 14 damage witnesses to be
16 presented in this case. We are not obviously planning, we
17 have some cross-examination. I think that they can
18 present their case on damages with far less than 14
19 witnesses that they listed, that they intend to call. And
20 I think talking about wasting precious time in this trial
21 and looking for some economy of effort, it would be
22 helpful to the Court and to the jury and to Counsel to
23 consider reducing the number of damage experts in multiple
24 categories.

25 THE COURT: Mr. Graham.

1 MR. GRAHAM: I think the key is multiple categories.
2 We have got a pediatric neurologist who will testify about
3 the injury itself and the effects that that has on the
4 inability to use certain muscles and that Alexia is a
5 one-handed girl and woman or young lady. So, I mean, I
6 don't know how we can try the case without a pediatric
7 neurologist, mainly on causation and to explain to the
8 anatomy and nerves so the jury has a clue what we are
9 talking about. Then we have Dr. Grossman who is a
10 surgeon, who will be able to testify about, to explain the
11 jury that has been done already. And also to testify
12 about damages from a surgeon's point of view, about how
13 the injury occurred and what the functional limits will be
14 going forward. And whether her situation is getting
15 better, worse or about the same, it is getting worse.
16 But, so that is two. We have a pediatric
17 neuropsychologist who is going to testify about the
18 certain test results she has done, as a predicate, as a
19 foundational source of evidence to support testimony from
20 a vocational expert. And she will also talk about
21 depression and anxiety, nobody talks about that. We have
22 got a lifecare planner.

23 THE COURT: I will stop you, Mr. Graham. Mr. Davis,
24 I will give you the same ruling. At a point, if you
25 believe the testimony has become redundant or cumulative

1 just make your objection and I will rule on it.

2 MR. DAVIS: I will do so. Thank you, Your Honor.
3 Number three on the motion, is the motion to exclude Dr.
4 Maureen Nelson who is a pediatric neurologist on the issue
5 of causation opinions. Clearly, deposition testimony from
6 this case, she did not offer any opinions as to the
7 specific cause of this child's injury in this case but
8 only eluded to possible causes. And that doesn't meet the
9 standard of care of an expert on causation or on anything.
10 The possibility, doesn't mean more likely than not within
11 a reasonable medical certainty. And therefore she should
12 be legally precluded under Rule 403 to offer any possible
13 causation opinions as to the injury.

14 THE COURT: Mr. Graham.

15 MR. GRAHAM: If, Your Honor, please. She is a
16 pediatric physiatrist. She is a treater, she was in
17 Charlotte when the pediatrician referred the child to her
18 at Levine Hospital. And some years later she transferred
19 to a hospital in Houston and the child has been out there
20 to see her in person, once I believe, and they have had
21 some zoom communication. But Dr. Nelson, just to get to
22 the causation point. Dr. Nelson has authored a chapter in
23 a pediatric book about brachial plexus injuries. And in
24 part of that book she has a, she has a paragraph or a
25 sentence or two, that addresses causation and it relies on

1 authorities in that field. And if she is limited, if she
2 is precluded from testifying about causation to that
3 limited general extent then that would apply to Defense
4 experts too that have these theories but they can't apply
5 it to this child. Like the presumed nerve weakness. They
6 can't tie that into this child. And all she said is, you
7 know, my opinion is in the book, the chapter that I wrote
8 and can I apply specifically to this child. I am not a
9 neurologist so I am going to stop short of that. But
10 relying on people that I respect, that is what it was.

11 THE COURT: I am going to deny the motion. I think
12 it is fair for an expert to give background opinion. The
13 causes of lung cancer are A, B, C, D, E, F. But as long,
14 if they then can't get anymore specific than that I would
15 say they can't offer testimony with regard to this
16 particular patient. But I think background information
17 from an expert is okay.

18 MR. DAVIS: And number four refers to Dr. John
19 Grossman, is a neurosurgeon in Miami, Florida; was deposed
20 many, many years ago, back in 2013. In his deposition he
21 refers to literature which is primarily OBGYN literature
22 that speaks of brachial plexus injuries being caused by
23 inter-uterine forces as, junk science. And we have cited
24 his deposition testimony in the motion. He says, well, it
25 is all junk science. Have you read it. No. But it is

1 all junk science. I don't think he should be permitted as
2 an expert on causation, to be able to so cavalierly
3 dispose, in his opinion, of OBGYN literature that he
4 hasn't even read. So I think that would be a reason to
5 limit his testimony, he can't talk about OBGYN literature
6 at all.

7 THE COURT: Mr. Graham.

8 MR. GRAHAM: If, Your Honor, please. What they
9 referred to obstetric literature about the causation of
10 nerve damage is hardly an -- you are talking about what
11 can cause nerve damage, what can cause permanent nerve
12 damage. Dr. Grossman is, he is retired now from being a
13 surgeon. But there are about brachial plexus centers
14 around the country, the closest ones from here are Miami,
15 Houston and Cincinnati. He has done more nerve resection
16 surgeries than, at least at the time he retired, than any
17 other brachial plexus surgeon in the world. People come
18 to him internationally. Ashby says he hasn't read the
19 literature. That is not true. He hasn't read all of the
20 literature but he has read a substantial amount of the
21 literature prior to the deposition date. And his point
22 is, you can't talk about the cause of brachial plexus
23 nerve damage which is a devastating injury where the
24 nerves get pulled out of the spinal cord and a giant
25 neuroma develops.

1 THE COURT: What does neuroma mean, I am not familiar
2 with that term.

3 MR. GRAHAM: I am sorry, what?

4 THE COURT: What is a neuroma.

5 MR. GRAHAM: Oh, I am sorry. A neuroma when nerves,
6 nerves can get damaged in several ways. Two of them we
7 don't need to worry about on the milder end of the
8 spectrum. One of them is called a rupture and when nerves
9 rupture it is kind of like a scab on your knee, if you
10 please. There is all kinds of stuff that gets released
11 from that. There is muscle tearing, there is all kinds of
12 soft tissue tearing. There is nerve tissue tearing. It
13 is a lot of all kinds of things called a neuroma which
14 affects the flow, the flow start in the spinal cord and
15 goes downhill to the muscle. And it, the nerve has been
16 ruptured and covered by a lot of scar tissue. And he
17 knows that permanent nerve injuries, in this case we have
18 got three nerves ripped and torn out of the spinal cord,
19 the worse kind of brachial plexus injury. We have two
20 nerve, we have two nerves that are ruptured which is
21 almost as bad. And then we have got this giant neuroma
22 that encompasses all five of those nerves. Five, six,
23 seven, eight and T-1. And when they present literature
24 that does not give a hint that they are talking about
25 temporary injuries, and they try to pass it off as being

1 relevant to what causes permanent injuries; he quite
2 correctly in my opinion calls it junk science. That's
3 what it is. It is trickery and they are trying to pull
4 the wool over the eyes of all kinds of people and it is
5 fair, I believe, for a nerve resection surgery that sees
6 what the tissue looks like. The obstetricians, virtually
7 no obstetrician has actually seen the tissue.

8 THE COURT: Mr. Graham, I think I have heard enough
9 on this one. I am going to deny the motion. It is
10 cross-examination material but Dr. Grossman will be able
11 to testify to that.

12 MR. DAVIS: The last motion is one I prepared and
13 sent to the Court on December 28th of 2021 regarding the
14 proposed causation testimony of a Dr. Armenta. Dr.
15 Armenta was first mentioned when this case was scheduled
16 for trial in December, 2020, that was COVID delayed. And
17 he was identified as a damage expert only. We elected, as
18 other damage experts have been disclosed --

19 THE COURT: Mr. Jordan has stuck his head in. Can
20 one of the Bailiffs tell him it is okay for him to come
21 in. I think he may of thought you were doing opening
22 argument.

23 MR. JORDAN: When Dr. Armenta was first mentioned to
24 us in 2020, sometime I think, he was only listed as a
25 damage witness. For just an economy of effort, my

1 Associate and I, Mr. Applebee at the time, talked about it
2 and decided we don't need to take his deposition if he is
3 going to talk about the issue of damages. They were many,
4 many we have already deposed. And we had other things to
5 do, we elected not to depose him. It was then revealed by
6 Mr. Graham, because of some health issues and I don't
7 dispute any of this, that he was not going to be able to
8 come to trial in December of 2020. Gosh, we saved some
9 time not taking his deposition, that is fine. On December
10 10th of 2021, after this case had been set for trial for
11 day certain --

12 THE COURT: This is the expert that we already talked
13 about briefly.

14 MR. DAVIS: Had a brief conversation. For the first
15 time on December 10, I am told that he is now going to
16 testify about causation. We try, I objected to it. I
17 told Mr. Graham it was a late disclosure and well within
18 30 days of trial. It violates the order, if not the
19 spirit of Judge Hall, when he in the 2020 December case
20 ordered a status conference hearing; that all discovery
21 for both parties would be done, no matter what the nature
22 of it, 30 days prior to trial. Less than 30 days prior to
23 this trial I get notified for the first time that a Dr.
24 Armenta, who has never formally disclosed in any
25 supplemental responses to interrogatories is going to

1 testify about causation in addition to all the other
2 causation experts. The Court was kind enough to have a
3 brief telephone conference without a Court Reporter the
4 day I was moving but I appreciate that. But we had a
5 brief conversation and the Court advised that the Court
6 was not comfortable with such a late disclosure in a case
7 this long. And I believe the Court's other comment was
8 that he encouraged us to try to get his deposition taken
9 if we can. Mr. Graham then gave me several dates, I
10 picked December 28th at 3:00 p.m. When that day came, my
11 fault, not his; he didn't send me his reports until
12 December 21. I was a little busy with the holidays and
13 trial prep. I did not see that email, that is not his
14 fault. I finally looked at it on December 28th and
15 decided I just did not have time to take his deposition
16 and I canceled it. I then filed this motion to not allow
17 his causation testimony. I have already notified Mr.
18 Graham in an email when I agreed to take his deposition,
19 such as I could, that I would object on the record at his
20 deposition to any of his causation testimony. And my
21 questions of him at that deposition would be subject to my
22 continued objection. The deposition was canceled, I
23 assume he still intends to call him to testify on damages
24 which I really don't have any objection to. But also
25 causation, which I do have an objection to, whether I have

1 deposed him or not. I didn't have time to get him
2 deposed, to get the transcript done on December 28th and
3 get it reviewed by my client and my experts to have any
4 kind of preparation for today. I think it is extremely
5 prejudicial to allow that.

6 THE COURT: Mr. Graham, when were you planning on
7 calling this witness, when during the trial?

8 MR. GRAHAM: On Thursday, around 3:00 to 3:30 our
9 time.

10 THE COURT: I need to review the case law on motions
11 to exclude witnesses and that kind of thing. And I would
12 prefer not to make a ruling off the cuff right now. If it
13 is not going to be called until Thursday, it sounds like I
14 can rule like tomorrow morning maybe.

15 MR. GRAHAM: Sure. Your Honor, may we have
16 permission to send you some of the correspondence that we
17 are talking about.

18 THE COURT: Both sides can send me whatever they
19 think I need to see. And, Mr. Graham, since Mr. Davis
20 spoke briefly, I really need to get started with the jury
21 but just give me a couple of minutes to your response to
22 what Mr. Davis just said with regard to your expert.

23 MR. GRAHAM: Yes, sir. I will have to go back before
24 the summer of '21, the summer of '20 to see exactly how we
25 identified Dr. Armenta the first time. There is an email

1 in the summer of 2020 from me to Ashby which made
2 reference to the fact that, as you know, these experts
3 that we have previously identified which included Dr.
4 Armenta. So I know that we had identified Dr. Armenta
5 prior to that date in the summer of 2020. I haven't gone
6 back behind that to see, you know, what that documented in
7 writing, was that a phone call, et cetera. But Dr.
8 Armenta is also a treater. I mentioned Dr. Nelson in
9 Charlotte. Dr. Nelson saw the horrific results from
10 surgeries done in some local areas that were not part of
11 one of the National Brachial Plexus Centers, where the
12 surgeons maybe do one of these a year instead of five a
13 week. And so he is a treater. Ashby, to the best of my
14 knowledge, Ashby had those records years ago, years and
15 years ago. But I don't want to assert that with certainty
16 until I go back and verify it. But Dr. Armenta's trips to
17 Houston, to be operated on by Dr. Armenta were included in
18 the lifecare plan. Sometime in late 2020 there was --

19 THE COURT: I think Mr. Davis was saying, he doesn't
20 object to him as a damages witness, it is causation
21 testimony.

22 MR. GRAHAM: Well in terms of causation, I would have
23 to go back and see exactly what we said when we identified
24 him. My standard custom is, when I identify a surgeon or
25 somebody along those lines I would typically say testify

1 as to causation damages and all other related matters.
2 But, again, I don't want to represent what I said verbatim
3 because I would have to go find it first.

4 THE COURT: If both parties can just send an email
5 this evening or tomorrow morning just briefly outlining
6 your position and attaching any documents you think are
7 relevant.

8 MR. DAVIS: I will be glad to do that. And if my
9 friend can show me supplemental interrogatories dated,
10 where he had identified Dr. Armenta as a damage and
11 causation expert and supplied his CV and identified him as
12 he has all of his other experts I will stand corrected and
13 understand. But to my knowledge that has never been done.

14 THE COURT: Both sides can submit by tomorrow morning
15 and I will rule tomorrow.

16 MR. GRAHAM: Thank you, Your Honor.

17 THE COURT: Anything else for me to decide?

18 MR. GRAHAM: No, Your Honor.

19 THE COURT: I know the jury has been waiting and we
20 need a break. So let's take a ten minute break and we
21 will pick up. We will bring the jury in at 11:30.

22 (Whereupon, a short break was taken.)

23 (Whereupon, the jury came into open court at
24 approximately 11:36 a.m.)

25 THE COURT: Ladies and gentlemen, thank you for your

1 patience. It is my fault we are getting a late start
2 today. I have tried to estimate how long it would take to
3 work through these legal issues in court and I estimated
4 too short of time. I am sorry about that, we are ready to
5 get started with the trial. We are, to kind of keep
6 things moving, we are going to have a half hour lunch
7 break today. But you are going to have pizza courtesy of
8 the County so you don't have to go anywhere for lunch. We
9 will do that today. That won't be the normal practice but
10 because the morning took so much longer than everybody
11 thought it would I want to keep things moving. So we will
12 do pizza today. So, ladies and gentlemen, this is the
13 case of Angela Patton, Next Friend of Alexia Lumpkin, a
14 minor child versus Gregory Mill, M.D. at Rock Hill
15 Gynecological and Obstetrical Associates. Case number
16 2009-CP-46-05195. I am going to ask my Clerk to swear you
17 in as jurors and I am going to make some brief opening
18 remarks and then I will turn it over to the lawyers.

19 (Whereupon, the jurors were sworn at approximately
20 11:38 a.m.)

21 THE COURT: Again, ladies and gentlemen, my name is
22 Judge Bill McKinnon, I will be the presiding Judge for
23 this matter. I am going to give you a general
24 introduction right now. I am not going to explain the
25 law, I will do that at the end of the case after you have

1 heard the evidence. But this is a civil case, meaning it
2 is a lawsuit. So the first thing I am going to mention
3 briefly is, the standard of proof is different than a
4 criminal case. In a criminal case you may have heard it
5 is beyond a reasonable doubt. In a civil case like this
6 it is the preponderance of the evidence which is a lower
7 standard. The attorneys will tell you more about that in
8 their opening arguments probably and I will, at the end
9 when I explain the law, I will go into great detail. Just
10 as a heads-up at the beginning, it is a different standard
11 of proof than in a criminal case. Ladies and gentlemen,
12 during the trial your job as jurors is to find and
13 determine the facts. You are the sole Judge of the facts
14 of the case. If at any time I make any comments regarding
15 the facts you should disregard it. You should determine
16 the facts from the testimony you hear on the witness stand
17 and any other evidence introduced into court. It is also
18 up to you to determine if there is any inferences which
19 you find are permissible or properly drawn based on the
20 evidence that you hear. It is specially important that
21 you perform your duty of determining the facts diligently
22 and conscientiously because ordinarily there is no way to
23 correct a mistake made by a jury as to the facts. On the
24 other hand, and with equal emphasis, the rules that make
25 you the judge of the facts make me the Judge of the law.

1 The law, as I explain it to you at the end of the case is
2 the only law you may consider. You must accept and follow
3 the law as I explain it to you even though you disagree
4 with it, if you disagree. I can't tell you, as jurors,
5 what the facts of the case are. And you cannot, are not
6 disagree with me about what you think the law is or what
7 you think it ought to be. It is your job to take the law
8 as I explain it to you and apply it to the facts that you
9 hear from the witness testimony and any other evidence
10 that has been introduced and then render your verdict. I
11 will go briefly over the same rules that I talked about
12 yesterday. As I said yesterday, please do not do any
13 outside research. Don't google any of the names of the
14 parties involved or the lawyers, don't try to look up any
15 of these medical things you may hear about. Don't look up
16 the law of South Carolina, don't do any outside research.
17 You will hear everything you need to decide the case here
18 in the courtroom. And similarly, you are not permitted to
19 discuss the case with anyone else out of the courtroom
20 while the case is pending. Again, when the case is over
21 you can talk with anybody you would like to. But while
22 the case is pending you can't talk about the case with
23 anyone else, that even includes each other until the end
24 of the case when you have heard all the evidence. At that
25 point I will tell you it is time to begin deliberations

1 and you will begin your deliberations. And then, you
2 never know, Rock Hill is still a fairly small town, you
3 never know what is going to make the news or the
4 newspaper, what is not. In the event there is some kind
5 of news report about this case please don't watch it or
6 read it, just change the channel or read a different
7 article. Ladies and gentlemen, further, you may run into
8 one of these lawyers in the hallway or the restroom or
9 something. They are not permitted to talk to you outside
10 the formal setting of the courtroom. So if you run into
11 them in the hallway or the elevator or something, they are
12 not going to chat with you. And they are not being rude,
13 that is just the rules of court and they are not permitted
14 to talk to jurors outside the formal courtroom setting. I
15 trust that y'all are going to follow all the rules I have
16 given you. But in the event one of your jurors does not
17 follow the rules as I have explained them to you please
18 let me know. Because if I find out during the trial it is
19 likely we can fix it. If I find out after the trial it is
20 likely we will have to do the whole thing all over again.
21 If someone is not following the rules as I explain them
22 please let me know. Ladies and gentlemen, it is important
23 you keep an open mind, not to decide any issue in the case
24 until all the evidence has been presented and the
25 attorneys have made their closing arguments and I have

1 explained the law to you. It is your solemn
2 responsibility to determine the facts of the case and your
3 verdict should be based solely on the evidence presented
4 and on the law as I explain it to you. Ladies and
5 gentlemen, you are going to see me, I have got a keyboard
6 and an iPad and as a Judge, I have to take notes during
7 the trial. So you will see me typing on this and that is
8 for, I have to make legal rulings. I do not permit jurors
9 to take notes and the reason for that is, some of you by
10 virtue of your education or the job that you have are
11 better note takers than others. And my experience, jurors
12 takes notes, the jury deliberation can become a battle of
13 who has the better notes. And that is not what we want.
14 The Court Reporter is taking down everything that is being
15 said in the courtroom, it is being recorded. If there is
16 critical testimony that you, if you are not sure what a
17 witness said, it can be played back for you during
18 deliberations but I do not permit witnesses, jurors to
19 take notes. Occasionally during the trial you will hear
20 one of the attorneys say something like, Your Honor, I
21 object or, Your Honor, I have a legal matter to discuss.
22 That means the attorneys want to discuss a legal issue
23 with me about what is allowed during the trial. And if
24 that happens I will excuse you to the jury room so you can
25 use the restroom or, you don't have to listen to our legal

1 arguments. In determining what the facts are in a case
2 you should decide whether or not the testimony of a
3 witness is believable. It is my job as the Judge to
4 decide whether a witness is allowed to testify. But once
5 I let them testify it is your job, as jurors, to determine
6 whether or not you believe that testimony. In deciding
7 whether to believe a witness you have the right to
8 consider any possible interest or biased or prejudice;
9 whether the witness had the opportunity to see or hear the
10 things which they are testifying about and the way they
11 act on the witness stand. So, ladies and gentlemen,
12 please pay close attention to the witnesses. I will try
13 to give breaks, in the event I forget or I just keep
14 going, just raise your hand and say, I need a restroom
15 break. I am not trying to torture anyone, you know, we
16 will give you a break if you need it. Or if your
17 interest, if you are having trouble paying attention, you
18 have been listening to testimony too long say, Your Honor,
19 I need five minutes to walk around or something. I will
20 be happy to give you a break. One last thing. On your
21 first break I am going to ask you to elect a jury
22 foreperson, what used to be called the jury foreman. In
23 South Carolina all jurors have an equal vote, one juror,
24 one vote. But the foreperson has two additional jobs.
25 The first is, to communicate with me, if there is any

1 issues. Like if it is too hot or too cold in the jury
2 room or you are having issues hearing witnesses or if
3 there is any issue at all the foreperson will write a note
4 and give it to the bailiff and they bring it to me and we
5 can address whatever the issue is. The second, when it
6 becomes time to deliberate as a jury it is the job of the
7 foreperson to make sure everybody has a chance to give
8 their opinion and one person doesn't dominate the
9 discussion. Other than those two jobs, the foreperson has
10 the exact same vote and exact same authority as all the
11 other jurors and your verdict must be unanimous. All
12 right. Ladies and gentlemen, that brings me to the end of
13 my opening remarks and I am going to give the attorneys a
14 chance to object in case I have said anything I shouldn't
15 of. And once that is done we will hear from the opening
16 statements of both sides and the Plaintiff has the burden
17 of proof so they go first. Any objection from the
18 Plaintiff?

19 MR. GRAHAM: No, Your Honor.

20 THE COURT: From the Defense?

21 MR. DAVIS: No, sir.

22 THE COURT: Thank you. All right. Mr. Graham.

23 MR. GRAHAM: Thank you, Your Honor. May it please
24 the Court.

25 THE COURT: Yes, sir.

1 MR. GRAHAM: Good morning.

2 JURORS: Good morning.

3 MR. GRAHAM: I know you have put a lot of time and
4 sacrifice into being here today. And you are probably
5 hoping that this will be an unusual case that might make
6 national headlines or something. This is not that kind of
7 case. This a medical malpractice case that occurs in our
8 Country over and over and over and over, every week. When
9 a doctor takes on the responsibility to delivering a baby,
10 that doctor has the obligation to pick the time to do the
11 job right. The doctor, if the doctor fails to do the job
12 right and the harm results on the baby then the doctor is
13 responsible --

14 THE COURT: Hold one second. Mr. Graham, the Court
15 Reporter is saying she can't pick you up. Mr. Graham,
16 there are wireless microphones so if you want to walk
17 around as long as you are willing to hold the microphone
18 that is okay.

19 MR. GRAHAM: Thank you. If the doctor has a baby who
20 needs special attention and the doctor has been trained to
21 handle that situation then if the doctor chooses not to
22 follow his training, and if the mother or baby is hurt as
23 a result then the doctor is responsible for the harm that
24 he caused. If a baby is coming down through the birth
25 canal, the natural way, and the baby's shoulder comes down

1 in such a way it might come down behind the mother's pubic
2 bone, the top shoulder may come behind the mother's pubic
3 bone. When that happens, doctors are trained how to
4 manage that situation. Doctors are trained how to get
5 that shoulder around the pubic bone so that the baby is
6 free to continue on down the birth canal. This happens,
7 different numbers, different percentages you hear based on
8 how people define the situation. And, but generally
9 speaking, somewhere in the range of one to two percent,
10 two percent rounded off of, all baby's in this country
11 come down with the top shoulder behind the pubic bone.
12 Doctors are trained how to manage that, how to get the
13 shoulder around. If a doctor departs from his training,
14 violates his training and harm results then the doctor is
15 responsible for the harm. The doctor is not allowed to
16 take shortcuts on patient's safety. The doctor is
17 required to follow the law and I will talk about that in a
18 minute, what the law is that applies to medical doctors.
19 I mentioned two percent of babies across the country have
20 the shoulder come down behind the pubic bone. That is a
21 condition called shoulder dystocia. Dystocia basically
22 means, in some language it means difficult; and shoulder
23 of course means that the labor or the dissent through the
24 birth canal is difficult because of where the shoulder is.
25 And in a moment I will show definitions of some of the

1 medical words. I have trouble with medical words. I use
2 legal jargon and other people don't like my words. So one
3 thing I will promise you today is, I am going to do my
4 best to avoid talking like a lawyer and I am going to do
5 my best to get the doctors to not talk like doctors so we
6 can all figure out what is going on and what they are
7 talking about. But of those two percent who come down
8 behind the shoulder, probably 10 to 20 percent of those
9 get injured in their nerves. I have to use a medical
10 term, brachial plexus nerves. When our brain tells our
11 arm to stick out, for example, the impulses go from the
12 brain, sometimes straight out to the body parts, sometimes
13 down the spinal cord and out to the body parts. Brachial
14 plexus nerve is the nerve that gives, to tell the muscles
15 to work, in your shoulder, all around the back of the
16 shoulder, triceps and forearm. And this, some ten to
17 twenty percent of the people, get that injury. Of those
18 people, the statistics, there is 20 percent of those get
19 permanently. There is a whole lot more that get temporary
20 injuries than those with permanent. That is part of what
21 this case is about and I am going to stop right here.
22 When I was in school, when I was in the first few grades.
23 In other words, I didn't want to memorize anything. And
24 instead of reasoning things out on my own I was just
25 basically told, do it this way. I am thinking in the

1 fifth grade, I had a teacher that I adored because she
2 taught me the first time that she gave me the tools to
3 figure out on my own. It would really help me and that is
4 what I want to do for you today. I am not here to tell
5 you what to believe. I am not here to tell you to
6 memorize. I hope that I will be able to give you some
7 tools and hope you figure out how to analyze the issues
8 that you are going to hear about. In one way this case is
9 very simple, that is the way we are going to explain it.
10 When this happened, doctors are trained to do several
11 maneuvers, get the shoulder out behind the pubic bone.
12 Moving furniture, you have a couch that wants to scrape on
13 the door the first time, what do you do. You got a friend
14 and you walk it outside and get the ledge and walk it out
15 and just maneuver. The same thing with a piano, anything
16 you can think of. You just, if the round peg won't go
17 through the square hole then, the square is big enough to
18 put around the peg through it it goes through it, if it
19 goes through the right angle. Having a baby's shoulder on
20 the pubic bone is not the right angle. So what is the
21 mystery that the obstetricians are, (inaudible). Move
22 that shoulder. It might be slow and then the baby comes
23 out. It is that shoulder that needs to be, and if the
24 doctor doesn't manage the shoulder, in accordance with his
25 training and if he causes harm then he should be held

1 accountable just like the rest of us. If we don't take
2 time to do the job right then maybe we get lucky, maybe
3 bad things happen, maybe horrible things happen. But if
4 we don't take time to do the job right then we should be
5 adult enough to hold a mirror up and say, what, I
6 shouldn't have done that. If you hurt somebody, you put
7 somebody at risk, you damage property, you killed somebody
8 maybe, you caused a devastating life changing injury to
9 someone and as an adult, taking responsibility,
10 recognizing how important accountability is in our
11 society, I would like to think that we would accept the
12 responsibility and do what it takes to make up the harm we
13 caused. I want to talk to you about some of these
14 building blocks. I told you I don't want to tell you what
15 to believe but I do want to give you some basic building
16 blocks and it has been a start, I said some of those
17 medical words I am going to stay away from. But the
18 reason for that is to take the medical words and translate
19 them into words that I hope we can all understand. And I
20 have, (inaudible), I am sorry, what? I am going to have
21 to step back here and read it.

22 We talked about brachial plexus nerve. Those nerves,
23 in the spine through the neck area, provide muscle
24 functions. That is what brachial plexus is. Nerves that
25 keep your arm from being paralyzed if they are working

1 properly. Brachial plexus birth injury kind of speaks for
2 itself. These nerves get damaged, they might cause
3 temporary problems, they might cause permanent problems,
4 they might cause life changing problems. Doctors try to
5 figure out whether an injury is permanent or not because
6 they know it is going to be permanent and they know it is
7 going to be horrifically permanent and they want to do
8 surgery quick because if they wait a year or two then you
9 won't be able to try to sew those nerves back together,
10 suture those nerves back together. So they wait one or
11 two years. Because the body, our bodies are miraculous,
12 how we, up to a point we can heal on our own. By the
13 grace of God, miracle of creation the way our bodies work.
14 So sometimes these injuries are not so bad in the sense
15 that they can recover on their own. So doctors, if there
16 is some flicker of return of function like a wrist moving
17 or a biceps, an elbow that can move then they say, well,
18 let's hold off, as long as there is some progression,
19 maybe within two years it will fix itself. But if it
20 hasn't recovered by two years then it is going to be
21 permanent. We talked about a temporary injury. I am a
22 sports guy, forgive me if you are not. When I think about
23 an arm injury, I do think about football. And it is ball
24 season, anyway we have got, there is something in football
25 that is commonly referred to as a stinger. It is kind of

1 like your arm or your foot going to sleep if you are
2 sitting still for a long time. You can also get that same
3 numb feeling, the inability to control your arm normally
4 if you get a sting. And most commonly it occurs in
5 football. Sometimes nerves will be hurt so badly,
6 (inaudible.) Sometimes those guys sit out a play or two,
7 sometimes those players go into the tent and don't come
8 back. Sometimes they can't finish the season. It just
9 depends on, is that a temporary stinker or is that
10 something more serious. So some people have season ending
11 injuries. Some people, (inaudible.) Shoulder dystocia,
12 we talked about that. Most of the time the shoulder --
13 once in a while the bottom shoulder might get stuck higher
14 up in the birth canal, in the pelvis there are a bunch of
15 medical names. One of those is called sacral promontory.
16 So you get higher up on your pelvis. There is this, it is
17 almost like a muscle that is, it has got this little part
18 and it is a lot smaller. But sometimes it can get stuck
19 up there. It is not anywhere near as stuck as pubic bone.
20 When you do have a posterior shoulder it is stuck higher
21 up where you can't see the head. And I mentioned that one
22 way, that children get brachial plexus nerves that we have
23 talked about, when the shoulder is stuck here and the
24 doctor puts so much force on the head and the neck so that
25 these nerves stretch beyond their ability to pop back.

1 Pull a rubber band and it will come back, pull it harder
2 and will come back but not as good. If you pull it all
3 the way that is called a --, if you have got a nerve
4 plugged into the wall on an electrical outlet,
5 (inaudible), yank that cord out, that is called, that is
6 the worst thing -- that means that it is not just the
7 second worse of rupture like popping a rubber band and you
8 try to make it grow back. And you do surgery,
9 (inaudible). You put it in here, grab this end of the
10 broken nerve to this end of the broken nerve, so you try
11 to get some electrical current from the nerve that goes
12 through there. When, there is no juice coming out of the
13 spinal cord that that nerve, it is like yanking out of the
14 ground to get a root out, it gets out of the ground. It
15 is not like you can somehow connect another down to the
16 end of that hole and it start growing again. So we have
17 got those injuries. I want to move on. You are going to
18 hear about some of these phrases as we go on. I just,
19 again, I want you to have the building blocks so you can
20 reach your own conclusion. I am going to take two of
21 these at one time. Okay. I kind of got ahead of myself
22 here. Traction is one of those words that means different
23 things. A group word is, a tractor, you have got a
24 tractor and you really pull heavy objects. In the medical
25 context, pulling the baby, the baby's neck as you pull on

1 the baby's head. That kind of traction, if it is more
2 than gentle then it can pop those nerves, it can pull
3 those nerves. Gentle traction is what doctors are trying
4 to do, rotate, gentle guide and around the pubic bone.
5 (Inaudible). You pull it hard, (inaudible.) Doctors use
6 more than gentle pulling force then they cause and they
7 are responsible. There is a couple of medical, we were
8 talking about traction. If you, the good kind of
9 traction. Axial traction, guide or pull the head,
10 parallel with the spine. You bend the neck over a half
11 inch, (inaudible). The bad kind of traction is collateral
12 traction. It would go up and bend the neck, bend it down,
13 it is, (inaudible). But anyway, doctors are suppose to
14 use gentle axial, not collateral traction. From now on I
15 am going to call that neck bending and pulling. We have
16 talked about rupture and I will say for now, for rupture I
17 will try to say, the nerve. Revulsion is like pulling
18 that carrot out of the ground, just yanking so hard that
19 you can pull nerve roots out of your spine. Okay. I want
20 to talk about two related ideas here. Just when you skin
21 your knee, (inaudible), skin your knee, scab on there.
22 When your nerves get ripped and torn or yanked out of the
23 spinal cord then that creates sort of a scar. It is not
24 the same. Inside your body you have got, you have got,
25 those nerves connect to muscle. So when your nerves get,

1 it is muscle, (inaudible). Some of those muscles, they
2 become part of the so-called scab.

3 THE COURT: Hold on one second, Mr. Graham.

4 (Whereupon, digital in inaudible due to Mr. Graham
5 moving around.)

6 MR. GRAHAM: So you have got fat, you have got
7 muscle, you got all kinds of skin that turns into a wad of
8 stuff that does no good. It just, it just grows around
9 the nerves. So if a surgeon is trying to figure out, how
10 do we try to fix this with a knife they have got, first
11 they have got to get rid of all the neuroma is what it is
12 called, get rid of all of that scar tissue. And then try
13 to figure out how you can connect one end with the other
14 end. And we will have surgeons here to talk about that
15 and to explain how all of that is done. We talked about
16 dystocia, you see the baby coming out. You have got the
17 baby coming down, you have got head first in this
18 direction. And you have got the baby, shoulder behind.
19 And when an obstetrician gets trained in obstetrical, they
20 are taught many ways of getting that shoulder unstuck. As
21 to do with the legs and where they go. This is a smaller,
22 it is just a random lady about to give birth. Her legs
23 are in stirrups. And that is the way a woman is normally
24 positioned in labor. And she might deliver in this
25 position but once the shoulder is stuck, (inaudible).

1 Grab one of these legs way back so that the knees, that
2 changes the angles of the birth canal. It doesn't give
3 you a whole lot more space, it is a little bit more space,
4 it is not like that the shoulder is, (inaudible). And
5 this does give you an idea of, what, in the position,
6 (inaudible). The way this is done, this is one nurse
7 doing two jobs. She is pushing that leg back and shoulder
8 to the chest. But this other arm is, this is the pubic
9 bone and just above the pubic bone you can feel that
10 shoulder. And so the medical term is, (inaudible.) All
11 that means the shoulder there pushing it around. And
12 pressure, are the two easiest way to get the shoulder,
13 this is the nurse. And this is the, (audible). Another
14 way that doctors are trained of the posterior, delivery
15 normal, that top shoulder first and get that top shoulder
16 under the pubic bone, then they can reach in and grab the
17 arm and pull it out like that and then it can get on
18 through. This is, there are two rotations. Is the one
19 that, (inaudible). You can imagine a woodscrew, kind of
20 like a cork screw. You rotate the baby out like pulling a
21 cork out of the bottle, just slowing pull out. And there
22 is a maneuver called woods, (inaudible), in an angle. I
23 don't want to talk about that stuff anymore. Let me move
24 on. One thing about these shoulder dystocia cases is, it
25 is totally random. A lot of these babies are big, you

1 don't have to be big. A lot of the mamas are relatively
2 short in stature but you don't have to be, it could be a
3 tall mom. You know, it affects people of all races, all
4 religious denominations, natural origins. It is random,
5 any of us could run into this situation and just put your
6 trust in your obstetrician to follow his training, follow
7 his or her training to get that shoulder unstuck so you
8 can count fingers and toes. Put a big smile on your face
9 and celebrate with pride, the birth of your new beloved.
10 I want to talk about the law a little bit. You are going
11 to hear some legal jargon that I am going to try to
12 shorten it for you. His Honor is the Judge of the law, by
13 far the smartest lawyer and our Judge. And it is his role
14 to tell what the law is. But I expect that he will tell
15 you that doctors are required to exercise the same degree
16 of care or carefulness as a reasonably prudent doctor
17 would use in the same or similar circumstances. So not
18 just reasonable but reasonable, act reasonably, as a
19 reasonably careful, prudent or careful doctor would do.
20 So, you know, it is not like the doctor has to commit some
21 kind, similar not a crime, this is not a criminal case.
22 The law, some people expect the law to be in writing, it
23 is not. We are talking about standard of care, the
24 standard of care is which a physician do reasonably, act,
25 to the generally accepted standards of care, reasonably

1 prudent. That is a bunch of words. I would just like to
2 call it rules. We all understand rules. The law is,
3 doctors must meet these standards of care, the doctors
4 must meet these rules. Do what a reasonably prudent
5 doctor would, to do what, not do what a reasonably prudent
6 would not do. Those rules are of the law. Not a criminal
7 law, nonetheless they are the law. Good time for me to
8 talk about burden of proof. I know you have heard about
9 the burden of proof, beyond a reasonable doubt. So on
10 this here, you know, you start, this is 100 percent
11 certainty. You don't, (inaudible), beyond a reasonable
12 doubt is close to the top. In a case like this the burden
13 of proof is called, another legal phrase, preponderance of
14 the evidence. A fancy word for saying, more than 50
15 percent. Okay. And in this case, if you feel like the
16 evidence is one percent more in favor of, (inaudible),
17 according to the law, follow the instructions of the
18 Judge. One percent of the law, (phone ringing), we
19 believe that the proof in our case is more true than not,
20 is another way of saying, (inaudible). The Judge had said
21 something about credibility and I want to talk about that.
22 You are going to have expert witnesses. These are
23 professionals that have special training, many of these
24 experts have trained in obstetrics. Some of them have
25 trained in neurology. Some of them are trained in

1 surgery. Some of them are trained in predicting what kind
2 of future, this child would have forever. Then we have an
3 economist to figure out how much money, creating the
4 future. The only, (inaudible). What kind does that rule
5 out, expert, (inaudible). Neuro, she does a lot of,
6 (inaudible), to figure out, the child tries to, it is one
7 arm, this (inaudible). Once her future, (inaudible). I
8 don't want to keep running my mouth, I want to give you
9 building blocks so you can figure for yourself that this
10 doctor, (inaudible). I want to talk just a minute before
11 I sit down about the kinds of things I believe you, I want
12 to be sure, (inaudible). What you will hear is that, once
13 that shoulder gets stuck the stop watch starts ticking
14 off, there is a certain time to get that shoulder unstuck
15 and get the baby before something real bad could happen.
16 That is what, (inaudible). Probably, I expect what they,
17 the doctor makes a choice, a potential choice, violate his
18 training, to cut the safety point, not to take enough time
19 to do the job right. He can change somebody's life. You
20 will hear from the doctor, let me talk a little bit more
21 about this. In this case the records, you will hear that
22 the doctor, (inaudible), of the records are two minutes.
23 We will say, somewhere in that range. And they will say,
24 we had to move. But the people that do the study know
25 that if your windpipe is cut off completely then

1 everything else being normal then it is going to take,
2 seven, eight, nine, twelve, twenty minutes. But who wants
3 to cut it close. None of us would want our children to
4 cut it close. So doctors have come up with a cushion.
5 Generally you hear, sometimes you hear, (inaudible), that
6 is the target, there is no risk of serious injury in the
7 sense -- and if you handle that, there, you don't have to
8 make that choice. If you choose to increase that force on
9 that head, and violate your training you have broken the
10 law. And they are going to say, really, five minutes,
11 that is a short time. You are saying we broke the law.
12 We are heros. That is not the, (inaudible), five minutes
13 is, but you are again a sports -- if it is first and goal
14 on the three, five minutes, you will need to throw a hail
15 mary. Do your job and, (inaudible). In basketball you
16 have got a certain second clock, (inaudible). You score
17 an incredible number of points in a second. Professionals
18 are trained to let time slow down, stay calm, clear
19 focused mind, don't panic, don't decide that it is time to
20 do that. This thing about, if you are on the front porch
21 and you open the screen door, (inaudible), choose to pull
22 harder instead of gently, figuring out. Or let's say you
23 are in a grocery store, you weigh your fruits and
24 vegetables and see how much it is going to cost you. Put
25 it in there, (inaudible), or you can pull it down to that

1 same weight and have a pretty good idea how hard you
2 pulled. Experienced doctors know that they are suppose to
3 have a feel of how much they pull. (Inaudible). If
4 something happened, you want to overcome that resistance.
5 He pulled that scale down like that, he has no clue, he
6 has no feel about how hard he is pulling. He made the
7 choice to pull, force. I haven't talked a whole bunch
8 about damages. I don't want to tell you too much, I want
9 you to, (inaudible). You have got, Alexia Lumpkin, her
10 parents on the first row. You will see her left arm, she
11 doesn't like, (inaudible), she wears clothing to try to
12 hide that arm. You will hear from Alexia's, you will hear
13 about the pressure of the, (inaudible), standing out. I
14 can't come back up here and respond to whatever Mr. Davis
15 is going to say. If he says something that you think,
16 (inaudible), just remember -- everything. And I am able
17 to, (inaudible), it is like we have a jigsaw puzzle. If
18 you, if there is, in the middle of that puzzle and you are
19 not around, (inaudible). Pretty, tranquil and then there
20 is all of these skyscrapers where you just can't see. You
21 have got to put it in context. Whenever you listen to Mr.
22 Davis, just remember, (inaudible). Mr. Davis, I am going
23 to challenge him, explain, it is okay for a doctor to rush
24 and not take the time to do his job right. I will ask him
25 if he can explain to you for a doctor to violate this

1 training. I am going to ask him to tell you whether or
2 not he thinks Dr. Miller caused this injury, or whether,
3 (inaudible). I am not going to tell you what to believe.
4 Thank you.

5 THE COURT: Mr. Davis.

6 MR. DAVIS: Ladies and gentlemen of the jury, my name
7 is Ashby Davis, I am privileged today to be here to
8 represent my client, Dr. Greg Miller. I want to introduce
9 him to you again. Dr. Miller, would you please stand.
10 Dr. Miller has been practicing OBGYN in this community and
11 lately in Beaufort, South Carolina, for the last eight
12 years, here for many years prior to that; is Board
13 Certified and has delivered over 9,000 babies, mostly in
14 this community. Dr. Miller is married, he has a home here
15 in Rock Hill, he has four grown children. What is not at
16 issue in this case, ladies and gentlemen, is the injury
17 suffered by Alexia and the tragedy that imposes on her now
18 and in the future and the disability that imposes on her
19 and on her family, it is not an issue in this case. On
20 April 5 of 2007 here in Rock Hill, Alexia's mother, Angela
21 Patton was in labor. Her delivery physician was Dr. Greg
22 Miller. At that time was practicing with Rock Hill GYNOB.
23 While in labor, now with her fourth child, most recent
24 child being born, I think, about seven years prior; there
25 was a concern as labor went on by Dr. Miller because on

1 the fetal monitor strips and you will see those fetal
2 monitor strips as the evidence is presented; that Alexia's
3 heart rate which is measured on these fetal monitor
4 strips. It is the only way the doctors can try to
5 determine the relative health or wellbeing of the baby in
6 labor. They can't take a blood pressure, they can't take
7 a temperature of the baby, they can't take a picture. The
8 only thing they have is indirect evidence from the fetal
9 monitor strips of what the heart rate is and how it is
10 doing according to what the strips show. And Dr. Miller,
11 as an experienced OBGYN, on that day on April 5, 2007
12 became professionally and experientially concerned because
13 Alexia's heart rate was decreasing, it is getting low.
14 The doctors call that bradycardia. And because of his
15 concern, he was at the bedside with her in the laboring
16 room and trying to encourage her, she had been in labor
17 for a long time. Mom's get tired in labor, they don't
18 call labor for nothing, it is work and you get exhausted.
19 But it was at a critical point in the labor, long labor,
20 because the heart rate going down for an extended period
21 of time that Dr. Miller became professionally and
22 understandably concerned for the health of Alexia in the
23 womb. And so he encouraged, Mom, try to push harder, you
24 have got to try to push harder. We don't blame her for
25 not being able to push effectively. That is not the issue

1 here. So he was there sort of as a cheerleader trying to
2 encourage a tired mom who had been in labor for a long
3 time, got to get this baby delivered because he is
4 concerned about a low heart rate. During that concern and
5 as she attempted to push and the uterus was continuing to
6 contract, as uteruses are designed to do, he decided,
7 well, maybe I can help, maybe I can help the baby to
8 descend, to come out a little bit by using a vacuum device
9 which is an appropriate assisted delivering device; that
10 doctors, OBGYN are experienced and trained and it is
11 appropriate to attempt those vacuums. He tried to put the
12 vacuum on the head of the baby, it never attached, he
13 abandoned that attempt. No expert in this case, on either
14 side is ever going to tell you that that attempt to use
15 the vacuum to assist in the delivery for those seconds
16 caused or contributed to any injury claimed in this case,
17 it caused no harm. Dr. Miller continued with his concern
18 as mom is trying to do the best she could to push and he
19 elected, in using his best clinical judgment on the
20 circumstances before him and his responsibility to his
21 patients, the child and the mom; I am going to recommend a
22 cesarean section. He talks to her about it, he ask for
23 her consent, she understood, she gave her consent. And
24 down the hall they went to the operating room. An
25 anesthesiologist, Dr. Susan Lupo was summoned to come to

1 do the anesthesia. A neonatologist, Dr. Mercado was
2 summoned to be prepared, because they didn't know what was
3 going to happen. All they knew is, the baby's heart rate
4 is not doing well, I am concerned, we need to get this
5 baby delivered. They got to the operating room, they
6 prepared her for surgery, for a cesarean section and which
7 is routine. What they do before they make that incision,
8 before they go forward with what has been consented to,
9 the Doctor appropriately says, let's check the baby's
10 heart rate again. They put the monitor on, they check the
11 baby's heart rate again. Now the heart rate was normal,
12 it was in a normal range and the doctors call that, it was
13 a reassuring heart rate. The pattern was reassuring, the
14 rate was reassuring. So Dr. Miller, there in the
15 operating room, ready to do a C-section if needed said,
16 the baby's heart rate has recovered, it is reassuring,
17 let's keep pushing. Let's try to get this baby delivered.
18 We are ready, let's push just a little bit longer. And
19 with more encouragement by the nurses, more encouragement
20 by Dr. Miller mom was able to push, the uterus was
21 continuing to contract and the head was finally delivered,
22 a great sign. Now what happens. Dr. Miller carefully
23 placed his hands on the baby's head, well within the
24 standard of care, it is what he is trained to do. And he
25 applied gentle downward, or sometimes they will call it

1 axial traction and he pulled gently on the head and
2 nothing else happened. And he immediately takes the hands
3 off the head. At that time he determines there is a
4 shoulder dystocia. He announces it to the nurses in the
5 operating room, we have a shoulder, I want McRoberts, two
6 nurses, one on each leg, grab each thigh of mom and pull
7 it back as far they could. That is called the McRoberts
8 maneuver. The nurses do it all the time. The very next
9 thing he called for is suprapubic pressure, where one of
10 the nurses in the operating room helping the doctor to
11 deliver will climb up on a little stool next to the
12 operating room table to get over the suprapubic area, near
13 the pubic bone, just behind the pubic bone and to get a
14 fist or her hand and push down to try to dislodge that
15 shoulder that is apparently stuck. Most of the time those
16 two maneuvers will deliver a shoulder dystocia but not
17 always. When the shoulder would not deliver with those
18 two maneuvers, appropriate maneuvers, appropriate done and
19 no expert is going to say that was improper, none, nobody,
20 no criticism here, none. Dr. Miller then decided I will
21 try what is called a posterior arm delivery. What does
22 posterior mean. Posterior is towards the floor. What
23 does anterior mean, it means toward the ceiling. I call
24 it up anterior, down posterior, it is easier for me, maybe
25 easier for you. But you will hear those words used

1 throughout the trial of this case. Let me show you, an
2 illustration, nobody was there with a photograph, a video
3 camera so we can't tell you this is a picture of what
4 happened, this is a medical illustration that hopefully,
5 ladies and gentlemen, will help you understand. I am not
6 a doctor, I don't pretend to be a doctor. We will call
7 doctors to the witness stand, they will testify under oath
8 and will explain to you in their opinion as experts what
9 all this is about. I believe you have seen this, Mr.
10 Graham.

11 MR. GRAHAM: Yes.

12 MR. DAVIS: For example, this first drawing or
13 illustration shows these arrows would represent the uterus
14 contracting, forcing, trying to expulse, it is the way God
15 created it, it happens. This bottom or injured left
16 shoulder, this is the right shoulder, this is the way the
17 baby presented, you will hear them call it LOP, left
18 occiput posterior. Basically the head is turned a certain
19 way, the baby is facing a certain way when they come out.
20 There are different positions, baby's present in different
21 positions. This baby presented this way, this is
22 documented in the medical records, you will see in
23 evidence. This is the up anterior right shoulder that was
24 not injured. This is the left posterior down shoulder
25 that eventually was injured or found to be injured. This

1 shows that that left shoulder stuck on what is called the
2 sacral promontory, it is called a posterior shoulder.
3 This just illustrates the brachial plexus, the nerves get
4 stretched. This happens before the head delivers. Again,
5 I will have the experts go over this for you, I am not a
6 doctor. We will have the doctors explain it. That is
7 what Dr. Miller is seeing, that is his perspective. The
8 baby presents with either a turtle sign or hands on the
9 head, can't deliver, take the hands off, you know you have
10 got a shoulder dystocia, now you have to deal with it.
11 Number three, rotational maneuver is performed while the
12 mother is in the McRoberts position. Eventually this
13 rotations maneuver was performed. We are going to have an
14 animation later in the trial to show you, let the experts
15 explain it to you, that better illustrates that than a
16 still board. Basically it is a cork screw, it is a
17 woodscrew maneuver, it is a rotational maneuver where the
18 doctor has to reach in and turn the baby. When he did
19 that, that left shoulder which originally was down, as he
20 turns the baby with this appropriate rotational maneuver,
21 well recognized in medicine, the baby rotates and that up
22 right shoulder gets unstuck and the baby then, and the
23 doctors describe this. The baby unscrews, the baby, it
24 comes out. That left shoulder, as it is rotated up to 180
25 degrees is now coming out toward the doctor and that is

1 all they have to do is put their hand on the baby's head.
2 Essentially just guide that baby out, catch the baby so it
3 doesn't hit the floor, nothing is stuck. Dr. Miller,
4 before he did that final rotational maneuver did attempt
5 what is called posterior left, in this case, down, arm
6 delivery. It is an appropriate maneuver to attempt and
7 when it works it delivers the baby. It didn't work and
8 that's what, what he had to go, according to his training,
9 the University of Florida where he did his residency
10 trainee to become a Board certified OBGYN. He was trained
11 to do the posterior arm, that is his protocol, that was
12 his maneuver. It didn't work and that is when he went to
13 the rotational maneuver and as he turned the baby the baby
14 came out. The doctor never, Dr. Miller will testify that
15 he at no time, during this entire 45 seconds to two
16 minutes ever use any excessive force or traction on the
17 head of this child, never. Dr. Miller wrote a delivery
18 note. It will be in evidence. I don't know about you but
19 that is hard for me to read. But that is Dr. Miller's
20 handwritten note, written after the delivery, about an
21 hour after the delivery. So what we ask him to do and I
22 think he might have done this in his deposition, is he
23 read this and so we transcribed it. I think that is a
24 little bit easier to read but you will have both of these.
25 So I am going to read this, this will be in evidence.

1 21:30, 4/5/07. Patient pushing poorly with lack of
2 coordinated effort. That is not a criticism of mom, she
3 is tired. Cervix now complete at zero station. Heart
4 rate decreased to 60 to 90 X 8 to 10 minutes. It is a
5 heart rate of 60 to 90. The doctors will tell you that a
6 normal fetal heart rate is in the 130 to 150, at 160
7 range. That is his concern. It went that way for 8 to 10
8 minutes. That is why he said, come on, Mom, we need to
9 push, we need to go to a C-section. Vacuum applied X one
10 to help facilitate delivery. However, would not hold
11 effectively. Caused no harm to Alexia at all. Patient
12 encouraged vigorously to push more effectively because of
13 fetal safety. However her pushing remained poor. We are
14 not criticizing Angela Patton for poor pushing. She was
15 tired, that happens. Warned that she would need a
16 cesarean section if effort did not improve and still did
17 not improve. Therefore consent signed and patient taken
18 to the operating room. And they wheel her down to the
19 operating room, there is no fetal monitor on the baby in
20 that transition. And they put her on this narrow
21 operating room table, getting things ready to go. In the
22 operating room the heart rate increased to 130's, that's
23 good, that's normal, with good acceleration. I will let
24 the doctors explain what that means. The decision made to
25 allow her to labor, that was his decision. Baby descended

1 with pushing, pushing was better. Head delivered LOP,
2 left occiput posterior, like these drawings. And I will
3 let the doctors define that better. The right shoulder,
4 which was up anterior shoulder would not deliver.
5 McRoberts maneuver, suprapubic pressure and third degree
6 episiotomy 00000 without success. All of those are
7 appropriate maneuvers. No one criticizes anything to this
8 point. Could not deliver the posterior shoulder or the
9 posterior arm and therefor woodscrew maneuver formed and
10 rotation of 180 degrees occurred to ROA, right occiput
11 anterior. The left shoulder now is up, the right shoulder
12 is down as the baby is coming out. Anterior shoulder
13 delivered using McRoberts, suprapubic moderate effort,
14 baby subsequently given to pediatric services immediately,
15 cord PA 7.028; baby weighted nine pounds, six ounces. Ms.
16 Patton previous baby delivered seven years before was nine
17 pounds, eleven ounces, no shoulder dystocia. With APCAR
18 four and seven, the doctors will talk about that.
19 Postpartum hemorrhage secondary to uterine atony occurred
20 which responded to Pitocin, massage, Cytotec and
21 Methergine. Estimated blood loss, 800 CC's. The OB was
22 Dr. Miller, anesthesia, local. That is his note and he
23 will explain it to you. They will tell you what all of
24 this means, then occurred. According to the medical
25 records it took between 45 seconds and 120 seconds to

1 resolve that shoulder dystocia, to go through all of those
2 maneuvers and deliver Alexia. Dr. Miller has been accused
3 in this case, in this lawsuit that he was negligent, that
4 he departed from the accepted standard of care of a
5 reasonable prudent obstetrician in the same or similar
6 circumstances. That is what they have alleged in this
7 lawsuit. They have alleged that he used excessive
8 traction and excessive force that caused this injury. Dr.
9 Miller, from day one, has denied that he was at any time
10 negligent and he has denied that he at any time ever used
11 excessive force at any second of this delivery. The
12 burden of proof is on the Plaintiff to prove their case,
13 it is not on us. They brought the lawsuit, they have got
14 to prove their case to you. And that burden or proof is
15 significant and it is serious and it is like a scale, if
16 you can imagine the old scales of justice. Like you weigh
17 in the old market places, you can imagine that. And one
18 side is Plaintiff and one side is the Defendant. Well,
19 there are two scales. And so the Plaintiff presents their
20 case first, somebody has got to go first. It is like
21 baseball, somebody has got to have the top of the first
22 and someone has got to have the bottom of the first. We
23 are common, y'all just wait, we are going to present our
24 case. Got to wait for the inning to end. So right now
25 there is no evidence before you, there is just statements

1 by lawyers and there is instructions, preliminary
2 instructions by the Court. You have no evidence so right
3 now those scales are perfectly even. As the Plaintiff
4 presents their case, they have the burden to prove the
5 case, to prove it ever so slightly, to tip those scales in
6 their favor. And through their case you may be, yes, I
7 think so. But it ain't over yet, we have got our defense
8 coming. We are going to put up our experts, we are going
9 to put up Dr. Miller, we will put up witnesses. And then
10 as you listen to the bottom of that inning, maybe and it
11 is up to you, as you weigh the evidence, as you hear it,
12 maybe that tilts back, maybe in Dr. Miller's favor ever so
13 slightly or maybe at the end of everything it is that
14 even. When you deliberate at the end of this case, you
15 determine what the facts are and you apply those facts as
16 you find them to the law that the Judge gives you. And
17 there are three possibilities as you go through that
18 process and we will talk about it again at the closing at
19 the end of the case. You weigh it, well, that sounded
20 pretty good and I kind of, sort of, it was tipping this
21 way and then let's look, maybe it is back this way. If at
22 the end of all of the deliberations, after the evidence
23 and you weigh that process collectively together; if at
24 the end of that process you determine unanimously, all
25 together agreeing, that, yes, it tips in favor of the

1 Plaintiff and that is your verdict, that is your decision,
2 you do whatever the law ask you to do. If on the other
3 hand it tips every so slightly, ever so slightly in Dr.
4 Miller's favor, would include, well, they didn't prove
5 their case and it is a defense verdict and that would be
6 your verdict. And there is a third possibility. As you
7 weigh things and you end up and the scales are even just
8 like they started like they are right now, your verdict
9 would be for the Defendant. Listen to all the evidence,
10 listen to the Plaintiff's evidence, listen to their
11 experts, listen to their opinions, listen to the basis of
12 their opinions. Do the same with the Defense experts. I
13 will talk just a little bit about the law and then I will
14 quit. It has been a long day already for you guys and I
15 appreciate your patience already. Elements of a medical
16 malpractice claim. The Judge will tell you what the law
17 is in this case and you take the law and whatever he tells
18 you it is, he is the law giver. I expect that when the
19 time comes he may tell you something along these lines.
20 What is the standard of care, we are going to hear a lot
21 about, what is the standard of care. The standard of care
22 is that which a reasonably prudent physician would or
23 would not do in the same or similar circumstances. What
24 is negligence. They have alleged that Dr. Miller was
25 negligent. The failure of the physician to do that which

1 an ordinarily prudent physician would do under the same or
2 similar circumstances or the doing of that which an
3 ordinarily, careful and prudent physician would not have
4 done under the same or similar circumstances. That
5 defines negligence. Well, that is a lot of legal words.
6 Hopefully the evidence and the opinion testimony that you
7 will see as the case develops will help you flesh out and
8 put meanings to these terms. Proximate cause, they have
9 the burden of proving a proximate cause. What does that
10 mean, it is a causal connection between any alleged
11 negligence, any proven negligence and any injury proven.
12 What is medical malpractice. The Plaintiff has to prove
13 to you, all 12 jurors who will make the decision on this
14 case, based on the evidence as you find them to be; they
15 have got to prove these things. Number one, that Dr.
16 Miller owed a duty to the patient according to the
17 accepted medical standard of care. Number two, they have
18 got to prove that Dr. Miller negligently departed from
19 that standard of care. Number three, that the negligence
20 of Dr. Miller was the proximate cause of the patient's
21 injuries. And number four, that the patient sustained,
22 that the Plaintiff sustained damages as a direct and
23 proximate result of such departure or negligence from the
24 standard of care. That is what they have got to prove.
25 Expert testimony is not just an option for the

1 Plaintiff's, in a medical malpractice case. The law
2 requires that they sustain and carry that burden all
3 through this case by their expert testimony. So they will
4 call expert witnesses and that is fine, we will too. Here
5 is what their testimony, their expert witnesses are
6 required to do. Number one, they have to persuade and
7 convince you what the standard of care is in this case.
8 Number two, they have to persuade and convince you how the
9 doctor, Dr. Miller departed from the standard of care.
10 And number three, did Dr. Miller's departure from the
11 standard of care that they alleged -- cause the injuries
12 that they claim. Calling experts is not an option, it is
13 not a nice thing to do, it is what the law requires of
14 them because they have that burden of proof. I expect the
15 Judge, at the conclusion of the case, may give you a lot
16 of good instructions on the law and please take the law as
17 he gives it to you which you have already agreed under
18 oath to do. He may talk to you at the end of the case
19 when he charges you on the law, after all the evidence is
20 in, about negligence. What is negligence in a medical
21 malpractice case. We have just gone over some of that, I
22 expect him to give you a charge on the law that sounds
23 pretty similar to what I have just gone over with you. It
24 is that which a reasonably prudent physician would do or
25 would not do given the circumstances in front of him.

1 That is standard of care. Hindsight, he may charge you
2 that hindsight is not to be used by you, the jurors, the
3 fact finders, the ones that are going to determine the
4 outcome of this case, the verdict in this case, based on
5 what hindsight might have revealed. No Monday morning
6 quarterbacking in this case. We all have, in all aspects
7 in our life, hindsight biased. The law says when you
8 judge Dr. Miller and what he did or didn't do, did he
9 comply with the standard of care or did he not comply with
10 the standard of care. What you know now, what we all know
11 now, in hindsight, is not how you apply that judgment. It
12 is based on what was in front of him at the time during
13 that 45 seconds to two minutes. He may charge you about
14 sympathy. Ladies and gentlemen, nobody is not going to
15 have sympathy for this child and her parents. That is not
16 even conscionable to suggest. Well the Judge may charge
17 you, however, at the conclusion of the case is, that
18 understandable reasonable compassion and sympathy and
19 feeling for anybody in this case should not be a part of
20 your decision in your deliberative process. We are not
21 going to ask you to set aside, that is, that is
22 impossible. What we are asking you is to follow the
23 Judge's instructions when he talks about sympathy. Thank
24 you. He may tell you that injury alone, evidence of
25 injury alone and there is injury here, we are not, we have

1 never denied that. But he may tell you that injury alone,
2 evidence of injury alone is not, cannot be the basis of
3 your determination, that there was negligence in this
4 case. That is not the law in South Carolina and the Judge
5 may tell you that. Let me talk to you about an emergency,
6 an obstetrical emergency. And the questions I want you to
7 ask as you go through this case and you listen to the
8 experts and you listen to Dr. Miller, the only eyewitness
9 who is going to testify about what happened in that
10 operating room when Alexia was delivered. The only
11 eyewitness that is going to tell you is Dr. Miller. Was
12 this an obstetrical emergency. Was Alexia in immediate
13 danger of serious bodily harm or death as a result of this
14 shoulder dystocia. Was it forceable, was it foreseeable,
15 was it predicable. And, yes, you will be asked to weigh
16 the testimony because it is not all going to be the same.
17 You are going to have some people saying this, some people
18 saying that, that happens in every case. When I was a
19 Deputy Solicitor in Greenville County many years ago, I
20 had the burden of proof, beyond a reasonable doubt. That
21 is a doubt for which you can give a reason, is what we
22 used to say in our criminal cases. It is not that way
23 anymore in a civil case, that is not the burden of proof
24 that we are talking about. But every case I have been a
25 prosecuting attorney on in a criminal case or in a civil

1 case such as this, there has always been an issue about
2 who you are going to believe. Because one witness is
3 going to say A; and another witness is going to say B.
4 And they are not going to be the same. So how do you
5 judge that. It is called credibility or believability and
6 you have to weigh the different testimony, the different
7 statements, the different facts, different evidence to the
8 extent it becomes important to you, who do you believe, if
9 that becomes important in this case. The Judge will
10 instruct you how to weigh credibility or believability.
11 Listen carefully to his instructions, I think it will be
12 helpful to you as you deliberate at the end of the trial.
13 I thank you for your time and your patience today.
14 Hopefully now we can maybe take a little short lunch break
15 and get this case started. Thank you for your patience.

16 THE COURT: All right, ladies and gentlemen, that
17 brings us to our lunch break and I thank you for your
18 patience. So the pizza is here. We will resume at ten
19 minutes to 2:00. Just remember, do not discuss the case
20 during your break. You can take a restroom break and
21 there will be pizza and drinks in there for everyone.

22 (Whereupon, the jury was excused from open court for
23 a lunch break.)

24 THE COURT: -- that leaves an hour and thirty-five
25 minutes for Dr. Duboe. Is that for cross and direct, is

1 that enough time?

2 MR. GRAHAM: Your Honor, I ask my staff to check on
3 flight. I haven't had a chance to see if she responded.

4 MR. DAVIS: I have looked at my outline for cross, I
5 really don't think it will take very long.

6 THE COURT: Let's cross our fingers. I have flown
7 out of Charlotte as I am sure y'all have a good number of
8 times. And I am very confident there will be multiple
9 flights to Chicago. I know that is frustrating. All
10 right. We will see everybody at 10 till.

11 (Whereupon, a lunch break was taken.)

12 (Whereupon, the jury came into open court at
13 approximately 2:02 p.m.)

14 MR. GRAHAM: Your Honor, one of these has been used
15 in opening.

16 THE COURT: Delivery note, okay.

17 MR. GRAHAM: And the other one is either the last
18 page of the heart monitor strips or close to the last that
19 says at the top, 45 seconds.

20 THE COURT: Any objection to the admission of those
21 documents, Mr. Davis?

22 MR. DAVIS: Not at all, sir.

23 THE COURT: Into evidence without objection. Mr.
24 Graham, you can call your first witness. The Plaintiff
25 calls Dr -- Oh, let me say for the record. I am going to

1 grant the motion to sequester witnesses. So those folks
2 who are in the room that are going to testify later in the
3 trial and are not part of this case, you need to wait
4 outside the courtroom. Mr. Graham.

5 MR. GRAHAM: The Plaintiff calls Dr. Fred Duboe to
6 the stand.

7 Dr. Fred Duboe, being
8 first duly sworn, testified as follows:

9 DIRECT EXAMINATION

10 By Mr. Graham:

11 Q Good afternoon.

12 A Good afternoon.

13 Q Dr. Duboe, you are a physician, licensed to practice
14 medicine, correct?

15 A Yes, I am.

16 Q Tell us about your speciality?

17 A Specialty for --

18 THE COURT: Dr. Duboe, for the record, if you will
19 give us your full name, please.

20 A Fred. J. Duboe.

21 Q And give us, you are an obstetrician, right?

22 A I am a OBGYN, yes, from Chicago area.

23 Q Please introduce yourself to the jury by telling
24 them, you know, about family and your professional
25 background, education background, that sort of thing.

1 A Sure. I have been in practice in the Chicago area,
2 an area called Hoffman Estates in the North West suburbs,
3 about 35 minutes from downtown Chicago. Since July 15th,
4 1984, about 37 and a half years or so now, I trained, I
5 initially received my biomedical sciences undergrad degree
6 at Brown University in Providence, Rhode Island. Moved on
7 to my home state, University of Illinois for medical
8 school in Chicago. And then after four years of medical
9 school in Chicago at U of I, then moved onto Northwestern
10 University, Northwestern Medical School, what is known as
11 Printice Women's Hospital, Maternity Center which is one
12 of the largest maternity centers in Chicago affiliated
13 with Northwestern. And right after residency, July of '84
14 I went right into private practice in the Northwest
15 suburbs where I still am. At the same hospital though, it
16 has changed names and ownership. Still the same place.
17 We have a group practice and OBGYN. At any given time we
18 may be doing 50 percent OB, 50 percent GYN or sometimes
19 60/40 or 40/60, depending on the weather in Chicago over
20 the winter and the birth rates. So along those lines, I
21 still work with four other partners and the nurse midwife
22 in our present group set up. I serve as the Chairman of
23 the Prenatal Advisory Morbidity, Mortality Committees at my
24 hospital, St. Alexis, St. Alexis is the official name.
25 And I also serve as Vice-Chairman of the Department of

1 OBGYN at my main hospital as well. We do some of our
2 work, about ten percent at another center known as
3 Advocate Lutheran General Hospital. Both of these are now
4 sites for training programs for residents and at Lutheran
5 General, also we have rotating medical students from
6 Rosalind Franklin Medical School, Chicago Medical School.
7 So that is part of what we do. That's it, kind of in a
8 nutshell. We take care of moms who are trying to get
9 pregnant, who are pregnant, who are or have delivered. We
10 take care of, obviously, deliver a lot of babies. When
11 those moms are no longer pregnant, they are past the
12 post-partum period we do gynecologic care. So this may be
13 well woman's exams, pap smears, problems regarding pelvic
14 pain, abnormal uterine bleeding, endometriosis, pelvic
15 inflammatory disease, pelvic infections, simple vaginal
16 infections. All kind of things that would beset women.
17 And then when folks are pregnant again we take care of
18 them again through their pregnancy, move them through
19 pregnancy. And there are those who are having trouble
20 getting pregnant who we will see for care and helping them
21 to get pregnant if they have basic infertility issues. So
22 I think that covers the gamut pretty much.

23 Q Thank you, sir. You mentioned the word, perinatal.
24 Tell us what that means.

25 A Well, perinatal is at or around the time of

1 pregnancy. That is what perinatal generally means.
2 Antenatal before pregnancy, postnatal after pregnancy.
3 During the general time of the pregnancy.

4 Q The labor and delivery part of the pregnancy?

5 A Perinatal can also be interpreted in labor and
6 delivery. It covers that time period as well. So time
7 during pregnancy, time during labor and delivery.

8 Q Let me jump to the main point. At my request, have
9 you reviewed the medical records in this case and done
10 other research; at my request to see what your opinions
11 and conclusions are about whether Dr. Miller complied with
12 the applicable rules or the lost standard of care in this
13 case?

14 A Yes, I did review the medical records in an effort to
15 make those, make whatever conclusions I was asked to come
16 up with. Whether he did or did not, whether there were
17 issues regarding the standard of care involving, in this
18 case, under these circumstances or not. That is what I
19 was asked to do and that's what I did.

20 Q And in my last question, I refer to standard of care,
21 law, rules. May we have an agreement that when I ask you
22 about law, that your answer will be, your answer about law
23 will represent an answer about generally accepted
24 standards of care of obstetricians under similar
25 circumstances.

1 A Yes, that's fine.

2 Q So you have concluded that Dr. Miller broke the law?

3 MR. DAVIS: Objection to leading, this is his expert.

4 THE COURT: I am going to sustain the objection.

5 Q Doctor, tell us what conclusion you have reached
6 about whether or not Dr. Miller conformed to the law or
7 broke the law?

8 A In terms of the management of this particular
9 delivery, I felt that he was beneath the standard of care
10 in the way which the delivery ultimately was accomplished
11 through the exertion of too much traction on the left arm
12 of patient.

13 Q (Inaudible), minimize medical jargon.

14 A Yes.

15 Q What is traction?

16 A Traction is pulling. Traction essentially is a
17 pulling force.

18 Q And with what effect does traction compress, does
19 traction stretch. What kind of effect does traction have
20 on a given object?

21 A Well, there are a couple of forces that work.
22 Traction being a pulling force. Normally when we are
23 delivering a baby we provide gentle axial traction, means
24 in line or parallel to the cervical thoracic spine with a
25 baby so the neck isn't bent downwards, has prevention

1 stretching the brachial plexus is what you want to try to
2 avoid. But it is okay to apply some gentle downward
3 pressure as long as it is within a plain event, cervical
4 sporosac spinal in 45 degrees. That is usually what we
5 are applying and most people would apply between zero and
6 12 pounds gradually. That is what at least the studies
7 show. Some may apply two, some may apply 12 or even 13
8 but that is not going to cause a problem. You are gently
9 applying traction to allow that anterior shoulder to slip
10 below the bone called the pubic symphysis, thick pubic
11 bone. It is strong. If the shoulder should come down, as
12 opposed to the oblique plain which, I believe was referred
13 to today, oblique plane being somewhat diagonal which
14 affords more room, the baby to pass underneath that bone.
15 If those shoulders should orient this way, exactly at a
16 right angle to the bone then it takes, this shoulder is
17 not simply going to slide underneath if it is impacted.
18 If it is this way it can take very little traction, gentle
19 traction to bring that baby down. Fortunately that's what
20 we face most of the time. In that 0.5 to 2 percent, the
21 current rates of shoulder dystocia are noted we have to
22 know how to deal with that obstetrical complication when
23 the shoulders are in this way and the baby doesn't come
24 down with gentle traction beneath the pubis. So that is
25 where we go to other maneuvers that both attorneys have

1 talked about today. So traction, essentially is the force
2 that is placed on the baby to deliver gently underneath
3 that anter-shoulder, underneath the symphysis. And once
4 that delivers and we see or feel it, visualize it we can
5 gently lift up and deliver the posterior arm and then the
6 baby comes out. In a shoulder dystocia other maneuvers
7 need to be done, you can't just keep pulling or you are
8 going to cause an issue with brachial plexus especially if
9 the neck is bent downward. When I say that it is right
10 ear to the right shoulder or left ear to the left shoulder
11 of the baby. And in this particular case, based on what I
12 have read, the records that I have reviewed, the severity
13 of the injury including nerve ruptures at C5, C6 and
14 again, avulsions or tearing those nervelets out of the
15 spinal cord at C7 and C8 which is essentially, and some
16 damage to T1 which was temporarily which later cleared up;
17 that is the first thoracic nerve. That constitutes the
18 definition of that entire set of nerves which is known as
19 the brachial plexus from C5 to T1. So in this case, what
20 I felt at the second part of the delivery that there was
21 excessive traction placed on Alexia's left brachial plexus
22 in an effort to deliver towards the second part of that
23 delivery. Initially it was recognized that McRoberts was
24 attempted, suprapubic pressure was attempted and a
25 episiotomy was, to gain additional room to try to do a

1 posterior delivery of the arm, the posterior arm. The
2 baby oriented at what is called LOP or left occiput
3 posterior. I think there is an exhibit up there that you
4 might have.

5 Q Can you come down.

6 THE COURT: You can step down, Doctor.

7 Q And before you do anything, what is the source of the
8 demonstration you are about to make.

9 A The source of the demonstration I am going to make.

10 Q Was it from reading depositions, looking at the
11 medical records. This is, with a thousand babies
12 identified. (Inaudible.) (Witness moved away from
13 microphone)-- is 37 years of questions. So that is the
14 basis -- And that is part of it. Right now are you
15 getting ready to demonstrate all the different positions
16 or the positions in this particular case.

17 A Yes.

18 Q In that sense what was your source of information
19 about the various positions of the baby in this case?

20 A The medical records, charts.

21 Q And is that the same charting that Mr. Davis showed
22 to the jury earlier, the hard to read parts as well as the
23 --

24 A (Inaudible.)

25 MR. GRAHAM: Mr. Davis, may we borrow the transcribed

1 one? Bear with me one second.

2 Q This is the part I was going to expand on. The
3 decision was made for a while, pushing at LOP or close to
4 it. This is the occiput. You folks, (inaudible), in this
5 direction, (inaudible).

6 (Witness has stepped down from the witness stand and
7 the audio is not clear at times.)

8 A This is, posterior would be the -- probably about
9 4:00 or thereabouts. This would be the right, my right.
10 So this would be presented, but in this case with the
11 right shoulder, (inaudible), at that point if the right
12 shoulder is not delivering and understand that since the
13 -- my fingers, it is stuck in this area. We can do some
14 things, (inaudible), move the legs and spread them out,
15 gives you a couple of more centimeters to work with. Top
16 shoulder in this case, right shoulder not delivering, not
17 slipping, need to, something to help baby come out,
18 abducting mom's leg, corrects some of the flatting, gives
19 you this much pressure on bone, trapped underneath. I
20 also mentioned in this case Dr. Miller could not,
21 posterior shoulder, making an effort to go in with the --
22 extended and try to do and slide in. In this case it
23 would be the left hand on the arm, out vaginally, drop
24 down. It did not work in this case. So therefore was a
25 ROA, and an ROA is this. You go all the way to this,

1 (inaudible). So that is done in this case is pressure was
2 placed LOP presentation, to help the baby this way, in
3 this position. And then, states the left shoulder using
4 McRoberts. The same types of, (inaudible), in that
5 reapplying those maneuvers, that even though had rotate
6 with it, the presentation to a ROA presentation. It still
7 hasn't dislodged. Normally when you rotate the baby, it
8 is like a corkscrew and there is, the baby rotates and
9 descends down a little bit. Apparently that didn't happen
10 and going to a --

11 Q What is going to be a curve?

12 A (Inaudible), you have to go to 180 degrees and it
13 hasn't resolved and that is when they went to this
14 shoulder and the pressure, called moderate, (inaudible).

15 Q Now, in your career, both in clinical practice and in
16 administrative work where you are reviewing the work of
17 other doctors, how do you interpret that note?

18 A Well, again, moderate effort of everything he did.
19 Moderate effort or something to that nature. I usually, I
20 interpret a moderate effort.

21 Q In addition, (inaudible), starting a C-section and
22 changed his mind.

23 (Attorney asking questions away from the microphone.)

24 THE COURT: Doctor, the Court Reporter is saying she
25 is struggling to record what you are saying. So I think

1 we will use one of the portable microphones there.

2 A Sure.

3 Q So there is a description, actually delivered the
4 baby, it is anterior left shoulder using McRoberts
5 suprapubic pressure. So --

6 MR. DAVIS: Your Honor, I object to, that was a
7 statement. That wasn't a question. And so I object to
8 that question.

9 THE COURT: I am going to sustain the objection.

10 MR. GRAHAM: Did you sustain it?

11 THE COURT: What was the question?

12 MR. GRAHAM: I read the note that has already been
13 read in opening. And then I said, they reversed moderate
14 effort. I can read this.

15 THE COURT: Okay, that would be great.

16 MR. GRAHAM: The sentence here, admits she is in
17 moderate effort.

18 A Yes.

19 Q We know from depositions that support that Dr. Miller
20 claims that moderate effort is repeating, here, that we
21 know that, said moderate effort with maneuvers.

22 A In my dealings for all these years in advisory,
23 reading delivery notes. That is what I would conclude,
24 yes.

25 Q And it is, in opening statement Mr. Davis said --

1 MR. DAVIS: Your Honor, I am going to object to a
2 question referencing opening statement.

3 THE COURT: I am going to sustain the objection.

4 Q References being made to the top left shoulder,
5 delivery using McRoberts suprapubic and moderate effort?

6 A Right.

7 Q Given that scenario, McRoberts suprapubic and
8 moderate effort, tell us whether or not there was
9 traction?

10 A There was traction because you are not going to
11 perform McRoberts suprapubic pressure without an element
12 of traction there, this shoulder was still impacted now
13 being the anterior shoulder. The shoulder hadn't released
14 before that time.

15 Q Some of there, do not (inaudible).

16 A Yes.

17 Q Which one?

18 A McRoberts maneuver does not alone involve traction.
19 That is just positioning and suprapubic pressure is
20 normally combined with traction but can be, can be applied
21 before you are asserting your traction. Ultimately you
22 are going to check the waters or test the waters by
23 applying gentle traction to see if your maneuver has been
24 successful in releasing that top shoulder.

25 Q If the maneuvers before McRoberts suprapubic moderate

1 effort, had been successful in releasing that shoulder,
2 would there be any, tell us whether or not there would be
3 any need for McRoberts suprapubic pressure?

4 A No, there wouldn't have been additional need for the
5 moderate effort and for additional traction. If the
6 shoulder is released then you proceed to bring the baby
7 down or not.

8 Q So in this context, I know you said that McRoberts,
9 might not involve traction. In this context, after these
10 other maneuvers, tell us whether or not traction was
11 involved to deliver this baby?

12 A Traction was involved to deliver the baby once the
13 left shoulder, otherwise was, now anterior would not
14 release with the rotation maneuvers.

15 Q Can you show us, go through these particular
16 maneuvers, show us. With maneuvers on the baby, show us
17 the maneuvers that were described here or just towards the
18 end.

19 A Well, again, the attempt of the woodscrew maneuver by
20 putting pressure on the inner aspect of one shoulder and
21 pressure on the back and trying to corkscrew the baby that
22 normally that comes with some descent underneath. This
23 didn't happen, the baby just went 180 degrees and
24 otherwise didn't release. At this point the left shoulder
25 became trapped in what is known as ROA positioning. Then

1 additional suprapubic pressure and Roberts and moderate
2 effort traction needed to be done to now deliver the left,
3 that was also trapped underneath. So that is that
4 rotation that ultimately the baby was brought down with
5 traction. It is my opinion that was always some element,
6 excessive traction, bending the neck away from that to
7 cause this severe injury involving the nerve (inaudible).
8 That is part of the basis for my opinion, is the dictation
9 as well as the nature of the severity and permanency,
10 (inaudible).

11 Q Are you expressing your opinion to a reasonably
12 degree of medical certainty?

13 A Yes. All my opinions are meant to be given to a
14 reasonably degree of medical certainty.

15 Q And the ones that, (inaudible).

16 A Yes, sir.

17 Q Now, before we go on, let me take a moment. Earlier
18 I asked you a number of questions about your professional
19 background. To do properly, officially as an expert
20 witness entitled to give opinions.

21 MR. GRAHAM: So we would do that at this time.

22 THE COURT: Any objection, Mr. Davis?

23 MR. DAVIS: No, sir.

24 THE COURT: Okay. Ladies and gentlemen, this witness
25 has been qualified as an expert. What that means is, that

1 normally witnesses are only allowed to testify about what
2 they saw, what they heard, what they smelled, things like
3 that. Expert witnesses are allowed to give their opinion
4 testimony. That is the difference. The fact that a
5 witness is qualified as an expert does not mean you need
6 to believe them. You should evaluate their testimony like
7 you would with any other witness.

8 Q Doctor, as part of an obstetrician's training, is the
9 obstetrician required or at least strongly recommended to
10 indicate the amount of traction that is used to deliver
11 the baby?

12 A In terms of?

13 Q In terms of, you know, gentle?

14 A Yes. I thought you were asking for like a
15 quantitation of numbers. Yes. Generally, again, our
16 standard of what we are trained to do is to provide no
17 more than gentle axial or gentle downward traction.
18 Again, within a 45 degree angle of where the baby's
19 cervical thoracic spine is and no deeper than that because
20 that causes excessive bending of the brachial plexus or
21 stretching of the brachial plexus. If it stretches hard
22 enough, beyond the plastic limits of that nerve, it can
23 snap. That is what happened here.

24 Q Given what you just told us about obstetricians and
25 their training, strongly recommend to list the general

1 characteristic of the amount of vacuum, what does that
2 tell you about placement of the word, and moderate effort?

3 A Well, moderate effort to me, certainly indicates that
4 it is more than just gentle traction.

5 Q If moderate effort had meant what we hear Dr. Miller
6 claims it was, would there be any referencing here to the
7 amount of traction?

8 A Not that I can see.

9 Q You talked about wood corkscrew earlier?

10 A Yes, I did.

11 Q And that was referred to in the delivery note?

12 A Yes.

13 Q All right. Would this document here be helpful to
14 you in terms of being able to explain what a woodscrew
15 maneuver is and how, and the result it should have if,
16 (inaudible).

17 A That is what I tried to indicate.

18 Q Would you mind just standing down.

19 A What this diagram should depict is examiner's left
20 two fingers being applied to the anterior aspect of the
21 baby's left shoulder.

22 Q The front --

23 A Yes, the front, thank you. This as opposed to this.
24 So this being done, showing that this is going in a
25 counterclockwise motion, baby moving in this direction.

1 That shoulder is still trapped underneath the symphysis
2 pubis but as that rotation continues and now the left
3 shoulder formulary, the down shoulder now becomes at 180
4 degrees, the up shoulder. Then that is when the shoulder
5 begins to emerge and come out from beneath that symphysis
6 pubis. That is what this is indicating with that
7 corkscrew motion where the baby can simply dislodge and
8 come out.

9 Q So if Alexia had been delivered correctly, with the
10 woods corkscrew maneuver would she have just come on out
11 after the woodscrew maneuver?

12 A Well, you would have felt or seen the anterior
13 shoulder dislodge underneath the symphysis pubis and then
14 you can go ahead and apply your gentle traction and
15 deliver the rest of the baby. The baby doesn't come
16 flying out. You still need to apply some gentle traction
17 to bring the baby out, once that shoulder dislodged. The
18 problem with dystocia you have got the impaction there so
19 that pressure you are putting on the brachial plexus when
20 it is trapped is, something you have to be cognizance of.
21 Once the shoulder has already passed the symphysis pubis
22 there is no resistance or very little resistance, just
23 soft tissue which is a big difference from a thick pubic
24 bone. That is the difference.

25 Q If woodscrew had been used correctly to deliver

1 Alexia, would there have been any further effort like
2 McRoberts suprapubic and moderate effort or traction.

3 A Well, if the woodscrew maneuver were successful it
4 would have likely delivered that now anterior shoulder
5 without the need for further maneuvers. I don't think I
6 was critical that the woodscrew is done incorrectly but it
7 wasn't successful which then forced them to move on to
8 additional maneuvers such as McRoberts, more suprapubic
9 pressure. And I think that is when the injury occurred
10 with that second set of point.

11 Q Just to follow up, when you say it was not
12 successful?

13 A Right.

14 Q Tell us whether or not a successful cork screw would
15 be in the direction of a cork screw pulling the cork down?

16 A It would and rotation maneuvers are known to exert
17 much, much, much less force on a baby or certainly the
18 brachial plexus than simply pulling downward. If you are
19 doing this correctly you shouldn't permanently injure the
20 brachial plexus based on rotational maneuvers. And there
21 is a lot of literature to support that.

22 Q And if you are doing woods maneuver correctly, I am
23 just confused how you can go from having right shoulder
24 behind the pubic bone and then after the woodscrew have
25 the left one behind the pubic bone?

1 A Normally the baby should descend when the baby is
2 being screwed out. In this case the baby didn't descent,
3 you know, it was not successful and perhaps it was, a
4 little bit of that additional light downward traction at
5 the same time this rotation was going on.

6 Q Would it be fair, would it be fair to characterize
7 the type of movement that occurred in this case as more of
8 a steering wheel as opposed to a cork screw?

9 A Yes, I think that is a good analogy that essentially
10 you are saying rotation without descent as opposed to cork
11 screw showing rotation with descent.

12 Q And is the steering wheel be correct to --

13 A No. The concept isn't to just make the left shoulder
14 the right or the left, or the right to the left. The
15 issue is to move the baby to a more oblique plane to give
16 you more room for that shoulder to slip underneath the
17 symphysis pubis. That is the whole concept involved. I
18 mentioned Rubins maneuver before Counsel did. Rubins
19 maneuver is pushing the shoulder in toward the chest to
20 reduce that, what is called the bisacromial which all it
21 is a fancy word for shoulder diameter. If you can reduce
22 that by a centimeter too, that also affords the baby the
23 capability of moving down beneath that symphysis pubis
24 when the shoulder is trapped, usually the top shoulder.

25 Q Thank you. Did you have any more comments you wanted

1 to make about Dr. Miller breaking the law and not
2 conforming to the standards.

3 MR. DAVIS: Your Honor, I am going to object to the
4 continual reference of breaking the law. That is not the
5 proper --

6 THE COURT: I am going to sustain the objection.
7 Refer to the standard of care, please.

8 MR. GRAHAM: Yes, sir. Would it be permissible, Your
9 Honor, instead of equating standard of care to the law, to
10 equate to rules that would be --

11 MR. DAVIS: Your Honor, I would object to that as
12 well. We are talking about standard of care, there is no
13 rules, it is not law. This is standard of care.

14 THE COURT: I will allow it and phrase that way.

15 Q So, is there anything else you wanted to tell us
16 about --

17 A Just in the medical records, 45 seconds of continued
18 suprapubic pressure indicated by, that was one of the
19 basis for my opinion, to continue for pressure going on
20 during all this entire time. So I was concerned that long
21 of period of excessive traction.

22 Q And, Doctor, by stipulation, this is page 229 of the
23 fetal heart monitor strips. And we have highlighted, we
24 have highlighted what is the computer annotation at the
25 top, correct.

1 A Yes, I can see that. Can I come closer.

2 THE COURT: As long as you speak in one of the
3 microphones.

4 A Okay. And you were asking, sir?

5 Q You mentioned 45 seconds of suprapubic, is this the
6 page where that is documented?

7 A Yes, annotation comment shows suprapubic pressure of
8 45 seconds, then shoulders delivered.

9 Q Highlight here to make it easier for me to read?

10 A It certainly is. And if I had any brains I would
11 have seen that on the bottom but I was too busy looking up
12 top so I am sorry.

13 Q Why is the 45 seconds important?

14 A Because it shows there is additional effort required
15 or additional effort to put forth, that is a lot of time
16 to be applying suprapubic pressure for a shoulder that
17 was, suppose to have released before that time. And it
18 shows, again, ongoing suprapubic pressure means there is
19 some traction throughout that period of time as well. It
20 is a long time under these circumstances.

21 Q Speaking of time. Let me ask, there has been
22 referenced to a window of time to safely release the
23 shoulder and keep the baby safe in all respects. How much
24 time, what is your conclusion about how much time is
25 allowed before there is any, any immediate risk of damage

1 to the baby related to the brain or something like that?

2 A In most cases, assuming the baby is looking fine in
3 the minutes proceeding delivery and that was the case here
4 with the heart returned reassuring when the C-section was
5 canceled. And I am fine with that decision, I don't have
6 a criticism with that decision, I agree with that. Then
7 you have got to five to six minutes to work with, before
8 you get concerned about potential cork compression and
9 fetal asphyxia. Some people may stretch that out seven or
10 eight minutes. But I would never to be critical of
11 anybody. I get concerned in five to six minutes and I
12 think most doctors do in a proceeding showing, what we
13 call variability and normal heart rate that proceeds the
14 actual delivery here.

15 Q If an obstetrician were to use excessive traction on
16 the baby's head and then the baby's neck, in a rough,
17 aggressive, forceful way, after five or six minutes would
18 you support a case like that if I brought it to you?

19 A Yes, because it is certainly better to have a
20 brachial plexus injury than brain damage. One is much
21 worse than the other. So I would be defending that type
22 of case and I have been asked to in a case like that and I
23 would agree and support that type of case.

24 Q You would defend the doctor in that kind of case
25 saying that he complied with the rules?

1 A Yes. If the doctor went through every maneuver,
2 nothing was working, went through every maneuver again and
3 nothing was working and the time getting toward that is
4 five to six minutes then you get the baby out by whatever
5 means you have to. And in that case, yes, I would defend
6 that type of a situation, I would defend that doctor.

7 Q After 45 seconds or two minutes, whatever it was,
8 between delivery of the head and delivery of the body,
9 what would you have the doctor do to comply with the rules
10 given all of these things he says he had already done?

11 A Well, again, you avoid excessive traction in any
12 event if you are talking about between 45 second and two
13 minutes. You go through maneuvers once again. You,
14 perhaps try a reverse wood corkscrew, go the other
15 direction if the first one hasn't been successful. Now
16 you can try perhaps to deliver the posterior arm which is
17 formerly the left arm and now is the right arm. That is
18 another maneuver that you could, you try, you have another
19 three minutes to work with before you start to worry
20 about; asphyxia, minimally. So you go through all of
21 those maneuvers and you perform them in the way you were
22 trained to do and until it works. And after that and the
23 five minutes are up and then you go to more desperation
24 types of maneuvers if need be.

25 Q I am guessing if I or a taxi driver or anybody else

1 who is not an obstetrician was in a position where you had
2 to deliver a baby, would you consider that a genuine
3 emergency?

4 A In a situation where a cab driver is delivery a baby
5 --

6 Q Shoulder dystocia, cab driver, shoulder dystocia?

7 A Sure. That would be an emergency because you have an
8 untrained person in that type of situation trying to
9 deliver the baby.

10 Q Do you make a distinction between a genuine emergency
11 of someone who does not receive obstetric training to
12 manage a shoulder dystocia and an obstetrician who is
13 trained to manage a shoulder dystocia?

14 A Again, I think I do make that distinction
15 recognition. Shoulder dystocia is considered an emergency
16 but it becomes certainly much more obstetrically emergent
17 after five minutes go by. It is very much a complication
18 of labor and delivery and it certainly has occurred to all
19 of us who have been out there long enough and delivered
20 enough babies. But it is different than the general
21 emergency. For someone in good hands, you know, it is
22 going to be someone who is well trained, it could be
23 successful in tracting the problem if you have been
24 trained to do so. And trained to do so without trauma to
25 the baby and that is what we are trained to do.

1 Q Tell us whether or not your opinion is that after the
2 head delivers and the shoulder is stuck, the beginning of
3 that five or six minutes is a lower degree, if you will,
4 of emergency than at four, five or six minutes.

5 A Yes. I would say that is completely true. You start
6 to get more severely concerned about the emergent nature
7 after five minutes passes from the time of recognition of
8 the shoulder dystocia. First one or two or three minutes
9 are not as emergent.

10 Q If there was, if there was a cardiologist or an
11 anesthesiologist in the hospital, in the delivery room who
12 had to take over a shoulder dystocia delivery because for
13 whatever reason an obstetrician is not there, would you be
14 critical of a non-obstetrician causing a brachial plexus
15 injury in the very beginning?

16 A No, because they hadn't been trained to manage this
17 type of problem, not an anesthesiologist, that's for sure.

18 Q Okay. Five minutes to me, I will confess, sounds
19 like a short period of time. Is it, is five minutes of
20 shoulder dystocia the same five minutes for an
21 obstetrician as it would be for anyone else?

22 MR. DAVIS: Objection to the form of the question,
23 Your Honor.

24 THE COURT: I will let the witness answer it if he
25 can.

1 MR. DAVIS: Thank you, Your Honor.

2 Q Does that make sense?

3 A Can you rephrase it?

4 Q Let me rephrase it by making an analogy. And, again,
5 anybody who is not a sports fan I apologize. But I have
6 heard that when a young quarterback gets drafted to the
7 NFL, it is tough on them. They have got all of these big
8 athletes coming at them and they get sacked and injured
9 and all of that stuff. And they have a hard time where to
10 throw the pass to. But then after some experience time
11 slows down for them and they can stay calm and do what you
12 would want your quarterback to do. In that sense do you
13 believe that time slows down for obstetricians with
14 experience after, when a shoulder dystocia presents?

15 A Yes. Because the experience has been gained and they
16 understand what to do, they go through their training and
17 protocol.

18 Q Okay. To a layman, a lay person who is not an
19 obstetrician and who has never dealt with the challenge of
20 resolving a shoulder dystocia, can you give us a sense of
21 how much stress or high anxiety you might feel in the
22 first two minutes as opposed to four or five or six
23 minutes?

24 A Well, a lot of studies do show that maneuvers are
25 done differently and with more force the later the

1 shoulder dystocia goes on and that's even with some
2 experienced obstetricians. So your level of anxiety at
3 one or two minutes is no where near what it is at five
4 minutes. And using censors as gloves and experienced
5 obstetricians there have been literature that states that
6 the longer the shoulder dystocia is ongoing the more force
7 tends to be used even by an experienced obstetrician in
8 that type of situation. So the adrenal and sometimes the
9 anxiety are going along with it can be an issue. But for
10 the first couple of minutes, for those who are
11 experiencing it, it shouldn't be. You have your training,
12 you know what you have gone through, you know what has
13 worked for you in the past and you are okay with that, you
14 are comfortable with that. But five minutes down the
15 line, a different set of circumstances can evolve but it
16 shouldn't be like that at 45 seconds or two minutes,
17 that's for sure.

18 Q We have heard from the Defense something about sacral
19 promontory. Can you please tell us what that is?

20 A The sacral promontory is a little bony ridge or
21 prominence covered by soft tissue in the midline just
22 above the first, second, third, fourth sacral vertebrae.
23 So it is just a little bony ridge and it is about, just
24 below where your iliac crest would be, iliac crest meaning
25 the hip bones, just a little bit down from there, a few

1 centimeters down from there in most people. That is the
2 sacral promontory, that's that little ridge of tissue that
3 is a bony landmark. It is not a thick bone as it is the
4 symphysis pubis. It is a relative ridge of bone
5 underneath a bit of soft tissue, usually not a major
6 stumbling block or something that would prevent proper
7 descent of the baby in most cases.

8 Q In terms of a potential obstruction through the birth
9 canal, how does the sacral promontory compare with the
10 pelvic bone?

11 A Well, it is, the pubic bone. It is not even close.
12 I mean, the head is still in the vagina at the time, when
13 a shoulder is reversing the sacral promontory, the head is
14 still inside. When you are talking about the pubic bone,
15 you are talking about a thick strong bone as opposed to
16 this tiny little bony ridge covered by soft tissue. I
17 mean, this is a total different encounter, a total
18 different obstruction and that is why shoulder dystocias
19 generally have to do with the anterior shoulders, not
20 traversing that pubic bone unless they can be turned to
21 one side or the other and approach an oblique plane from a
22 right angle, perpendicular plane. So big difference.

23 Q Which is more likely to cause a significant
24 obstruction?

25 A Well, the pubic bone is the one more likely to cause

1 obstruction. Normally a shoulder posteriorly will pass
2 over the sacral promontory. You might get a bit of
3 stretch but you are not going to get multiple nerve
4 ruptures as you might when someone tries to pull a baby
5 down with excessive traction when that anterior shoulder
6 is impacted behind a very thick and strong pubic bone.
7 There is a difference.

8 Q Let me ask you, I really don't want to get bogged
9 down with medical literature but I know there will be some
10 coming. So let me ask you a few things. How has, has it
11 been in recent years or decades to try to teach
12 obstetricians and obstetrical residents how to deliver
13 gently to avoid damage from force on a shoulder dystocia
14 situation.

15 A Yes. We are required, in not only my hospital but
16 everywhere in the Chicago area for instance. Has to do a
17 training course, a simulation course every two years to be
18 credentials in most of the hospitals. It is certainly
19 true in both hospitals I work in. Even though we have
20 been doing this for years, we deliver seven, eight, nine,
21 ten thousand babies, we still go through this type of
22 training. So simulations in training are ongoing for
23 those who want it, still be credentialed, then having
24 privileges at their hospital, this is required of us.

25 Q It is a requirement?

1 A Again, I am not saying this way in every hospital
2 across the country, I am saying where I come from and
3 where we work this is done and there have been National
4 increases in this requirement over the course of the last
5 decade. So training sessions to go over the maneuvers and
6 to reduce the chance of fetal arm, reduce the chance of
7 morbidity, mortality are the purpose of these types of
8 programs. And they usually involve with other societies
9 that recommend them such as the Joint Accreditation of
10 Association of Hospitals.

11 Q I want to ask you if you consider a certain article
12 to be reasonably reliable. This was published in 2015 by
13 the Royal College of Obstetricians and Gynecologist. Is
14 that in England, publication?

15 A Yes.

16 Q How does this, how does the obstetrical community in
17 this Country view the Royal College of Obstetricians and
18 Gynecologist and their publication.

19 A How does it view it?

20 Q Yes, sir.

21 A Well, we read their literature and it is considered
22 peer review literature so it is respected. I don't have
23 any dealings myself with the Royal College. But being
24 Board Certified by the American Board of Obstetrics and
25 Gynecology since 1987 or so, that is something that we

1 would pay attention to and often come into contact with
2 their articles. We have to do annual recertification
3 every year and these articles may come up with what we
4 have to read and be tested upon. Is that the --

5 Q I am holding an article that is entitled, Prevention
6 of Brachial plexus Injury. Twelve Years of Shoulder
7 Dystocia Training and Interrupted Time Series Study.
8 There are several authors listed. The lead author is J.F.
9 Crofts, C-R-O-F-T-S; do you consider or are you familiar
10 with it?

11 A I am, yes.

12 Q Do you consider this article to be reliable?

13 A Yes.

14 Q I want to read you some of this and ask you if you
15 agree with it.

16 MR. DAVIS: Your Honor, we need to take something up
17 outside the presence of the jury.

18 THE COURT: Ladies and gentlemen, I have a legal
19 issue to discuss with the lawyers. So I will ask you to
20 step back to the jury room, if you have not already done
21 so now would be a great time to elect your Foreperson.

22 (Whereupon, the jury was excused from open court for
23 a break.)

24 THE COURT: All right.

25 MR. DAVIS: Your Honor, he has not established,

1 according to our exception to hearsay under learned
2 tristesse, he has not qualified and laid the proper
3 foundation to now use any medical literature in
4 examination of this witness. All he asked was, are you
5 familiar with it. Yes. Do you think it is reliable.
6 Yes. Now he wants to quote from it. As I read the
7 exception to the hearsay rule, I think it is paragraph 18
8 to the hearsay rule. It indicates that the expert witness
9 must also agree that a particular article is not only
10 reliable but authoritative. In the deposition of Dr.
11 Duboe, which I took on March 15, 2021, at page 23; line 6
12 and following. I ask him, do you consider any particular
13 medical literature, Williams Obstetrics or Gabby or ACOG;
14 or any particular medical literature, both reliable and
15 authoritative in your opinion. And his response on line
16 ten was, to me authoritative means everything in it is
17 absolutely true and correct. So I don't consider a single
18 source of medical literature authoritative. He has never,
19 I have never been notified to this moment that he has had
20 any change in his opinion. So I object to this line of
21 questions. He is not qualified and he has already
22 testified under oath at his deposition in March of 2021
23 that he doesn't consider anything authoritative. Now he
24 is being asked to, vouch for something and he still hasn't
25 even been asked if it is authoritative. So I object to

1 this line of questioning.

2 THE COURT: I always try to look at the Rules. I
3 pulled up Rule 803(18) says it has to be reliable
4 authority. Doesn't use the word, authoritative. So we
5 will just a quick proffer, Mr. Graham. If you want to ask
6 the question.

7 MR. GRAHAM: Thank you, Your Honor.

8 THE COURT: You want to check with the jury to see if
9 they are rest-rooming or electing their Foreperson. We
10 can take a short break in here as well. Tell the jury, we
11 will be on break to 3:16.

12 (Whereupon, a short break was taken.)

13 THE COURT: Let's bring the jury, please.

14 (Whereupon, the jury came into open court at
15 approximately 3:16.)

16 THE COURT: You can resume direct examination.

17 MR. GRAHAM: Thank you, Your Honor.

18 DIRECT EXAMINATION

19 By Mr. Graham:

20 Q Right before the break, Doctor, I had asked you a
21 question about an article by Dr. Crofts. I want to phrase
22 that question a little bit differently. Do you consider
23 this article that we talked about earlier to be a reliable
24 authority in your field?

25 A Yes, not authoritative per say, but reliable

1 authority.

2 Q Is it your understanding that this article was based
3 on 12 years of training at the particular hospital?

4 A Yes, that is my understanding.

5 Q Let me ask you if you agree with this sentence. That
6 none of 17,039 babies in the last cohort suffered
7 permanent brachial plexus injury challenges. Let me start
8 over. That none of the 17,039 babies in the last cohort
9 suffered permanent BPI challenges commonly held view that
10 permanent is largely unavoidable. Permanent brachial
11 plexus injuries must no longer be viewed as inevitable of
12 complication of shoulder dystocia. Do you agree with
13 that?

14 A I do. Basically in this article show that the
15 training essentially minimized the risk of permanent
16 brachial plexus injury out that huge number of patients to
17 virtually zero after training programs have been
18 instituted. If there was an ongoing brachial plexus
19 injury permanency rate, just ongoing unavoidably, one
20 would expect that that would be consistent despite the
21 training programs. And this shows it does make a
22 difference.

23 Q And tell us whether or not the training programs that
24 emphasize gentle guidance or gentle traction are far more
25 successful than other training programs that priorities

1 McRoberts or something like that?

2 A Gentle traction is emphasized and the usage of
3 rotational maneuvers as opposed to pulling are, is
4 emphasized in all of those training sessions. And that is
5 what is emphasized in our training sessions and our
6 practice sessions and our simulation sessions nowadays as
7 well.

8 Q What is a retrospective obstetrical study leading to
9 a article publication?

10 A As I understand it is looking backwards at a given
11 scientific technique, looking at results and analyzing
12 them in hindsight.

13 Q Are you aware of any literature on the topic of
14 shoulder dystocia that is a prospective study. In other
15 words, instead of looking back at doctors records who you
16 don't know and you don't know how truthful they are,
17 actually watching deliveries in realtime.

18 A There is a prospective study that I do know of that
19 involved over 36,000 patients that has been out for some
20 number of years now. That is the Mollberg study, I
21 believe.

22 Q How do you compare the reliability of a prospective
23 study as opposed to a retrospective study?

24 A Well, again, generally if you can perform a study
25 prospectively that is the preferred way to do it. That

1 reduces the chance of hindsight bias by looking at
2 prospectively.

3 Q You mentioned a Mollberg article, Margareta Mollberg?

4 A Yes.

5 Q I have in my hand an article by her accepted in
6 October of 2006; it has got an ACTA Obstetrics, I am
7 butchering the name. But it is published in 2007. Under
8 the Title, Obstetric Brachial Plexus Palsy. A prospective
9 study on risk factors related to manual assistance during
10 the second stage of labor. The lead author is Mollberg.
11 Do you consider, are you familiar with this article?

12 A Yes, I am.

13 Q Do you consider this article as being a reliable
14 authority?

15 A Yes.

16 Q Let me ask you if you agree with some of these
17 sentences. Forceful downward traction applied to the head
18 after the fetal third rotation represents an important
19 risk factor of obstetric brachial plexus palsy in vaginal
20 deliveries in cephalic presentation.

21 A I would agree with that, yes.

22 Q And what is cephalic presentation?

23 A That is head delivering otherwise known as vertex or
24 cephalic; head delivers as opposed to another part such as
25 breach baby.

1 Q Is that what we had in this case?

2 A Exactly what we had in this case, cephalic
3 presentation, vertex presentation, head first, yes.

4 Q See if you agree with this sentence. At 18 months of
5 age, 16.1 percent of children had residual functional
6 deficits and downward traction with substantial force was
7 applied in all of these cases.

8 A The question, I am sorry?

9 Q Do you agree with that?

10 A I agree with that, yes, that is exactly what the
11 article showed.

12 Q I will move on. There are a whole bunch more of
13 similar statements here. But we have talked mainly about
14 violations of the rules applicable to this situation and
15 similar situations. Have you reached a conclusion or
16 opinion about what caused Alexia's nerve damage.

17 A Yes, I have. I feel it was excessive traction on the
18 left brachial plexus due to excessive bending of the neck
19 away from the head on that side, at the time of delivery.

20 Q And do those, does that explanation that you just
21 expressed, is that consistent with the cause being Dr.
22 Miller's violation of the rules applicable to this or
23 similar situations?

24 A Yes, it does.

25 Q Recognizing that you are not a neurologist did you

1 read records to suggest just how severe and permanent this
2 injury is?

3 A Yes, I did.

4 Q What, if anything, about the nature of the injury and
5 severity of the injury relates to your opinion about
6 causation?

7 A Well, when you see permanent injuries involving all
8 the nerve roots in the brachial plexus, my opinion, this
9 is due to when you have got two evulsions or two nerves
10 pulled out of the spinal cord such as C7, C8, you have
11 ruptures at least at C5, C6. And you have got at least a,
12 what is called a transient Horner's Syndrome with T1, has
13 to do with drooping of an eyelid, dryness of the eye,
14 inability of the pupil to constrict, something called
15 Horner's Syndrome. That fortunately did clear up for
16 Alexia. But when you see the entire nerve roots,
17 requiring multiple surgeries to try to improve or repair,
18 my opinion this didn't come from some simple force of
19 labor or from uterine contractions or from mom's pushing
20 efforts. These are compressive forces related to,
21 parallel to the spine and the baby asserted by the uterus.
22 The uterus doesn't create so much force that we have ever
23 noticed in the literature that would cause this severe of
24 any injury. But for an abnormal baby, a baby that is
25 asphyxiated or acidotic; or has a tumor or has an

1 infection or has prolanger mal-positioning; or has, in a
2 mom with uterine fibroids or an abnormal uterus.

3 Something that would make that baby less protective
4 against the effects, normal forces of labor.

5 Q You mentioned the word, fibroids, what is that?

6 A Fibroids are smooth muscle tumors of the uterus
7 common in up to 40 percent of women at some point in their
8 lifetime.

9 Q So you covered this pretty thoroughly but let me just
10 make sure I understand.

11 A Sure.

12 Q Is it your opinion in conclusion, that there are a
13 number of potential causes of permanent nerve damage other
14 than excessive downward traction force, bending of the
15 neck?

16 A Yes. In looking at this case that is what I had to
17 do, is rule out all of those other potential confounding
18 factors that weren't ultimately present in this case and
19 left with medical records, the way in which delivery was
20 accomplished, the severity of the injury and the
21 documentation of additional suprapubic pressure,
22 additional McRoberts and required not only the one
23 position, LOP; but also ROA. That is how I came to the
24 conclusion that more likely than not within a medical
25 degree of certainty that there was excessive traction

1 causing this severe and extensive nerve injury.

2 Q And we know or suspect that the Defense is going to
3 come forward with some literature about neck bending as
4 the baby goes through the birth canal. What opinion or
5 conclusion have you reached about whether or not a baby of
6 this size is at risk of having anything other than a tiny
7 amount of neck bending.

8 A There has never been scientific evidence that one,
9 the shoulder is impacted and with forces being applied by
10 either uterine contractions or by mom's pushing that, once
11 that shoulder stops, the head somehow keeps going. Once
12 that body stops, it is like me being impacted under a
13 doorjamb, somebody could push me from behind but if my
14 shoulder is impacted at that doorjamb I am not going
15 anywhere. If somebody wants to pull me back from the
16 other side, holds me down hard enough and I could come
17 through that doorjamb. But with compressive forces such
18 as a uterus which is designed to protect a baby for nine
19 months of pregnancy and not cause damage to a baby,
20 suddenly in labor, one would expect, in this case, with
21 outside evidence of this happening that this is not how
22 these permanent injuries occur. There can be stretches,
23 we have seen this. I have said that at depositions.
24 There can be transient stretch injuries otherwise related
25 to forces of labor but not enough force to cause this much

1 of a permanent persistent all encompassing, what we call a
2 pan-plexus injury involving every root and tearing out
3 nerve roots from the spinal cord. That's the difference
4 here. That happens due to forces of labor. In terms of
5 bending the neck, everybody pretty much agrees that is you
6 have excessive bending of the neck and you pull and that
7 shoulder is obstructed by that symphysis pubis, it is
8 going, if you bend it far enough you are going to cause an
9 injury. It is a matter of accreditation, how quickly you
10 pull and what angle you pull. So no one has ever
11 witnessed in the birth canal, in the narrow birth canal
12 the head actually deviating so far away from that ear,
13 again, right ear to right shoulder, left ear to left
14 shoulder on a baby in a narrow birth canal, if that is
15 happening. No one has ever seen that happen. Once the
16 head is out, however, that can happen because whoever is
17 pulling down on that neck can extend forces and cause that
18 brachial plexus to exceed its plastic limit. Which means
19 its tensile strength and when you exceed it you can get
20 ruptures and tearing.

21 Q Let me ask you about some of those words. You said,
22 tensile strength and something else. Could you, tell us
23 whether or not you are saying that some doctors might
24 break the rules by pulling so hard that they rupture the
25 nerves or avulse the nerve roots from the spinal cord?

1 A Right. And I am not saying intentionally, no one
2 would ever do that. But other than but for, if you have
3 to pull the baby out desperately to save brain at six
4 minutes, then that is a different story. And do whatever
5 you need to do but that's not the set of circumstances in
6 this particular case.

7 Q It wouldn't be an intent to harm?

8 A No.

9 Q But intervening with extra force and bending would be
10 a choice?

11 A Yes.

12 Q By the doctor?

13 A Sure.

14 Q An intentional choice?

15 A Yes. Although, again, in some cases there has been
16 literature that states that a doctor under duress may not
17 be as well aware of the amount of force they are putting
18 down on the brachial plexus. That has been written.

19 Q Exactly. But you mentioned something earlier about,
20 it depends on the angle and the speed. In terms of the
21 speed, is the speed of the force what takes away the feel?

22 A Yes. If you pull hard down once you are not going to
23 get the same feel as gently putting gradual traction and
24 then feeling if there is give, feeling what you are
25 suppose to feel. If you do it forcefully and quickly you

1 are going to lose that sensation.

2 Q So what role do you believe speed plays in terms of
3 the devastating injury that this child sustained to all of
4 her nerves?

5 A Well, either we are talking about such an extreme
6 angle to stretch that plexus to point of rupturing nerve
7 roots or we are talking about asserting traction at a very
8 high rate of speed. It could be one or the other or both.

9 Q I am almost done but let me just ask one more
10 question. Could this injury had been prevented and if so,
11 how?

12 A Well, it could be have been presented by doing a
13 C-section which I am not saying was necessarily indicated
14 after the heart -- was improved. And it could have been
15 avoided by using gentle rotational maneuvers and moving
16 through the other maneuvers when these didn't work and
17 avoiding excessive traction. That is how the injury could
18 have been avoided.

19 Q Thank you, sir. Please answer any questions --

20 THE COURT: Mr. Davis.

21 MR. DAVIS: Thank you, Your Honor.

22 CROSS-EXAMINATION

23 By Mr. Davis:

24 Q The article that you referenced earlier that Mr.
25 Graham had from England. What year was that article

1 published?

2 A 2006, I believe.

3 Q Thank you. And you were asked about your hospital
4 mandates use of simulators. Did I hear that correctly?

5 A We do simulations every two years to be
6 re-credentialed at both of our hospitals, yes sir.

7 Q Do you have any idea what the requirements were in
8 2007 at Piedmont Hospital here in Rock Hill?

9 A No, I don't.

10 Q Thank you. You do expert witness work. I mean this
11 isn't the first case you have testified as an expert?

12 A That's correct.

13 Q You started reviewing cases in 1987?

14 A Yes, sir.

15 Q And the last 15 years or so you have reviewed an
16 average of one or two cases a month. Testified in three
17 or four trials a year and given depositions about once a
18 month over the last 15 years?

19 A Yes, sir.

20 Q You have given a couple of hundred depositions and
21 reviewed several hundred medical malpractice cases as an
22 expert witness?

23 A Yes.

24 Q You testified in medical malpractice trials about 60
25 times over the past 34 years?

1 A Yes, that is correct.

2 Q You charge \$450.00 dollars an hour to review a case;
3 \$550.00 dollars an hour for deposition; and \$5,000.00
4 dollars a day for today at trial?

5 A Yes sir, that is correct.

6 Q Prior to your deposition that I took of yours in
7 March of 2021 and in this case you told me you had spent
8 about 20 hours in review, prior to your deposition. About
9 how many hours have you spent since March of 2021 on this
10 case preparing for your testimony today, sir?

11 A I would say about eight hours.

12 Q Okay. You agree that a rotational maneuver such as
13 the woodscrew maneuver is designed to rotate the baby, to
14 allow the baby to descend; and to allow the baby to
15 corkscrew underneath the pubic bone as the rotation is
16 being made and the baby descends. That is how it is
17 designed to work?

18 A Yes, sir.

19 Q When the woodscrew maneuver or a rotational maneuver
20 is performed, the rotation could be at 180 degrees
21 depending on how large the baby is or what the mother's
22 pelvis is like. True?

23 A Yes.

24 Q And would you agree that the medical records in this
25 particular case document that the most recent baby born to

1 Angela Patton, several years before, was 9 pounds, 11
2 ounces?

3 A I believe that is true, yes.

4 Q And Alexia was 9 pounds, 6 ounces?

5 A Yes.

6 Q And there was no shoulder dystocia reported in the 9
7 pound, 11 ounce baby, with the same mom, was there?

8 A Correct.

9 Q You agree that there was no evidence in this cases
10 that Dr. Miller was not adequately trained to handle a
11 shoulder dystocia at the time Alexia was born, true?

12 A True.

13 Q And the various maneuvers that one may imply
14 including McRoberts suprapubic; posterior arm delivery;
15 woodscrew maneuver, episiotomy; do not have to be in any
16 particular order within the standard of care. Is that
17 fair?

18 A That's fair, yes.

19 Q So when a physician is trained in his residency, and
20 explain to the jury, Doctor, if you would, you go to
21 medical school for four years typically and then you apply
22 competitively for a residency in the field of medicine you
23 want to specialize in. Is that right?

24 A Yes.

25 Q And do you have to match or be accepted into a

1 particular program to train as a particular type of
2 specialist?

3 A Yes, you do.

4 Q And you went through that process?

5 A I sure did, yes.

6 Q And Dr. Miller went through that process?

7 A Yes.

8 Q And he trained, and he was accepted and trained at
9 the University of Florida. You may have remembered that?

10 A Yes, in Gainesville, I believe.

11 Q Is it at the, in the residency, after medical school
12 training to become a specialist, as you have become and
13 Dr. Miller has in obstetrics and gynecology, is it at
14 during those years of residency, post-medical school
15 training, where the young -- such as yourself, is taught
16 the various maneuvers in how to best handle shoulder
17 dystocia?

18 A Yes, there may be some eliminative teaching also in
19 medical school but residency is more of the brunt of it.

20 Q Okay. So in medical school, for example, if you went
21 through an OB residency or OB rotation, excuse me, maybe
22 as a third or fourth year medical student or your hands-on
23 more, is you went through an obstetrical rotation for a
24 month or two months or whatever in your medical school,
25 you may be exposed to a shoulder dystocia and how the

1 OBGYN attending resolves it. And you might learn as a
2 medical student, oh, this is how it is done. That would
3 be fair, is that what you are talking about?

4 A Yes.

5 Q And then in residency, for Dr. Miller at the
6 University of Florida, that is where he is taught, that is
7 where the OBGYN to be, is educated in training and gets
8 hands-on experience on how to resolve a shoulder dystocia?

9 A Yes.

10 Q And telling the jury your opinion that this was a
11 second left shoulder dystocia after the right shoulder
12 dystocia, that you opine or claim that Dr. Miller caused,
13 when he performed the woodscrew maneuver, you would agree
14 that normally, normally the woodscrew maneuver, when its
15 performed, will reduce, will produce the descent of the
16 baby underneath the pubic bone after the right, in this
17 particular case, impacted shoulder becomes dislodged.
18 Correct, and that is how it is suppose to work?

19 A That is how it is suppose to work, yes.

20 Q Okay. And but in your opinion, and your opinion
21 apparently that did not appear to you to happen in this
22 case. Is that fair?

23 A That is fair, yes.

24 Q And you think that Dr. Miller appeared to encounter a
25 left shoulder dystocia with the new positioning as he

1 rotated the baby 180 degrees, is that right, after the
2 rotational maneuver?

3 A Right. Otherwise the right had gotten to 20 or 30 or
4 40, with the right shoulder dystocia, that would have
5 caused the right arm to simply dislodge initially but that
6 didn't happen.

7 Q In your opinion? That is what appeared to you?

8 A Well, that is the way it was charted, because the
9 baby went all the way to ROA and had it dislodged the baby
10 would never made it to ROA from LOP.

11 Q Remember when I took your deposition in March of
12 2021?

13 A Sure, yes I do.

14 Q And have you had a chance to look at your deposition?

15 A I have, yes.

16 Q Doctor, to refresh your memory and I know March was a
17 long time ago and I respect that. But we have got your
18 deposition and if you would, please, turn with me, please
19 Doctor, to page 31, line 5. And I am going to read a
20 portion of your deposition testimony. I want you, sir, if
21 you would, please, to read along with me and then I am
22 going to ask you a question after that. All right, sir?

23 A Sure.

24 Q All right. Page 31, your deposition, under oath,
25 line 5. You are talking in the context and please correct

1 me if I have gotten this out of context. We were talking,
2 I was asking and you were discussing the rotational
3 maneuver.

4 Is that kind of fair here?

5 A Yes.

6 Q Quote, your testimony; Normally this type of rotation
7 will produce some descent of the baby underneath the
8 symphysis pubis but apparently, your word, that didn't
9 happen here. And the reason who we know that is because
10 the effort now to perform the McRoberts and suprapubic
11 again takes place.

12 These are your words.

13 A Right.

14 Q And as Dr. Miller states with, moderate force. He
15 delivers the anterior shoulder at this point. The fact
16 that he had to use McRoberts and suprapubic pressure once
17 again means that not only did he have a right shoulder
18 impaction initially in the LOP presentation but now Dr.
19 Miller appeared, your word, to encounter a left shoulder
20 dystocia with the ROA which is the new position after the
21 rotation presentation.

22 Did I read that correctly?

23 A Yes, you did.

24 Q Thank you. Doctor, in your opinion it seems to you
25 that the shoulder dystocia ranges, the time, ranges

1 between 60 seconds and 120 seconds, fair?

2 A I think 45 to 120, I believe, is what we --

3 Q Do we need to go back to your deposition to page 16
4 where you said, 60 seconds.

5 A No, no. I will stand by what I said at the
6 deposition. I was just thinking of what, again, 60 to 120
7 seconds would be reasonable. I will stand by that.

8 Q Thank you. Do you consider any single source of
9 medical literature to be authoritative?

10 A No.

11 Q Do you agree that there are certain maternal forces
12 involved in the mom's uterus during labor and also when
13 she is contracting that results in pushing the baby
14 towards the vaginal opening in the delivery. Is that
15 fair?

16 A Yes.

17 Q And the uterine forces the uterus compresses, would
18 that be a fair way to say it, asserts force against the
19 body of the baby to help the baby deliver?

20 A The compressive force is pushing on the rump of the
21 baby down and forward, parallel to the cervical thoracic
22 spine of the baby.

23 Q And that is known, I mean that is not a mystery?

24 A Correct.

25 Q And does a uterus know when the baby is impacted as a

1 shoulder dystocia or whether it is posterior or anterior.

2 Does the uterus just stop pushing?

3 A I don't know how to answer that. It doesn't just
4 stop pushing. Well, the inherent nature of the muscle is
5 to contract but you can make it reduce in pushing by
6 giving a medication. You can make it stop pushing by
7 stopping Pitocin. But given the absent of those things,
8 no, the natural inherent ability is to contract.

9 Q Okay. So whether the baby has got the shoulder hung
10 up somewhere on the sacral promontory or on the pubic bone
11 or both, I suppose either one or both, the uterus doesn't
12 know that and the uterus continues to push?

13 A Well, mom doesn't continue to push, per se.

14 Q The uterine continues to contract?

15 A Yes, you can see contractions.

16 Q You can tell, mom; mom, stop pushing?

17 A Right.

18 Q You can control that?

19 A Sure.

20 Q You can't tell the uterus, hey, stop doing that, can
21 you?

22 A No, you can give medication to stop it but you are
23 not going to tell the uterus.

24 Q That is not the standard of care required, oh, give
25 medication to stop the uterus from contracting. You don't

1 do that, do you?

2 A That's correct. You have the mom stop pushing, that
3 is standard of care once you recognize the dystocia.

4 Q Okay. When a woodscrew maneuver is employed and it
5 is successful, you agree that when the baby first presents
6 in an LOP position, as in this case, and the right
7 shoulder is up or anterior and is impacted, that after the
8 maneuver is successfully performed, even if it takes 180
9 degrees to turn the baby, the shoulder should dis-impact
10 that right anterior shoulder. Is that right, that is the
11 design?

12 A Yes. It is designed to do that, it doesn't work 100
13 percent of the time but that is what it is designed to do.

14 Q Right. And when that right up anterior shoulder
15 becomes dislodged in that maneuver, that allows the baby
16 to, I think you used the word, unscrew, or to be delivered
17 at that point. Would that be fair?

18 A Yes.

19 Q The baby is actually coming out when that maneuver is
20 successfully done, the baby unscrews and is coming toward
21 you as a delivering position. Is that fair?

22 A Well, it doesn't come barreling down towards you.

23 Q I didn't say barreling down, that is your word.

24 A Well, coming toward. There is a little bit of
25 descent once that shoulder releases anteriorly but you

1 still may have to deliver that baby.

2 Q Sure, you still put your hands on the head and use
3 gentle downward traction?

4 A Well, depends at what point. But, yes, once the
5 shoulder releases and you detect that, you can feel it or
6 see it, then you are allowed to provide gentle axial
7 traction at that point on the baby's head, once you know
8 that the shoulder dystocia has resolved.

9 Q In fact, after you do McRoberts and suprapubic
10 pressure, it's totally appropriate within the standard of
11 care to then, as a delivering physician, to place your
12 hands appropriately on the baby's head that has already
13 delivered and to gently pull down axial traction, gentle
14 traction to test whether or not your McRoberts and
15 suprapubic was successful in dislodging the shoulder,
16 right?

17 A Yes, very gently. When you say, down, you have to
18 keep it again within 45 degrees of the axial plane.

19 Q We will call it axial, would that be a fair way to
20 say it, axial direction?

21 A Yes, yes.

22 Q And that is okay. And if that is done and there is
23 still not, there is not a descent, the baby is still not
24 coming, you take your hands off the baby's head and you do
25 the next thing, don't you?

1 A Yes, you do.

2 Q Whether that is a posterior arm attempt, delivery
3 attempt or a woodscrew delivery attempt or where ever your
4 next maneuver is until you get that baby delivered, right?

5 A Right. Whatever maneuvers have not yet been tried
6 preferentially, whether it is a reversed woodscrew or
7 Rubins one or two maneuver. Yes, you would implement
8 those, if nothing else had worked prior to that time.

9 Q And you mentioned a moment again, I think, correct me
10 if I did not hear this correctly, sir. But I think one of
11 the things, I think you said the Rubins would do, would be
12 to reduce the diameter, the measurement or the distance
13 between one shoulder than the other. So instead of this,
14 it reduces that distance some?

15 A Yes.

16 Q And whenever, however that is done by the doctor,
17 when that distance is reduced that also gives you more
18 hope and maneuverability to get that baby delivered?

19 A Depending on the size of the baby and the pelvis,
20 yes, it can.

21 Q It can't hurt. The distance of the shoulders cannot
22 hurt in a shoulder dystocia?

23 A Probably not going to hurt, yes.

24 Q Probably going to help. Hopefully it is going --

25 A If you get a large enough baby and a small enough

1 pelvis that's why these rotational maneuvers may not work
2 and that is why you have to resort to something else such
3 as delivery of the posterior arm.

4 Q And, Doctor, as an experienced OBGYN yourself, sir,
5 you agree that normally the anterior shoulder, the up
6 shoulder will begin to dislodge from underneath, as it
7 begins to dislodge from underneath the symphysis pubis,
8 whether it is by suprapubic and McRoberts or whether it is
9 posterior arm delivery or whether it is rotational
10 maneuver, however it is done; when that shoulder dystocia
11 is resolved or is resolving your hands are on the baby's
12 head, you are testing the waters, I think you used the
13 term, to see if the baby is free. Is that a fair term?

14 A Well, if you feel or visualize that shoulder release
15 then you are allowed gentle traction. You can apply
16 gentle traction after you have been -- maneuvers, to see
17 if they worked and that is acceptable to test those waters
18 but only gentle traction.

19 Q And, that's fine, thank you. And you agree that an
20 experienced obstetrician like yourself can, and I am going
21 to use the word, you may have used it, I think you already
22 did, feel. It is a feel thing if the shoulder has been
23 released?

24 A You can feel it, often times you can visualize it,
25 depends on the situation. But, yes, it is something that

1 you can often detect.

2 Q And the more you do it, the more shoulder dystocia's
3 you are involved with, as your experience increases over
4 the years, if you get the national average of, what did
5 you say, .02 to, what, how much percent?

6 A 1.5 percent.

7 Q One and a half percent. So out of, what four million
8 babies born in a year, that comes out to be how many
9 shoulder dystocias?

10 A I majored in bio, not math. It is a significant
11 number.

12 Q It is a big number, isn't it, it is like 20,000 or
13 whatever it is. Whatever the math scrunches out to be.
14 Okay. So this wasn't the only shoulder dystocia in 2007,
15 the one that Alexia suffered. This wasn't the only one?

16 A Correct.

17 Q Okay. You agree that you are taught to apply gentle
18 downward, I will use the term, axial traction. As a
19 prudent obstetrician develops sort of a feel for the
20 amount of traction to employ. Would that be fair. You
21 learn it as you go, it is a feel thing. You know it when
22 you see it?

23 A Well, that would be part of it, the other is
24 visualization and detecting resistance when you are
25 performing maneuvers. So it all goes together. It is a

1 package.

2 Q And that feel, and I am specifically talking about
3 the feel aspect of this, the feel comes with experience,
4 it comes with knowing what to do. Fair?

5 A Yes, that's fair.

6 Q After a successful woodscrew maneuver, once the
7 obstetrician is sure that the anterior right stuck
8 shoulder has become dislodged, then he can place his hands
9 on the baby's head and use a gentle downward traction to
10 effect delivery, right?

11 A Yes.

12 Q And in your deposition you mentioned some devices or
13 some models that you had heard about or maybe read about,
14 that can somehow alarm or alert an obstetrician that he
15 was using too much force, (inaudible)?

16 A I am not sure the answer to that but I would suspect
17 that's true.

18 Q You mentioned somebody like Dr. Robert Allen in your
19 deposition who has written some things about forces of
20 traction and delivering babies; and that he had done some
21 studies about measuring the use of force on a delivery but
22 you agree that Dr. Allen is an engineer, he is not an OB,
23 right?

24 A Agree.

25 Q You agree that when an obstetrician needs to proceed

1 with further maneuvers after doing a McRoberts, after
2 doing suprapubic, the baby, and the baby still needs the
3 dislodgment or the releasing of the stuck shoulder.
4 Anterior shoulder we will use in this example, a posterior
5 arm delivery and the Rubins or the woodscrew that may be
6 used, it would be unusual for mom to continue to be, it
7 would not be unusual, excuse me, for mom to continue to be
8 in that McRoberts position?

9 A That's fair.

10 Q That would kind, let me see if I can simplify this.
11 I am not sure I follow myself. So the first thing that
12 the doctor, shoulder dystocia, McRoberts. A nurse on each
13 side pulls the legs and thighs as far as we can to kind of
14 open the door, to give more room. That is the nature,
15 that is the design of that maneuver, right?

16 A Yes.

17 Q You wouldn't expect that if that in suprapubic and
18 episiotomy, posterior arm delivery doesn't work and the
19 doctor proceeds with the rotational maneuver, that they
20 are going to take the legs down and undo the McRoberts,
21 would you?

22 A Not necessarily, no. Sometimes it is done, give the
23 mama a brief rest but it is okay to leave them up.

24 Q In this case do you have any evidence that she wasn't
25 continuing to be in that McRoberts position when he was

1 doing his maneuvers?

2 A No.

3 Q Okay. When do you opine that Nurse Bibb first used
4 suprapubic pressure in this case?

5 A At the time that the shoulder dystocia was called,
6 when the baby was presenting left, posterior.

7 Q Would it have been the right shoulder was first noted
8 to be impacted, would that be when you think it happened?

9 A Perhaps. Unclear from the note.

10 Q How long did she use suprapubic pressure at that
11 initial point?

12 A It is not charted that I can tell.

13 Q It is not documented, is it?

14 A Not that I can tell.

15 Q And what time do you opine that Nurse Bibb may have
16 done a second suprapubic pressure application?

17 A I think it is not charted, that I can tell. I think
18 it was charted about 20:50 and resolving about 20:51, if I
19 remember the notations correctly. So the chart is 45
20 second.

21 Q Well, is it your opinion that she applied for a
22 continuous 45 seconds from the very beginning or started,
23 did some, stop and did some at the end. I mean, tell me
24 what your opinion is and what it is based on?

25 A What I told you at deposition and I will stick with

1 now, 45 seconds at the time when the baby was stuck in ROA
2 presentation, after the failed woodscrew.

3 Q I will show you, the fetal monitor strips. And these
4 are the baby's heart rate?

5 A Yes.

6 Q And down here is the contractions, this is the bottom
7 part?

8 A It is.

9 Q And here, I think you were referring to this earlier,
10 sir. 04, 05, 5 of 2007, this is (inaudible.) So what is
11 this 20 --

12 A That is when it was charted.

13 Q So the record of this nurse, not criticizing her, but
14 you would agree with me that she did and was very involved
15 in whatever she was doing, with Dr. Miller.

16 A No and that is not surprising because a nurse
17 involved in delivery is going to stop what she is doing
18 and then enter, she is going to enter when she has time
19 after the procedure which is fine.

20 Q And according to her notes down here, vaginal
21 delivery for Dr. Miller and there is a three and is that
22 note there for the time that she is dedicating, would that
23 be fair to interpret that way?

24 A Yes.

25 Q And she has 20:51 too.

1 A Right. She is saying the number three here responds
2 or corresponds to 8:51 p.m.

3 Q I appreciate your helping with the military time and
4 civilian time. 20:51 is what --

5 A 8:51 p.m.

6 Q Thank you, sir. Thank you very much. Would you
7 agree that there is nothing in this medical record that
8 you have reviewed, sir, that documents Nurse Bibb using
9 suprapubic pressure continuously through all the
10 rotational maneuvers including posterior arm delivery and
11 the woodscrew maneuver. True? There is nothing where she
12 documents that?

13 A Not specifically in those words. The way it is
14 charted in the monitor led me to believe that this was 45
15 seconds in the ROA presentation as I mentioned before.

16 Q And she had an hour to kind of think through what she
17 did and make her documentation. And she doesn't document
18 it, anything, I did it for 45 continuous seconds, does
19 she?

20 A Not in those words.

21 Q Okay. You agree that Dr. Miller and in his sworn
22 testimony in 2011 in this case explained to Mr. Graham
23 under oath what he meant when he said moderate effort.
24 You read that?

25 A I did, yes.

1 Q But in your opinion moderate effort means moderate
2 traction. That is your opinion?

3 A That's in my line as perinatal morbidity. Yes, I
4 have seen that charted exactly and that is why I come to
5 that opinion because I have seen this hundreds of times.

6 Q You agree that Dr. Miller never documented or even
7 wrote the word, traction, on this note, did he?

8 A Not that I see.

9 Q Well -- inaudible), (attorney moving around.)

10 A No.

11 Q You agree that he never documented anything about
12 excessive force or traction?

13 A Well, I expect that to be documented, no.

14 Q But you do, in your deposition testimony, because you
15 were asked about this on direct examination under oath in
16 2011, answering seven hours of questions that Mr. Graham
17 -- he said what I meant by moderate effort is everything
18 we had to do to deliver this baby. Suprapubic pressure,
19 McRoberts, episiotomy, posterior arm delivery, rotational
20 maneuver and gentle axial traction. You remember that,
21 don't you?

22 A That's what he said. It is an unusual way to put it
23 in terms of moderate effort but that is what he said.

24 Q Part of the basis of your opinion that when you see
25 effort you see traction, is based on the injury suffered

1 by this child?

2 A In the context in the way this is dictated, yes, not
3 always but in this particular dictation, yes. And similar
4 dictations that I have seen in my position, yes.

5 Q You are not claiming that Dr. Miller somehow used
6 significant traction in the heat of the moment and didn't
7 realize how much pressure he was using, are you?

8 A You asked me that in deposition and I said, no.

9 Q You have no opinion how many pounds of pressure Dr.
10 Miller used as pulling during this delivery, do you, sir?

11 A It is not documents, but I think when you asked me
12 that I told you what I thought the beginnings of what
13 would cause permanent injury were in terms of
14 documentation, numbers of pounds of force.

15 Q You are not aware of any way of measuring a delivery
16 obstetrician's points of pressure used in any delivery,
17 true?

18 A Other than putting on a pair of censored gloves,
19 correct.

20 Q Didn't have any censored gloves, did he?

21 A Not that I am aware of.

22 Q You know if they were available in 2007 at Piedmont
23 Hospital, sir?

24 A I wouldn't think so.

25 Q You, shoulder dystocia, a predicable foreseeable

1 event, are you?

2 A No, I think it can be an anticipated event given
3 certain situations but not predictable.

4 Q And you are not saying it is predicable or
5 foreseeable in this case, are you?

6 A No, I didn't say that.

7 Q You agree in this case when Dr. Miller was delivering
8 Alexia that he never used, that if he never used anything
9 other than gentle downward or axial traction, along with
10 the other documented maneuvers, in this case, that he met
11 the standard of care regardless of the very unfortunate
12 injuries to this child, true?

13 A I am sorry, please repeat it, if you would. It was a
14 long question, I am sorry.

15 Q I will be glad to, sir. Do you agree that in this
16 case, when Dr. Miller was delivering Alexia, April 5 of
17 2007, that if he never used anything other than gentle
18 downward or axial traction along with the other documented
19 maneuvers, then he met the standard of care regardless of
20 the unfortunate injuries to Alexia? True?

21 MR. GRAHAM: Excuse me, Your Honor, may we have a
22 rule of completeness to put that in context? It is a
23 question.

24 THE COURT: I am not sure I, can y'all approach the
25 bench.

1 (Whereupon, a bench conference was held in the
2 presence of the jury but out of the hearing of the
3 jury.)

4 A Answer in a hypothetical it would be correct.

5 Q Nothing further, thank you.

6 THE COURT: Any redirect, Mr. Graham?

7 MR. GRAHAM: Yes sir, Your Honor.

8 REDIRECT EXAMINATION

9 By Mr. Graham:

10 Q On that last point, Doctor, I believe you have your
11 deposition there.

12 A Yes.

13 Q Please follow along with me on page 39?

14 A Yes.

15 MR. DAVIS: Your Honor, I am going to object to this.
16 Cross-examination, I asked him a question, he answered the
17 question. Now he is going back to his deposition. I
18 object.

19 MR. GRAHAM: I put in into context.

20 THE COURT: Counsel, approach the bench, please.

21 (Whereupon, a bench conference was held in the
22 presence of the jury but out of the hearing of the
23 jury.)

24 Q Doctor, the last question, I wanted to make sure I
25 had the language right. But when you were asked about

1 whether or not Dr. Miller would have complied with the
2 standard of care. If he met, if he is only gentle
3 traction, you ask him to clarify whether he is asking
4 hypothetically, correct?

5 A Yes.

6 Q Did he use gentle traction?

7 A Not in my opinion, no, not to cause these injuries,
8 the severity of this injury, no.

9 Q So did the hypothetical that Mr. Davis posed to you
10 have anything whatsoever to do with the facts of this
11 case?

12 A Not in my opinion, no.

13 Q There was a question about is shoulder dystocia
14 predicable. What I would like to ask you, sir, is, is
15 brachial plexus injury of a perplexes, all the nerves
16 predictable if you pull as hard as Dr. Miller did?

17 A It is a very high risk, yes. It is predicable if you
18 pull like that.

19 Q There were questions about what the uterus knew. Did
20 God make women's uterus' so that pushing would be from
21 behind, in front of the uterus, around the baby would
22 soften and spread to allow the baby to go through without
23 the kind of force he is taking about?

24 A Well, it certainly knows that the upper segment of
25 the uterus is the active segment and the lower segment of

1 the uterus is the passive segment such as the cervix. It
2 has to relax in order to allow the baby to descend and
3 deliver vaginally. And that is the way the uterus and
4 cervix are set up as a team to do that. It is the upper
5 portion that is considered active and these are
6 compressive forces acting in line with the spine of the
7 baby, not bending the neck away from the head which is
8 what it takes to cause this type of a severe injury.

9 Q If I understand the questions and the theory,
10 hypothetical correctly, it sounds like they are asking if
11 those compression forces could cause harm. So my question
12 for you, sir, is, are women's bodies built so that they
13 have various layers of skin and muscle and so on to
14 protect the baby inside of their uterus?

15 A Yes. This is why weight is generally put on during
16 pregnancy, why certain muscle tend to loosen, certain
17 seems to thicken. And why certain bones tend to stretch
18 in pregnancy and spread to get ready for the requirements
19 put forth by the labor process.

20 Q And inside the woman, inside her uterus, does the
21 baby also have protective tissue, soft tissue and muscle?

22 A To an extent, depending on the size of the baby,
23 sure.

24 Q Compression forces were, in fact, capable of causing
25 damage to baby's nerves, would you expect to see damage to

1 something between the nerves and the outside of the uterus
2 that would show some kind of injury in between?

3 A I would usually expect to see something else, perhaps
4 just congenital atrophy or some sort of other --

5 Q Was there anything like that in the records?

6 A No.

7 Q And you mentioned other possible causes. Did any of
8 those have anything to do with this case?

9 A No, it did not.

10 Q Did God make women's uterus' so they would protect
11 the baby?

12 MR. DAVIS: Your Honor, this is a leading question,
13 it has already been asked and answered. I object.

14 THE COURT: I am going to overrule the objection.

15 MR. DAVIS: Thank you, Your Honor.

16 A No. The way, if you asked me yes, was the uterus
17 created to protect the baby, the answer is yes. Was the
18 uterus created to damage the baby, the answer no.

19 Q Nothing else.

20 THE COURT: Anything else, Mr. Davis?

21 MR. DAVIS: No, Your Honor.

22 THE COURT: Any objection to this witness being
23 released?

24 MR. DAVIS: No, Your Honor.

25

1 (Whereupon, a bench conference was held in the
2 presence of the jury but out of the hearing of the
3 jury.)

4 THE COURT: Mr. Graham, you can call your next
5 witness.

6 MR. GRAHAM: We call Dr. Trevor Resnick.

7 Trevor Resnick, being
8 first duly sworn, testified as follows:

9 DIRECT EXAMINATION

10 By Mr. Graham:

11 Q First of all tell us about your background.

12 A I am a pediatric, (inaudible).

13 (Whereupon, witness was inaudible due to being away
14 from witness stand.)

15 MR. GRAHAM: Your Honor, we move for this witness --
16 for expert.

17 THE COURT: Any objection, Mr. Davis.

18 MR. DAVIS: None, Your Honor.

19 THE COURT: Ladies and gentlemen, Dr. Resnick has
20 been accepted as an expert in pediatric neurology.

21 Q Doctor, by my request to stand here and I request you
22 review the records, make determinations about the nature
23 of the causation -- let me ask you, (inaudible). I am
24 also going to --

25 A Can you hear me better?

1 COURT REPORTER: Yes.

2 A So let me just start out where, if I move my hand the
3 way in which I move my hand, if there is an area in the
4 brain that is responsible for controlling movement of my
5 arm or my hand, and the message goes from there down into
6 the brain stem, down my spinal cord and out the spinal
7 cord through some nerves to a muscle that allows me to
8 move my hand. Any interruption of that pathway will
9 result in my inability or weakness in terms of doing that
10 act. Could be a stroke in the brain, damage to the spinal
11 cord, or damage to the nerves. In this case, in Alexia's
12 case the area that was involved that interrupted that
13 message, getting to her arm so that she can move her arm
14 correctly is in this area called the brachial plexus.
15 Brachial comes from an old Latin word meaning arm; and
16 plexus means a group of different nerves moving together.
17 So in Alexia's case and in everybody's case this is the
18 spinal cord and the roots of nerves come out of the spinal
19 cord and then go down the arm. The reason they are called
20 roots is they look like the roots of a tree. And for
21 example this root over there that comes out is called the
22 C5 root because it lies just about the C5 vertebrae. So
23 we know from experience that when you have a lack of
24 movement in a certain muscle we assume that lack of
25 movement is because of damage in the C-45 roots. I don't

1 have to have a picture of what this looks like by
2 evaluating and examining Alexia. I can say, well, she has
3 inability to move this muscle, therefore that nerve roots
4 or that nerve is involved or not functioning normally. So
5 these nerve roots from C4 through T1; C means cervical
6 which is the neck; and T1 means thoracic. So it is all of
7 these nerves that come out of the neck, that go down to
8 supply the sensory which is feeling and the movement part
9 of the arm are involved in this brachial plexus.

10 Q You have got two diagrams on this board. The one on
11 the top left, is that normal anatomy?

12 A Yes. So this was normal anatomy, these are the
13 nerve roots coming out of the brachial plexus which then
14 form different nerves and go to different muscles that
15 allow us to use your arms. Can I talk about that one?

16 Q Yes, please.

17 A Can we switch places?

18 Q Yes.

19 A So this is a picture, a diagram of what Alexia's
20 brachial plexus looked like at the time of surgery. And
21 you can see a couple of things which I will review with
22 you. You can see if you look at the nerve roots on the
23 normal side, at C7 and C8, the nerve roots have been
24 pulled out of the spinal cord. In addition to that, there
25 is this big red mass of tissue over here that is fibrous

1 tissues. Is what happened is if you pull a nerve and you
2 separate it, it is called a rupture. It is like taking a
3 piece of string or elastic band and you pull it so that it
4 is no longer is attached. The nerves and the nerve roots
5 try to find each other and they grow out, fibrous and
6 nerve tentacles looking for the other side. But if it is
7 not in direct approximation it goes in multiple different
8 directions and you end up with this big pile of nervous
9 tissue and fibrous tissue because of the one side of the
10 nerve trying to find the other side of the nerves. That
11 is called a neuroma. So in Alexia's case, when the
12 surgeon went in to see what was happening they found that
13 these two nerve roots were evulse, means that they were
14 pulled out of the spinal cord. And C5, C6, C7, C8 and T1,
15 there was this large neuroma underlying the brachial
16 plexus and when they went to try and investigate by
17 separating it out there were ruptures underlying that
18 neuroma. So in summary, what we have is two arises where
19 there is, where there is an evulsion from the spinal cord
20 and ruptures underlying the neuroma involving the entire
21 brachial plexus.

22 Q I missed the last bit of your testimony. When you
23 comment on --

24 A T1.

25 Q I know that, with your direction, this was colored in

1 gray and those are yellow. Can you explain that?

2 A The reason, this is colored in gray is because at
3 surgery they didn't expose enough to see T1. So we don't
4 know whether there was an evulsion at T1 or there wasn't.
5 And the reason it is in gray is because when I examined
6 Alexia she did not have function that would be assumed by
7 T1. T1, the thoracic nerve, number one is responsible for
8 fine finger movements in the hand. So if you don't have
9 fine finger movements in the hand, either there is an
10 evulsion at T1 or somewhere along the way from T1 going
11 down to the hand is a rupture. From a practical
12 standpoint it doesn't make a difference which one it is
13 but I had a question mark because I didn't know.

14 Q To a reasonable degree of medical certainty what is
15 your opinion about whether or not the convulsion,
16 (inaudible)?

17 A I don't know, I don't know because there just as
18 easily be a total rupture at T1 subsequent to the nerve
19 roots and because I don't know which one it is, I can't
20 get you an opinion.

21 Q So does it make any difference what Alexia can do and
22 cannot do?

23 A No, it doesn't matter where you cut the elastic band
24 or the nerve. The bottom line is it doesn't work
25 downstream.

1 Q (Inaudible)?

2 A Yes.

3 Q Now, I know this one has an awful lot of words, and I
4 don't really want to get, in the interest of time.

5 A So what I want you to do is not worry about the
6 words, just look at the colors. And you can see there is
7 green and then blue and then purple and then red. And
8 remember we discussed the brachial plexus being C5 all the
9 way down to T1. So the higher part of the plexus is
10 involved in making sure that the higher part of your arm
11 works properly. The middle part of your plexus involves
12 the middle part of your arm which would be blue and
13 purple. And the bottom part of your plexus, C8 and T1 are
14 in red. So when I am doing an examination, in my mind I
15 am saying, if the inability to move is high up in the arm,
16 that means that the upper part of the plexus is involved.
17 If the inability to move the arm is the lower part of the
18 plexus it means that the lower part of the arm was
19 specifically the hand is involved. And if the entire
20 plexus is involved or the inability to move involves the
21 whole arm, it means the entire plexus is involved to a
22 greater or lessor extent.

23 Q Just quickly, do these colors identify the muscles in
24 the arm?

25 A Yes, they do. If you look at C5 and C6, so the nerve

1 roots that come out of C5 and C6, parts of those nerve
2 roots go to supply a muscle called the supraspinatus
3 muscle which elevates your shoulder. And I have been
4 doing this for years and I -- so don't worry about it. So
5 to just to give you an idea of how it works.

6 Q Is there anything else you want to say about these --

7 A No in terms of the anatomy, I think that that
8 describes what the plexus is, what it does and in general
9 that upper plexus injury causes upper movement weakness
10 and lower plexus injury, causes lower arm and hand
11 movement.

12 Q Let me ask you one question before you go back. You
13 have just expressed a number of statements. Do those
14 statements represent conclusions and opinions that you
15 hold to at least a reasonable degree of medical certainty?

16 A Yes.

17 Q Can I get you to commit that for the rest of your
18 testimony, you will not answer my question unless it is
19 with a reasonable degree of medical certainty.

20 A Yes.

21 Q Please take your seat. Doctor, did you have a chance
22 to examine Alexia?

23 A Yes, I did.

24 Q Did you also have an opportunity to examine her again
25 today before your testimony?

1 A Yes, I did.

2 Q Getting better, worse or about the same?

3 A The same.

4 Q And do you have an opinion, as to the most probable
5 cause of her nerve damage?

6 A Yes.

7 Q What is it?

8 A It is a stretch injury to the brachial plexus. In
9 other words, the brachial plexus was stretched to the
10 extent that it caused an avulsion of two nerve roots and a
11 rupture of many of the other nerve roots in her arm.

12 Q Do you think more specific, when you talk about
13 strength?

14 A It would be an injury where the brachial plexus was
15 stretched or pulled on. And mostly, in order to create
16 that kind of injury, it has to be a lateral flection of
17 the head away from the shoulder.

18 Q Before you do that, I am trying to stay away from the
19 medical lingo. What is lateral flection?

20 A I was going to show it.

21 Q Oh, okay.

22 A So the easiest way to understand it, is if we are
23 sitting like this and I ask you all to put your hand on
24 your head like this, and then pull your head over to one
25 side. You can feel, when you are pulling the muscle you

1 can feel tension and that is what a lateral stretch is on
2 the head away from the shoulder. So if you think of
3 nerves coming out of your neck, going down your arm, and
4 you laterally stretch your head like this, what you are
5 essentially doing is pulling on those nerves. Now, we see
6 that unfortunately, not too infrequently also, in kids who
7 ride motorcycles. And when they fall off of their
8 motorcycle the helmet, their head gets switched to one
9 side and the shoulder stays down and they tear or pull the
10 nerves in exactly the way but for a different reason. So
11 that mechanism of injury is not uncommon in terms of
12 seeing why and how it happens.

13 Q You just demonstrated pulling, bending the neck with
14 the left ear toward the left shoulder?

15 A I was just doing it pictorially. I wasn't choosing
16 one particular side or another.

17 Q But if before bending the neck down toward the ear to
18 the shoulder, if the head was twisted a little bit and
19 then pulled, would you, what affect would that have on the
20 shoulder?

21 A I don't know. That is more of a physics question. I
22 think any kind of movement that results in stretching and
23 the most common movement, well the most likely movement to
24 do that would be lateral stretching of the neck. And I
25 would defer to obstetricians who are involved more in

1 terms of the actual twisting or turning that relate to it.
2 But from a neurological standpoint this is a stretch
3 injury, a severe stretch injury to the brachial plexus and
4 with it was lateral traction plus -- I don't know.

5 Q Tell us whether or not this injury is permanent?

6 A Yes, it is permanent.

7 Q Do you have an opinion to a reasonable degree of
8 medical certainty as to whether the injury occurred before
9 the head emerged from the birth canal, after it, or after
10 it emerged.

11 A Again, that is more of an obstetric question but the
12 issue relates to, I guess I would have to answer it this
13 way. It is a stretch injury so there is some force that
14 is occurring on the head stretching it away from the
15 brachial plexus and the question is, what kind of force or
16 how could that happen. Now, I described one force which I
17 know which was lateral traction that I see as well in
18 motorcycle accidents. And it has been reported that
19 lateral traction, that is why, as I heard earlier
20 testimony before, gentle traction will not cause an
21 injury. And that is why the idea is always to have
22 lateral, gentle traction. Whether that was the sole
23 mechanism, I don't know.

24 Q But can you tell us whether or not Dr. Miller used
25 gentle traction or some --

1 A I am not an obstetrician. I would only, the way I
2 would characterize it, is to say whatever traction was
3 generated was sufficient to cause an injury as in her
4 case.

5 Q How would you characterize her injury, moderate,
6 severe or any other?

7 A Severe injury, a very severe injury.

8 Q Doctor, at this point I would ask you, if you are
9 willing to do that, to step forward in front of the jury
10 and do a brief pediatric neurology exam of Alexia. Are
11 you willing to do that?

12 A Sure.

13 MR. DAVIS: Your Honor, I object.

14 THE COURT: Counsel, let me see you at the bench,
15 please.

16 (Whereupon, a bench conference was held in the
17 presence of the jury but out of the hearing of the
18 jury.)

19 MR. GRAHAM: Alexia, will you please step up.

20 A Alexia, I am just going to ask you to do some
21 movements that show us, that show us your ability to move
22 the arm. Okay. So what I want you to do first with your
23 right arm, I want you to take your right arm and put it
24 above your head.

25 Now, on top of your head.

1 Now, behind your head.

2 Good, now put it down. Thank you.

3 Now take your left arm and put it on top of your
4 head.

5 Okay. So that movement, our ability to move the arm
6 up over your head is the upper part of your plexus, it is
7 your shoulder. And the big movements of your shoulder are
8 your ability to, to raise your arm up and the other big
9 movement that we use without upper part of the arm is to
10 turn your arm out. That is called external rotation. Can
11 you, hold your arm like this, and turn this arm out. Now,
12 can you do the same thing with that arm.

13 So that shows you that the two major muscle groups
14 that we use with the shoulder, Alexia is pretty much
15 unable to do those two movements. The next two, your
16 biceps and your triceps which you are suppose to do this
17 and your ability to do that.

18 So do that with the good arm. Okay.

19 Down, very good.

20 Now, do it with that arm. Bend your arm up, okay.

21 And bend your arm forward.

22 So she does have some movement of the bicep. She can
23 move it against gravity and get it up to a certain part.

24 So that would be the middle part of the plexus, C5, C6.

25 Now what I want you to do with this arm, put your arm

1 like that. And I want you to turn it so your palm faces
2 upwards and now turn it so your palm faces downwards.
3 That is called supination and pronation. if you are doing
4 a screwdriver or you are working in the kitchen your needs
5 to do those two movements, you really can't use your arm.
6 If your hands could be perfect but if you can't do this
7 and this, you really can't do it. Again, that is the
8 middle part of the plexus but more further down. And now
9 the hand, put your wrist up, down, open your fingers and
10 make a fist.

11 Can you do that with this arm? Put it up like that,
12 supinated, pronated. And open your fingers, make your
13 wrists go down, up and wiggle your fingers. I am going to
14 come to this side. Can you turn supinate or pronate. No.
15 I want to hold your arm up. Can you do anything,
16 movements with the hand or the fingers. No. You were
17 fantastic, thank you so much.

18 MR. GRAHAM: Please answer any questions Mr. Davis
19 may have.

20 MR. DAVIS: Mr. Traylor is going to ask.

21 THE COURT: Okay, absolutely.

22 CROSS-EXAMINATION

23 By Mr. Traylor:

24 Q Dr. Resnick, you are certified in pediatrics and
25 neurology, correct?

1 A Yes.

2 Q So you are not a OBGYN?

3 A Correct.

4 Q Thank you. As far as the standard of care goes, you
5 are not going to testify that our client, Dr. Miller,
6 violated the standard of care in any way, are you?

7 A Correct.

8 Q Thank you. Now, this case came about with Dr.
9 Graham, I am sorry, Ed Graham contacted you?

10 A Yes.

11 Q And you have done, I believe it is several different
12 reviews for Mr. Graham at this point, correct?

13 A Yes.

14 Q And for each hour that you review you charge about
15 \$450.00 dollars?

16 A \$500.00.

17 Q That rate has gone up since your deposition?

18 A Yes.

19 Q And the last time we had spoken at the deposition you
20 had done about 10 hours of review. I know you mentioned
21 you had met with Alexia and referred her again. At what
22 point, has that amount gone up at all?

23 A The amount that I told you was my current amount.

24 Q The amount of hours?

25 A Oh, I think it is an extra two hours.

1 Q Roughly 12 hours?

2 A Yes.

3 Q And for a deposition you charge \$600.00 dollars an
4 hour, a minimum of two hours, correct?

5 A Yes.

6 Q And then for a trial it is about \$7,500.00 dollars
7 for a day?

8 A That's correct.

9 Q It doesn't matter how long you testify for?

10 A Correct.

11 Q All right. In your career as a pediatric neurologist
12 have you had, you have had multiple occasions to examine
13 children who have been injured from birth with this
14 similar type of injury, correct?

15 A Yes.

16 Q And in your publications, anything that you have had
17 the occasion to publish as a medical doctor, have any of
18 these publications dealt specifically with the area of
19 shoulder dystocia?

20 A No.

21 Q So it would be fair to say that you are not claiming
22 to be an expert as an OBGYN?

23 A Yes, I think I already said that.

24 Q During the birthing process would you agree that a
25 baby, if it is not delivered in time and has a shoulder

1 dystocia that it runs a risk of suffering from hypoxic,
2 ischemic, encephalopathy?

3 A Yes.

4 Q And that can result in permanent brain damage?

5 A Yes.

6 Q It could result in death?

7 A Yes?

8 Q And you have seen that, you have testified in cases
9 where that has happened?

10 A Where what happened.

11 Q Where any sort of brain damage has occurred when the
12 baby, shoulder dystocia was not delivered in time?

13 A I can't recall that, that I specifically have
14 testified in a case where there was permanent brain damage
15 because of failure to deliver a baby due to shoulder
16 dystocia.

17 Q Earlier when Mr. Graham was questioning you, you
18 mentioned just as a comparison, a motorcycle accident.
19 You are not alleging that Dr. Miller pulled with the same
20 force of a motorcycle, are you?

21 A No. I was referring to the nature of the injury and
22 the issue of lateral traction causing a brachial plexus
23 palsy as a demonstration of kind of stretch injury that
24 can cause a brachial plexus injury.

25 Q From my understanding, because the visual I have,

1 based on the testimony today, is that during this
2 motorcycle accident the rider is just on his head and his
3 neck has been torqued down. Are you saying the shoulder
4 is the part that is --

5 A Well, no. It is the head. If you are sliding along
6 the ground and the head is in one direction and the
7 shoulder is in the other direction. You are separating
8 the head from the shoulder and you get a brachial plexus
9 injury.

10 Q The pressure is coming from behind and pushing down
11 on the shoulder?

12 A No.

13 Q It is traveling in one direction?

14 A The body is traveling in one direction and the head
15 has been stretched away.

16 Q I am just failing to see how that is analogous to a
17 delivery process in that regard?

18 A It is a description on how when you separate the head
19 away from the shoulder you can tear the plexus.

20 Q Okay.

21 MR. DAVIS: No other questions.

22 THE COURT: Any redirect?

23 MR. GRAHAM: Very quickly.

24 REDIRECT EXAMINATION

25 By Mr. Graham:

1 Q There was a question about, if a shoulder dystocia
2 last long enough that there would be a risk, brain damage
3 or dead. You are not suggesting that this case had
4 anything to do with that risk?

5 A No, I understood that as a hypothetical question.

6 Q Counsel referred to a person named Alexia. When you
7 answered those questions were you talking about Alexia?

8 A Yes.

9 Q There was a big deal made out of me hiring you
10 before. Have you also testified against me?

11 A Yes.

12 Q Thank you, nothing further.

13 THE COURT: Mr. Traylor, any redirect?

14 MR. TRAYLOR: No sir, Your Honor.

15 THE COURT: Any objection to excusing this witness?

16 MR. TRAYLOR: No, sir.

17 THE COURT: You are excused. Thank you, sir. Ladies
18 and gentlemen that brings us to the end of the evidence
19 for today. I am about to send you home, just remind you
20 of the rules. Don't discuss the case with anyone
21 including each other. Please don't do any outside
22 research tonight or look at any news articles. Otherwise,
23 I hope y'all have a great evening and we will see you back
24 at 9:30 tomorrow.

25 (Whereupon, the jury was excused from open court for

1 the day, to return at 9:30 a.m.)

2 THE COURT: Mr. Davis, we discussed your objection to
3 the exam on the bench conference. You want to make a
4 record on that issue?

5 MR. DAVIS: Thank you very much, Your Honor. Your
6 Honor, I respectfully object to the Court's ruling
7 allowing Dr. Resnick to physically examine Alexia in front
8 of the jury in this case. The basis of my opinion was
9 that it is a 403 objection, that any possible probative
10 value is far outweighed on the prejudicial nature and
11 intent by the Plaintiff by doing that and proffering that;
12 with sympathy and compassion for this jury based on her
13 current condition. So I object to that and I appreciate
14 you letting me put that on the record. I do respect your
15 ruling, I respectfully request that, respectfully note my
16 objection.

17 THE COURT: Thank you, Mr. Davis.

18 MR. DAVIS: Thank you, sir.

19 THE COURT: Anything from the Plaintiff before we
20 break for the day?

21 MR. GRAHAM: No, Your Honor.

22 THE COURT: Mr. Davis?

23 MR. DAVIS: No, Your Honor.

24 THE COURT: See everybody at 9:30 tomorrow morning.

25 (Whereupon, the trial will resume the next morning at

1 9:30 a.m.)

2 THE COURT: I am relying on the Burke v. Republic
3 Parking System case from 2018. I am going to deny the
4 motion with reservations. The witness was disclosed late,
5 I mean it sounds like that Mr. Davis did not hear until
6 early December that the witness was going to be disclosed.
7 My reading of the law, I am to look at, assuming the
8 witness is late disclosed and the factors I am considered
9 are first, the type of witness involved to the content of
10 the evidence emanating from the proffered witness. Three,
11 the nature of the failure and neglect to refusal to
12 furnish the witness' name for the degree of surprise.
13 And, five, prejudiced to the opposing party. So I will
14 walk through the factors. On the type of witness
15 involved, I think, is in the Plaintiff's favor. It is an
16 expert witness, obviously having to deal with a new fact
17 witness can change the complexion of a case in a way that
18 can be unexpected surprise at trial. But an expert
19 witness is different for the content of the evidence and
20 the degree of suppose and the prejudice factor, the Court,
21 can fall into one. The causation testimony is the
22 question. And we have a witness whose name was known to
23 the Defense Counsel but not as a causation witness, just
24 as a damages witness. So the degree of surprise is
25 lessened and Counsel on both sides, of course, know that

1 causation is going to be an issue in the case. Then Mr.
2 Davis is going to have causation testimony so I think that
3 the degree of prejudiced and the degree of surprise and
4 the content of the evidence weigh, also weigh in the
5 Plaintiff's favor. The third factor, the nature of the
6 failure or neglect to refusal, I think that weighs in the
7 Defendant's favor. This case has been ongoing for a very
8 long time and we had, you know, Judge Hall's order in 2020
9 so I think that factor weighs in the Defendant's favor.
10 But overall I understand the Defendant's frustration in
11 this case. But given the five factor test that I am
12 suppose to look at in this case, I am going to permit the
13 testimony on causation.

14 MR. DAVIS: Just for the record, my objection to Your
15 Honor's ruling is noted.

16 THE COURT: Is there anything else you want to put on
17 the record, Mr. Davis?

18 MR. DAVIS: No sir, thank you very much.

19 THE COURT: Yes, sir.

20 MR. GRAHAM: Your Honor, we have agreed, Ashby and I
21 have agreed to stipulate to the admission of certain
22 records.

23 THE COURT: Hold on so I can type. Alright, go
24 ahead.

25 MR. GRAHAM: We stipulated to the admission of the

1 office records, the prenatal office records from Dr.
2 Miller's group, his practice group. I am sorry, Your
3 Honor, I misspoke. We will have those later. What we
4 have right now are neonatal records on the child at
5 Piedmont right after the birth. And we also have the
6 labor and delivery records from the hospital from Piedmont
7 related to the mother's admission for this labor and
8 delivery. Further we had stipulated that before these
9 documents go to the jury we will carefully review them for
10 any needed redaction, to collateral source and presumably
11 that is the only thing but we can address anything else.
12 And finally, on a different matter, we do not have in the
13 courtroom the original deposition of Dr. Miller who we
14 intend to call as our next witness. We have agreed and
15 stipulated that we may use a copy at this time and submit
16 the original as soon as it returns to our possession.

17 THE COURT: So you are going to call Dr. Miller as an
18 adverse witness.

19 MR. GRAHAM: Yes, sir.

20 THE COURT: Okay. So make sure what we have is,
21 parties have stipulated to the admission of the neonatal
22 records from Piedmont Medical Center and the labor and
23 delivery records from Piedmont relating to the delivery.
24 And Counsel will jointly review for redactions prior to
25 submission to the jury. And then Counsel have also agreed

1 a copy of Dr. Miller's transcript will be acceptable. Is
2 that correct, from the Plaintiff's point of view?

3 MR. GRAHAM: Yes sir, Your Honor.

4 THE COURT: Mr. Davis?

5 MR. DAVIS: Yes sir, that is correct.

6 THE COURT: My tech guy says everything has worked
7 out for the WebEx witnesses. I mean, WebEx is not my
8 favorite product. From y'all's perspectives has
9 everything worked out? Okay.

10 MR. DAVIS: Your Honor, I don't know. I am going to
11 leave all of that to my technological friends across the
12 way here.

13 THE COURT: They tell me is the only thing they can't
14 figure out is a way that I can be heard by the remote
15 witness. In the event I need to say something I can ask
16 one of y'all to relay it to the witness. I don't think
17 that is going to be a big issue. Anything else we need to
18 take up before we get started.

19 MR. GRAHAM: Do we need to mark this now or --

20 THE COURT: I think marking it now. If you are going
21 to use it with Dr. Miller, I think it is better to mark it
22 now.

23 MR. GRAHAM: Thank you, Your Honor. Your Honor,
24 there is one more thing. Your Honor, for easy access we
25 have a -- that we will restore.

1 THE COURT: The Court Reporter has also mentioned to
2 me that she is having continual issues hearing attorneys,
3 primarily you, Mr. Graham. So I have told her that, I am,
4 she has tried to email me and I am listening to the
5 witness and I am not looking at my emails. So I have
6 asked her to speak out loud and say, Mr. Graham, can you
7 go back to the microphone or something like that. Again,
8 we have to be especially careful in this case, when we
9 have a court monitor instead of a court reporter, because
10 the audio recording will be the only record of the
11 proceedings. I just ask her to speak up if she needs to.
12 Is the Plaintiff ready to proceed?

13 MR. GRAHAM: Yes, sir.

14 THE COURT: The Defense?

15 MR. DAVIS: Yes, sir.

16 THE COURT: Let's bring them in.

17 (Whereupon, the jury came into open court at
18 approximately 10:08 a.m.)

19 THE COURT: Good morning, ladies and gentlemen, and
20 welcome back. We have been working on some tech issues.
21 You can imagine with COVID and everything, we are going to
22 have a couple of witnesses that are going to appear
23 remotely, meaning over video. And the tech stuff is going
24 beyond me, we have had people working on it, we think it
25 is all going to work well. Has everyone been able to

1 follow the rules that I have given you over the evening?
2 Thank you, ladies and gentlemen. I appreciate everyone
3 being on time. So we are ready to get started. Mr.
4 Graham, you can call your next witness.

5 MR. JORDAN: Your Honor, the Plaintiff would call Dr.
6 Gregory Miller.

7 Dr. Gregory Miller, being
8 first duly sworn, testified as follows:

9 DIRECT EXAMINATION

10 By Mr. Jordan:

11 Q Good morning, Dr. Miller?

12 A Good morning.

13 Q Dr. Miller, you do remember some things about Angela
14 Patton, don't you?

15 A Yes, I do.

16 Q And I believe the last time you saw Angela Patton, it
17 was at a postpartum delivery appointment, is that correct?

18 A That is correct, yes sir.

19 Q And the memory is that Angela made progress during
20 the delivery up until a certain point and then there was
21 some concerns about fetal heart rate. Is that correct?

22 A My memory is much deeper than that.

23 Q But you do remember that aspect?

24 A I remember some of that, yes.

25 Q And when the baby was not coming out in a timely

1 fashion you proposed C-section?

2 A Yes, sir.

3 Q And Angela was taken to an operating room, is that
4 correct?

5 A That's correct.

6 Q And can you describe that room, was that the regular
7 operating room at Piedmont, where was this?

8 A So at the time at Piedmont, this was the women's
9 center. We had three different operating rooms there, we
10 had one, two and three. This is actually operating room
11 two. We use operating room one and two for, you know,
12 obstetrics. Two could sometimes be flipped and used for
13 gynecologic surgeries. This is operating room two,
14 typical normal operating room. The only difference a
15 typical operating room and one that has some obstetrical
16 capacity, typically obstetrical capacity, they have an
17 offset room for the neonatologist to be there.

18 Q And is it fair to say, Dr. Miller, that you don't
19 recall what people were present in the room?

20 A No. I think from my earlier testimony I did recall.
21 You know, the anesthesiologist, the neonatologist; myself,
22 Julie Bibb; of course Angela, yes.

23 Q You don't recall which family members of Angela were
24 present?

25 A The problem in that situation is, Angela did not have

1 an epidural when she came back to the OR. And so what
2 happened in the delivery room is that Alexia experienced
3 bradycardia which we feel the heart rate begin to drop.
4 We tried different things, to deliver the baby in the
5 delivery room itself. But the delivery room doesn't have
6 the capacity to do an operation. So we wheeled her back,
7 the problem is when you wheel somebody back nobody is
8 allowed to come back initially. There are no family
9 members back there because that is an operating room. In
10 a situation where there is an emergency like this, she is
11 going to have to get general anesthesia. So in the
12 regular OR there is no family members allowed in an
13 operating during general anesthesia. So at that point
14 when she first came back it wasn't until we determined
15 that things, the heart rate had improved, things had
16 stabilized; that the only person that we allowed back
17 would be a spouse.

18 Q I appreciate your answer, Dr. Miller. But my
19 question was, do you remember who was eventually present
20 in that room at the birth?

21 A I remember the people I just discussed, yes sir.

22 Q You do not remember the father, Antwan, will you
23 stand up?

24 A No, I do not.

25 Q And I believe in your deposition you were asked, you

1 are not saying that he wasn't present or that Angela and
2 Antwan are lying about him being present, are you?

3 A Oh no, absolutely not.

4 Q You just don't recall. Now, you actually saw Angela
5 while she was at your practice, correct, I believe back in
6 March before the baby was born. You saw her at least
7 once, correct?

8 A I saw her at least once, yes.

9 Q And Angela had some hyperemesis, is that correct?

10 A She sure did.

11 Q And that is basically nausea and vomiting?

12 A Well, what is called hyperemesis gravidarum. And it
13 is typically a condition that is associated with pregnancy
14 itself. It often bothers women in the first trimester,
15 the first, week eight, week twelve, sometimes as late as
16 week fourteen to sixteen. So she did have some
17 hyperemesis gravidarum, yes.

18 Q That didn't have anything to do with this brachial
19 plexus injury, did it?

20 A No it did not, no sir.

21 Q And what is the medical term for when there is a
22 larger baby, what is that term.

23 A Well, you can use LGA which large is for gestational
24 age or you can use macrostomia.

25 Q And in this instance Alexia was a large baby,

1 correct?

2 A She was a large baby. Yes, she was.

3 Q And you were on call that --

4 A But I would say she did not meet the definition of
5 macrostomia, that is in the community.

6 Q And is macrostomia, well macrostomia in a current
7 pregnancy, you would agree, wouldn't you, Doctor, that is
8 a risk for shoulder dystocia?

9 A Absolutely, yes it is.

10 Q And Angela had a prior baby that was 9, 11?

11 A She did.

12 Q And Alexia was 9, 6, I believe?

13 A When she delivered she was 9, 6, yes.

14 Q And you were on a 24-hour call?

15 A Yes, sir.

16 Q And I believe you came on the morning of April 5th?

17 A That would be correct.

18 Q And you would go off the morning of April the 6th?

19 A That's correct.

20 Q And Angela came in the evening before, correct?

21 A Yes, she did.

22 Q And, Doctor, do you remember what time she came in?

23 A I wasn't on that particular night. So I wasn't
24 there, certainly by the records here it says she came in
25 almost 10:00 o'clock.

1 Q And so had she been laboring all night?

2 A She was, they were working on inducing her, trying to
3 get her into labor.

4 Q And she needed to be induced because it was a large
5 baby, isn't that true?

6 A Well, the induction was set up by one of my
7 partner's, Dr. Robinson. And in all honesty I don't think
8 he actually documented why he set the induction up.

9 Q And you don't have an opinion as to why he set the
10 induction up?

11 A No, you know, we worked, our practice worked as a
12 team and I don't know his exact reasons why, so no.

13 Q And isn't it true that often times induction is for
14 the benefit or scheduling of the physician as opposed to
15 the mother?

16 A Absolutely not.

17 Q And there is also some medications that you give that
18 push the labor along, is that correct?

19 A There are medications that help the labor, yes.

20 Q What are those medications?

21 A So, you sort of break them down for two medications.
22 One is for induction, trying to get somebody into labor or
23 getting the cervix to dilatate further. And the other is
24 Pitocin.

25 Q What is the one called you are trying to get them

1 into labor, induce labor. Is it Cytotec.

2 A Cytotec is one of them, yes.

3 Q That is a brand name?

4 A Yes.

5 Q And what is the regular name?

6 A I don't know that I can either, what they call an
7 Prostaglandin E1.

8 Q So Cytotec was given, what is Pitocin for, Doctor?

9 A Pitocin is for contractions. And that is the typical
10 hormone, that is a hormone called oxytocin when it is
11 naturally produced in the mother. When we give it it is
12 called Pitocin.

13 Q What does Pitocin do with contractions?

14 A It is designed, just as it does naturally, it is
15 designed to help generate contractions.

16 Q Doctor, I want to show you here, we have got Cytotec
17 given at 00:23, that is right after midnight. Is that
18 correct?

19 A It says 00:25, yes.

20 Q Okay. And Pitocin is given also?

21 A Yes, it is.

22 Q Pitocin was started at 7:41 that morning?

23 A Yes.

24 Q And then it is increased?

25 A Yes, there is a protocol.

1 Q 8:00 o'clock, 9:00 o'clock, 9:44, 10:41, 11:43,
2 15:50, 16:55, 17:39 and then Cytotec again at 20 -- do you
3 see that?

4 A The Cytotec at 21:00 was actually after she had
5 delivered and that was to take care of another life
6 threatening problem, she developed postpartum hemorrhage.
7 Just as it works in helping to get the uterus to contract
8 or hopefully to get the cervix to open and go into labor,
9 after somebody delivers Cytotec is used to try and save
10 their life to keep them from bleeding too much, that they
11 might bleed to death. So it is a different reason and it
12 is after the labor had finished.

13 Q She was given a lot of things?

14 A She was given the typical dose of Pitocin, yes.

15 Q Doctor, after you took her back to the operating room
16 and that was because of the fetal decline and the fetal
17 heart rate, correct?

18 A Yes, sir.

19 Q Late deceleration, is that what it is called.

20 A No, bradycardia.

21 Q Bradycardia, okay. And she was taken back and then
22 the heart rate settled down or increased.

23 A The heart rate improved.

24 Q So there was no longer that concern, was it?

25 A Oh, there is always a concern. Once somebody has

1 bradycardia there is always concern. You don't know when
2 or if that bradycardia is coming back and if the second
3 time it comes back, since you don't know when it is going
4 to come back, you don't know how catastrophic it can be
5 that second time.

6 Q Isn't it true, Doctor, that you called the C-section
7 off and allowed to --

8 A Yes.

9 Q So if the fetal heart rate had been such at the level
10 that it concerned you, you would have kept on with that
11 C-section, wouldn't you?

12 A So if you want to bring up the tracing, I can show
13 you the improvement in the fetal heart rate, that might
14 make it easier. But I think each expert witness has said
15 that that was perfectly handled. But the tracing did
16 improve, there was a ten minute gap in transferring the
17 patient from the labor, delivery room to the OR. So that
18 is the other concern, we don't know what is happening in
19 ten minutes. I don't know if that heart rate improved,
20 immediately after start moving her or it just improved
21 right after we got back to the OR. So there is a
22 significant amount of concern.

23 Q The rate is being monitored, correct?

24 A For that ten minute window it was not. And when you
25 are transferring the patient that rate is not being

1 monitored.

2 Q You did not continue with the C-section, Doctor?

3 A No, we did not.

4 Q And if you had felt like there was concern with that
5 heart rate you would have continued with that C-section,
6 wouldn't you?

7 A Yes, we would have.

8 Q Doctor, what is traction?

9 A Traction is a force.

10 Q Is it a force or an effort?

11 A No, it is a force.

12 Q Do you remember giving a deposition back in 2011?

13 A Yes sir, I do.

14 Q Isn't it true at the time of your deposition that you
15 defined traction?

16 A I did and I tried to qualify that and explain that
17 further because that is taken out of context in this case.

18 Q Doctor, if you had put moderate traction in your
19 report, and I am going to pull that up in a second here.
20 If you had put moderate traction in your report you would
21 be admitting to a violation of the standard of care,
22 wouldn't you?

23 A No.

24 Q Isn't it true, Doctor, that anything greater than
25 gentle traction is a deviation of the standard of care?

1 A It is, no it is situational. And I think even Dr.
2 Duboe mentioned that yesterday.

3 Q And the only situation where you can use more than
4 gentle traction, would be when it, the baby is about to
5 suffer brain damage?

6 A Absolutely.

7 Q And that was not the situation here because you are
8 allowing the mother to push, right?

9 A I never used anything more than gentle downward
10 traction.

11 Q Very good. But you agree with me that your
12 definition of traction was force or effort?

13 A My definition of effort is something different and I
14 qualify that in the deposition. I can qualify that today,
15 if you would like. The definition effort to me, what that
16 meant was, some total of events. So when you do so many
17 maneuvers to try and deliver a baby that requires moderate
18 effort.

19 Q Doctor, I have pulled up and the handwriting is
20 perhaps a little bit hard to see. But let me get a laser
21 pointer, that might help. If you would read what you say
22 there. Left shoulder delivered using McRoberts and
23 suprapubic pressure and moderate effort. Is that what it
24 says?

25 A Is there any way you can put the entire note up here

1 instead a part of the note.

2 Q I will do that. But my question is, isn't that what
3 it says, that portion?

4 A That's correct. Yes, sir.

5 Q And so you are listing things here that were used.
6 Left shoulder delivered using McRoberts suprapubic
7 pressure and moderate effort. That is your words,
8 correct?

9 A And that effort is to include all the other prior
10 maneuvers used, yes.

11 Q But that is not what your notes says, is it?

12 A Yes, it is. In my mind that is exactly what it says.

13 Q And my question again, Doctor, if you would put
14 moderate traction. In this circumstance that would be a
15 deviation of the standard of care. If instead of use the
16 word, traction, you would agree with me, Doctor, that
17 would be outside of your training?

18 A I did not use moderate traction.

19 Q And that is not my question. My question is, Doctor,
20 if you had put in that note, instead of moderate effort,
21 if you had put moderate traction, you would agree with me,
22 wouldn't you, Doctor, that would be outside of your
23 training?

24 A No, not necessarily.

25 Q You would agree with me, Doctor, in this circumstance

1 you used, what you said, was general traction, correct?

2 A That's correct.

3 Q And if you had of used more than general traction,
4 you would agree with me, wouldn't you, Doctor, that it
5 would be outside of your training?

6 MR. DAVIS: Your Honor, I think he just asked that
7 question. It is just, isn't that the exact same question
8 he just asked. Asked and answered.

9 THE COURT: I am going to overrule the objection. Go
10 ahead.

11 Q Doctor, if you can answer my question?

12 A Yes, sir.

13 Q If in this situation, and I understand your testimony
14 that you used nothing but general traction. But my
15 question is, Doctor, if you had of used more than general
16 traction you would agree with me that that would have been
17 outside of your training?

18 A Yes.

19 Q You agree with me, Doctor, that if you had of used
20 more than general traction that would have been a
21 deviation in the standard of care?

22 A Depending on the situation, it could be, yes.

23 Q And instead of traction, your notes says effort,
24 correct?

25 A That's correct.

1 Q And in your deposition you defined traction as force
2 or effort.

3 MR. DAVIS: Your Honor, I know that has already been
4 answered a couple of times.

5 THE COURT: This is an adverse witness, I am going to
6 allow it.

7 A This is being out of context. In this context, in
8 the delivery note itself, effort means, actually, some
9 total of maneuvers.

10 Q And, Doctor --

11 MR. JORDAN: Your Honor, I have a copy of the
12 deposition here. I would like to refer him to page 91.

13 Q Page 91, starting on line 17. You were asked, what
14 is traction.

15 A I said traction is delivering, it is using force or
16 effort, yes.

17 Q Traction in delivery you are using force or effort?

18 A That is correct, yes.

19 Q Doctor, in this circumstance there was a, you
20 encountered a shoulder dystocia and that was with the
21 right shoulder, is that correct?

22 A That's correct.

23 Q And you used McRoberts suprapubic pressure,
24 episiotomy you did also, is that correct?

25 A Yes.

1 Q And you ended up doing a maneuver where you turn the
2 baby 180 degrees, correct?

3 A I also attempted a posterior shoulder delivery as
4 well.

5 Q That's correct, I am sorry. You tried posterior
6 shoulder and then you did the screw maneuver, correct?

7 A The woodscrew maneuver, yes.

8 Q And woodscrew maneuver, the purpose is to dislodge
9 that shoulder and allow the baby to corkscrew down, to
10 send down, correct?

11 A Yes sir, that is correct.

12 Q It is not like a steering wheel, you rotate 180
13 degrees, is it?

14 A I have never seen that listed and have never heard
15 that terminology. I don't think that type of maneuver
16 exist.

17 Q And in this case, the baby was rotated 180 degrees,
18 correct?

19 A That's correct.

20 Q And then we have got the left shoulder that stopped?

21 A No.

22 Q Left shoulder was never stopped?

23 A No. If you look at the literature and it is very
24 clear, on a woodscrew maneuver. A woodscrew maneuver not
25 only allows the baby to turn, but it allows the baby to

1 descend. So that anterior shoulder is now below the pubic
2 symphysis. And that is what happened in this case.

3 Q But you had to do McRoberts suprapubic again in 45
4 seconds, correct?

5 A So the McRoberts, typically when you put somebody in
6 McRoberts, you never take them out of McRoberts until the
7 delivery is completed. The suprapubic is a maneuver, and
8 I sort of like to continue it in this situation because I
9 always worry that if that shoulder does pop below the
10 bone, I like that there is pressure about that to prevent
11 any way that that shoulder could pop back up. So the
12 suprapubic is there just to make absolutely certain that
13 there is no way that that could pop back up. So that is
14 routinely what I do.

15 Q Doctor, during that time, with the suprapubic
16 pressure, you are also using traction, aren't you?

17 A No, no, not during that.

18 Q In the record here, suprapubic pressure for 45
19 seconds and then shoulder is delivered?

20 A Yes, that is correct.

21 Q And then the next note is vaginal delivery per Dr.
22 Miller?

23 A Yes.

24 Q And is it your testimony that you were not using any
25 traction at that time?

1 A So --

2 Q You had the baby's head in your hands, didn't you?

3 A What I was going to say, if I can finish. There is
4 not, no, you are not using traction. You are guiding that
5 baby and doing the screw maneuver. The forces are sort of
6 the way a nut screws into a bolt. Traction would be going
7 down the long axis of that bolt. But this is a circular
8 motion that is turning around. And so you are actually,
9 in this case my left hand, my left hand was behind her
10 left shoulder. And it is rotating that baby. Traction
11 would have been able to point down or I might have been
12 putting some pressure on the neck. That wasn't happening.
13 We are rotating that baby around. So now there is really,
14 virtually no traction on the baby, the head or the neck at
15 that time.

16 Q Doctor, you would agree with me, wouldn't you, that
17 you don't know how many pounds of pressure you are using
18 or traction, do you. You never --

19 A First of all we weren't using traction so I don't
20 know how to answer that question.

21 Q When you use gentle traction do you know how many
22 pounds of pressure. You do not, do you?

23 A I don't think that, unless you are at a teaching
24 center that actually has pressure monitors; and even
25 those, I know Dr. Duboe talked about finger sensors on.

1 That actually doesn't measure traction, that just measures
2 pressure applied to the baby's skin and they run through
3 equations to try to figure that out. But I don't know
4 that anybody knows how much traction they put on a baby
5 during gentle downward traction.

6 Q And you have never done any, later testing since
7 Alexia was born, have you?

8 A I am actually, I actually have, yes. If you need, I
9 have --

10 Q At the time of your deposition --

11 A No, so back, unfortunately in 2007, I think simulator
12 training was very, very new, not being used very widely.
13 Still not used in the State of South Carolina, as much as
14 it does sound like it is in the City of Chicago. But what
15 we had was, the Medical University of South Carolina had
16 an outreach program to all the smaller hospitals to offer
17 doing simulator training. And I think in 2019, 2019,
18 before COVID, I think it was Dr. Guitteray, in charge of
19 the simulation lab up in MUSC, came to our hospital and
20 really the purpose of this was to sort of try to make sure
21 doctors and nurses had a coordinated effort to deliver
22 babies. So it was a voluntary sign up. And for the seven
23 physicians I was the only one that signed up so it meant I
24 was the guinea pig for about two hours which each team of
25 nurses to sort of go through routines and talk about how

1 we deliver those babies. So I have had the simulator
2 training, yes.

3 Q Out of all of the physicians you were the only one
4 that signed up?

5 A That's correct.

6 Q Of course, this case was pending at the time you
7 signed up, right?

8 A No, I signed up because at the time I was Chairman of
9 the Department and the woman, Patty Valentino, who was the
10 Chairman of Nursing, Chairman of the Department of OBGYN
11 was concerned we weren't going to have any physicians show
12 up. She thought it was important we had a physician with
13 the nurses. I said, I raised my hand and said, I will
14 show up.

15 Q You would agree with me, wouldn't you, Doctor, that
16 excess lateral traction is not another maneuver to try in
17 shoulder dystocia, correct?

18 A That's not one of the maneuvers that I do, no.

19 Q Now, you did a woods maneuver, but there are other
20 maneuvers that can be used to relieve shoulder dystocia,
21 correct? Something called a Rubins.

22 A Another woodscrew maneuver type, yes.

23 Q There is a Gaskins maneuver, isn't there?

24 A A Gaskin is really considered extreme. And I think
25 even Dr. Duboe talked about it a little bit. There are

1 maneuvers that I consider sort of, the typical movements
2 that you might do which is gentle downward traction which
3 typically don't list; and then you have the moderate
4 maneuvers which are things like posterior shoulder and
5 woodscrew maneuver. And then you have the extreme
6 maneuvers and I think, you know, I disagree with Dr. Duboe
7 when he said, the emergency was really an emergency. But,
8 you know, Gaskin is basically the woman gets up on all
9 fours --

10 Q Changes position.

11 A So she is in all fours and in fact, I know this is
12 hard to think about, what you are doing is, you are going
13 to deliver that posterior shoulder as if it is an anterior
14 shoulder. So she is upside down and you are going to try
15 to deliver that posterior as an anterior shoulder. And
16 that is what is called a Gaskin. Now there is other
17 really sort of extreme maneuvers, if we are going to talk
18 about all the maneuvers.

19 Q The other one is a Zavanelli, isn't that right?

20 A Well, there is more than just that. The Zavanelli is
21 probably your last resort. The Zavanelli is you try to,
22 so the baby's head is out and those shoulders are
23 impacted. And typically by the time you get to the
24 Zavanelli it is a life threatening issue. The studies
25 have shown that the more maneuvers you use the more, the

1 more dangerously it is to the baby and the more likely the
2 baby has an adverse outcome. And so by the time you get
3 to Zavanelli, and I have actually done the Zavanelli once,
4 I wasn't actually responsible for it because it was in my
5 residency and Dr. Patrick Duff did it, I assisted him.
6 But the Zavanelli, what you have to do, is you have to and
7 this is a good point to what you were saying. You do not,
8 you make sure you do not use lateral traction on the head.
9 What you are going to do is you are going to take the head
10 and you have to sort of almost reverse the maneuvers that
11 the baby came out. So the last thing the baby does, it
12 extends its head underneath the pubic bone. You have got
13 to flex the head back and then you have got to try to push
14 the shoulders as far as you can and you are going to turn
15 around and do an emergency C-section. And as you can
16 imagine, that takes time and that is time that you don't
17 have in a shoulder dystocia and very rarely do children
18 even survive a Zavanelli because it is one of the last
19 resorts. Sometimes when baby's come out the cord will
20 wrap around their neck. And one of the first things you
21 want to do when the cord is wrapped around the neck you
22 want to reduce, and sometimes the cord will come out
23 before the baby and that can happen in any of these
24 delivered. When you do a Zavanelli the first thing you do
25 is you do not touch that cord, you do avulse that cord,

1 you do not clamp that cord because once that cord is
2 interrupted you have got seconds at that point. You do a
3 Zavanelli you then put a, what is called a field scapula
4 electric on the baby's head because this whole time, once
5 again, you don't know what is happening. And that gives
6 you an idea, you can electronically at least monitor or
7 sort of see how dangerous or life threatening it is as you
8 are trying to negotiate through that. So the Zavanelli is
9 another one and I have never seen anybody do this. I
10 can't imagine doing this, it just sounds horrible. But
11 you break the child's clavicle. You take the clavicle
12 between your two fingers and you snap it. Because what
13 you are trying to do, the problem in a shoulder dystocia
14 is what they call is the bisacromial diameter and it is
15 the diameter between one shoulder to the next. And you
16 have to reduce that somehow and so breaking a child's
17 clavicle, although it sounds really barbaric, I have never
18 done it, I haven't known anybody that has done it. Baby's
19 to sometimes, after a delivery, come out with a fractured
20 clavicle because it was done by doing some of the other
21 maneuvers. And that is another thing. And then the last
22 thing that you do which is probably on the same lines as
23 Zavanelli is the two pubic bones is connected by what is
24 called pubic symphysis which is extremely tough fibrous
25 cartilaginous tissue and you cut that which means you cut

1 straight down in the woman's skin. And as you can
2 imagine, that is pretty barbaric too. Those would be
3 extreme effort or extreme measures.

4 Q You have never done a Gaskins or one of those?

5 A No. I have delivered babies, sometimes mother's like
6 to be knee chest, I have delivered babies from knee chest
7 but not for shoulder dystocia.

8 Q The stations of delivery, you use five or three?

9 A I think five is becoming pretty much universal.

10 Q And so tell the jury, the baby starts out where, what
11 station?

12 A I am sorry. The baby is actually floating, not at a
13 station. So basically that means the leading edge of the
14 baby's head is above what we call the pelvic inlet and
15 that is where the sacral promontory, and if you drew a
16 line from the sacral promontory across the pubic symphysis
17 that is the plane, the baby is floating above that. And
18 so as soon as that baby starts entering the plane then you
19 can start --

20 Q That would be a zero station, correct?

21 A No, no, that's not.

22 Q Tell me, what is a zero station?

23 A A zero station, so further, you would go from
24 floating to -4, -3, -2, -1.

25 Q You are engaged, would that be zero?

1 A What is that? Let me just finish, if you don't mind.

2 Q I will let you finish.

3 A So what happens is when they get down to zero
4 station, that means that the leading edge of the head sort
5 of almost half way down the pelvis and there are two
6 little bony protrusions called the ischial spines that
7 stick out. And so when the baby's head gets to zero you
8 are at that station. And then once you get below that the
9 baby continues to descend further, it is +1, +2, +3, +4.
10 And then usually +4, +5 is when you can actually see the
11 baby's head extending out of the vagina. You can see at
12 least the top of the head coming out of the vagina.

13 Q How far does the baby move in this station?

14 A Each station is approximately, what we try to do is
15 try and keep it, so that everybody is on the same page, a
16 centimeter.

17 Q And how long was Angela in labor?

18 A I would have to look at the chart to tell you
19 exactly. I want to say that she, we were looking at the
20 contractions. Diagnosing labor depends on two things,
21 regular contractions and when the cervix starts if you,
22 particularly starts to dilate.

23 Q She was induced about 7:00 o'clock that morning, how
24 many centimeters did she move until Alexia --

25 A Until she was actually born. Well, I mean, so can I

1 look at the strip and talk to you about that, if you would
2 like.

3 Q Doctor, I don't have it pulled up but I can look for
4 that while we are talking.

5 A I think there was a point where the baby was -2 and
6 it was -2 to 0 close to an hour and a half or so. At that
7 stage the baby was not making very little, if any progress
8 down. The cervix was dilating and I think even when she
9 got completely dilated the baby is still pretty high,
10 still at the 0 station. So it is still up there pretty
11 high. But if I am not mistaken, you know, technically and
12 again, this is just a rough call because I don't have the
13 chart and this was 15 years ago. It was probably around
14 dinner time or so, we would say she was having regular
15 contractions and the cervix was starting to change.

16 Q My question is, how many centimeters totally did
17 Alexia move during that labor?

18 A From floating or from -2?

19 Q From 0, engaged, from engaged.

20 A When the baby is entirely out or just the head is
21 out?

22 Q Entirely out.

23 A Oh. So I guess if a baby is 20 inches long and
24 Alexia was a big baby, maybe 21 to 22 inches. If you take
25 the count of that 21 to 22 inches, from a 0 station there

1 is about, you know, five to maybe six centimeters. Five
2 to six centimeters plus 21 to 22 inches, is that what you
3 are asking?

4 Q So the head would move, until the head, the head is
5 coming out, about five or six centimeters. Is that
6 correct?

7 A Until the head comes out?

8 Q Yes.

9 A So we would be, it would be, once the baby reaches
10 the vagina, I am sorry, the vaginal opening and the head
11 is crowning. You can see the head, it is probably five to
12 six centimeters travel, yes.

13 Q And how long a period of time and it is a slow
14 progress, labor can be faster but this was a long labor
15 for Angela, wasn't it?

16 A No, no, it wasn't.

17 Q Well she was induced early so that was a long period
18 of time that day?

19 A No, she was induced, you know, first thing in the
20 morning. And if she didn't start really laboring until
21 around 6:00, that is pretty, she had delivered before,
22 that is pretty short.

23 Q Doctor, go back just a moment to the operating room.
24 After you decided that you are not going to do a C-section
25 and you said you don't remember Antwan?

1 A No, I don't. I am sorry.

2 Q Antwan was there.

3 A That is my standard protocol. If we take somebody
4 back and we do change direction, I am going to ask the
5 husband because the husband is pretty important to
6 coaching the mom and inviting encouragement. If he says
7 he was there, I believe him.

8 Q Antwan would have been somewhere behind you, correct?

9 A No. He is not allowed behind me.

10 Q On the side of you?

11 A No, he is, his primary purpose is, Antwan's primary
12 purpose is taking care of Angela. So he is not allowed
13 down or even next to.

14 Q Do you ever remember Antwan asking, why are you
15 pulling so hard on my baby's head?

16 A If I don't remember him there I certainly can't
17 remember that. But, I mean unfortunately there would be
18 no way that he would be able to possibly see that. You
19 know what happens is, in Angela's case, we went back and a
20 patient's bed in the room is large enough that actually
21 two people can sleep in it. But in an OR bed is average
22 20 inches wide, some of the beds are up to 24 inches but
23 they are 20 to 24 inches wide. When you are going to do a
24 C-section it is, the bottom of the bed is horizontal with
25 the top of the bed. The way the beds in the OR are built

1 is you can lower the bottom of it. And once we
2 determined, so when she first got back, she was on what we
3 call dorsal lithotomy position, fully laying down. Once
4 you say, hey, this baby looks like its doing well and she
5 was pushing a whole lot better back there. And so, okay,
6 we need to break the bed down, which means lower the
7 bottom of the bed and we put stirrups on. And so these
8 stirrups are to help hold her legs up. But we still try
9 to do this as sterile as possible. So there is a drape
10 that is put across her legs so that, you know, honestly
11 nobody but me or maybe my scrub tech behind me can see
12 what is going on. It is not done for that reason, it is
13 done to just to sort of try to maintain some degree of
14 sterility in the OR. Because there is still a chance,
15 there is still a chance that if that baby's heart rate
16 does start to go down quickly that we go back to plan B
17 and say, we are just going to go do the C-section now.

18 Q Doctor, let me ask you this. Are you aware of any
19 case where a child sustained a permanent brachial plexus
20 injury, diagnosed at birth that was caused by something
21 other than excessive lateral traction on the child's head
22 and neck?

23 A Yes.

24 Q Do you recall being asked that question at your
25 deposition in February of 2011?

1 A Yes.

2 Q And at that time you said, in all honestly, I am not
3 aware of any case. Do you remember saying that, page 154,
4 if you want to --

5 A No, because I would love to see it. Because I think,
6 I think that deposition is somewhat --

7 Q Look at page 154.

8 A Okay.

9 Q Line 7 is the question, your answer starting on line
10 12.

11 A Yes, I thought that was pertaining to any personal
12 knowledge.

13 Q And so you didn't have any personal knowledge of
14 that?

15 A No.

16 Q Your answer doesn't qualify that, you just say I am
17 not aware of any case?

18 A Well, when I say any case, that means any case that I
19 would know of, yes. That is sort of personally
20 qualifying.

21 Q And, Doctor, at the time you dictated the note that
22 we looked at earlier, you were not aware that Alexia had a
23 permanent injury, were you?

24 A I didn't dictate any note.

25 Q The handwritten note?

1 A Oh, the handwritten note. Actually, yes I was.
2 Because, but I was shocked, which arm. The neonatologist
3 at the time, you know, because we were doing a C-section
4 for bradycardia and the neonatologist was not actually in
5 the labor and delivery room. She is in the side room
6 there. She came back and told me, you know you have got a
7 weak left arm. I was shocked, are you sure it is her left
8 arm, it should have been the right arm. The right arm is
9 the one that we had the shoulder dystocia on. She said,
10 no, it is the left arm. And I was shocked.

11 Q My question is, did you know it was permanent?

12 A No, I don't think you know anything is permanent for,
13 anywhere from one to two years.

14 Q At the time you wrote the note, handwritten note, you
15 did not know that Alexia had a permanent brachial plexus
16 injury, did you?

17 A I don't think anybody does. I don't think you can
18 define it as permanent at that time.

19 Q Doctor, at the time of your deposition, you did not
20 have any evidence to what caused this permanent brachial
21 plexus injury with Alexia?

22 A I had, the way the question was asked, do I have any
23 opinion what caused it. And I said, no, I had an opinion
24 of what didn't cause it. And that opinion that didn't
25 cause it was, I did everything right. The only shoulder

1 dystocia that happened in this case, the only one involved
2 the right shoulder. And if you look at every single
3 expert witness, they are going to say I did the maneuvers
4 correctly. And that right shoulder was delivered safely.
5 The left shoulder, there was no shoulder dystocia on that
6 left shoulder. So I know, A., it is not the right
7 shoulder. B, I didn't cause the left shoulder because
8 there was no left shoulder dystocia. So at that point, do
9 I know exactly when and where. No, I just know when it
10 didn't happen.

11 Q Doctor, you would agree with me that Alexia has what
12 is called an avulsion injury. The roots are actually
13 ripped from the spinal?

14 A Based on the testimony I heard yesterday and what
15 limited reading I have done, yes.

16 Q (Inaudible.)

17 A No absolutely not.

18 Q The roots were ripped from the spinal cord?

19 A The roots were separated, yes.

20 Q And, (inaudible).

21 A Several other levels were separated as well.

22 Q (inaudible), ruptured, you wouldn't do anything
23 different?

24 A No, I didn't do anything wrong. You know, there is
25 something called a posterior shoulder dystocia and this is

1 a classic example of a posterior shoulder dystocia. And
2 that happens in much higher in the birth canal where the
3 birth attendant has to control over the delivery. And
4 that is exactly what this was. So would I do anything
5 wrong, do anything again or do anything differently. I
6 have delivered over 9,000 babies, I am probably one of the
7 most experienced obstetricians in the State of South
8 Carolina. I have never, I don't even know if I have ever
9 had more than a transient brachial plexus injury. So you
10 are asking me to change what I did based on something that
11 I didn't even cause. No, sir.

12 Q So, Doctor, if you didn't cause it in the technique
13 that you were using, is it your testimony that somehow
14 you, (inaudible), in the effect of a woman's uterus that
15 would cause nerve roots to be ripped from the spinal cord?

16 A Over 50 percent of brachial plexus injuries have no
17 associated shoulder dystocia event with them. And it has
18 been documented in many, many times about a posterior
19 shoulder, neonatal brachial plexus palsy. It as also been
20 documented that in C-sections there is a risk for a
21 neonatal brachial plexus palsy. So there is lots of
22 reasons why people can have a brachial plexus palsy. And
23 shoulder dystocia, and again, the left arm was not a
24 shoulder dystocia. The right arm was and that was fixed.
25 So she meets the criteria of being a posterior shoulder

1 dystocia. But, you know, there are other reasons and I
2 think the experts will argue those.

3 Q And, Doctor, are you aware of how Piedmont, what
4 Piedmont called this injury?

5 A I have no earthly idea.

6 Q Injury to brachial plexus due to birth trauma?

7 A Okay.

8 Q And in this case that is a birth injury, isn't it,
9 Doctor?

10 A No. That is a CPT code and that is just for coding
11 and that is actually, unfortunately, that is for getting
12 paid. That has nothing to do with anything other, they
13 want to somehow get paid for this.

14 Q And, Doctor, I want to go back and ask something I
15 think I was not clear on. I believe Alexia was 21 and a
16 half inches long?

17 A Okay.

18 Q I have got the records, if he needs to refer to
19 anything. And my question, Doctor, Alexia, I think she
20 was 21 and a half long --

21 A I am sorry, I was --

22 Q 21 and a half inches long. From the time her head
23 was engaged through the time that Alexia, full baby was
24 out, how far did Alexia's toes travel?

25 A How far did her, from the time she was engaged?

1 Q How far did she travel?

2 A So engagement actually happens when the tip of the
3 head actually enters the pelvis, where the sacral
4 promontory and the, that line of the sacral promontory and
5 the pubic symphysis. And so that's right before they are
6 floating so they are very high. So you would estimate
7 that that might have five to six centimeters, maybe
8 another, getting down to the ischial spine. And so that
9 is all the minus numbers has it dropping down. And the
10 plus numbers it is coming below that. And so just
11 roughly, I have never been asked that question. Anywhere
12 from 10 to maybe 12 in that. And then if you add the 21
13 inches long, you know, in which case the baby's feet are
14 up here. And you say 21 plus maybe 12 centimeters,
15 something along those lines, if that is what you are
16 asking.

17 Q So total distance is how many inches or centimeters?

18 A I wish I could use my phone. So 21 inches times,
19 what, 2.5 centimeters. So that might be 50 centimeters
20 plus another 10 to 15 centimeters. So this is rough,
21 rough, but I would say somewhere between 60 and 70
22 centimeters.

23 Q And, Doctor, assuming that Angela was in labor about
24 eight hours and six minutes, 8.1 hours, and the baby
25 traveled that distance and that long, 8.1 hours. We have

1 calculated.

2 MR. JORDAN: Beg the Court's indulgence.

3 Q And, Doctor, if you would, tell me what time the
4 baby's head was engaged, what time was the engagement
5 here. You can look back at the records, if you would?

6 A I honestly, I don't know if we know exactly when that
7 is.

8 Q The number of hours?

9 A If we stick strictly to the record, I am sorry, might
10 not have enough records here to figure that out. And I
11 don't know if I have enough records to figure it out.
12 Chance are we don't know exactly when engagement occurred.

13 Q But is it fair to say, Doctor, that the baby traveled
14 a very short distance or very long?

15 A The baby, the typical appropriate distance over the
16 typical appropriate time, yes. That is what I would say.

17 Q And, macrostomia, did you ever diagnose Alexia?

18 A Alexia? She technically was not in that macrostomia.
19 There is multiple definitions for macrostomia. Typically
20 the one I like to use is, so there have been studies to
21 try and use C-sections in a way to try to avoid shoulder
22 dystocia and neonatal brachial plexus injuries. What ACOG
23 likes to say, the American College of OBGYN's, at least
24 helps put all the date together and give us guidelines.
25 They say if a baby is over 5,000 grams then that warrants

1 a C-section. No attempt, excuse me, can you hear me. No
2 attempt at vaginal delivery, you offer them a C-section.
3 Okay. Now, that is if something is non-diabetic. You
4 knock that down to 4,500. I think our last ultrasound of
5 Alexia said she was 815 and I want to say that put her at
6 4,050 something grams but I think that, her actual birth
7 weight of nine foot, six inches put her at 4,220 or
8 something. So she didn't meet the criteria. I like to
9 use the word, LGA, well sometimes use those
10 interchangeably. But what I really am trying to be
11 specific, I try to fall back on what ACOG says because
12 then you have more grounds to do a C-section, a primary
13 C-section on somebody. So she didn't really meet that
14 criteria.

15 Q Doctor, you are trained to handle shoulder dystocia,
16 correct?

17 A Yes, sir.

18 Q And unlike cardiologist or family practitioner or
19 some other medical provider or layperson, like myself, Mr.
20 Graham, Mr. Davis, encounter shoulder dystocia.

21 A I hope not.

22 Q You are trained for that specific circumstance?

23 A For that and many more, yes.

24 Q And, Doctor, when you are trained for something you
25 are trained to handle that much more in an emergency,

1 isn't that true?

2 A No. It is not an issue of training. This is
3 strictly an issue for safety for that baby. The minute
4 you diagnose shoulder dystocia every single literature
5 source will say that is an emergent from that point
6 forward. It is an emergency whether you are a cop on a
7 beat; it is an emergency whether you are a taxi car
8 driver; it doesn't matter. You have got a baby's life on
9 your hand. And bad things happen really quickly. Okay.
10 You and this is where Dr. Duboe and I disagree. I
11 disagree completely with six to eight minutes. That is a
12 farce in my world. You have got four to five minutes.
13 This is a baby's life, whose life is on the line. So you
14 try to do things really, you try to have a routine
15 protocol. You are not going to wait five or six minutes
16 before you get serious about a shoulder dystocia. That is
17 one of the true classic obstetrical emergencies in our
18 literature.

19 Q And something that you are trained for?

20 A Yes.

21 Q And, Doctor, you mentioned safety and you always want
22 to do the safest thing for the patient, for Angela and
23 Alexia, right?

24 A Yes.

25 Q Using excessive traction would never be the safest

1 thing in this circumstance, would it?

2 A I would never use excessive traction.

3 Q Because that would be unsafe for the baby?

4 A Would be dangerous for the baby, yes.

5 Q And isn't it, you can't sit here and tell the jury
6 how many of traction or pressure you used?

7 A No. Determining how much traction you use, in
8 general downward traction, that is a feel. And that is
9 something you learn over time and over in experience. You
10 first start learning about it, in fact when I was a
11 medical student, Dr. Duboe talked about, then you learn
12 more and more about it in your residency. You know, I did
13 493 deliveries in my first year of my residency. And I
14 ended up with close to 1,500. You learn and you learn
15 what is, what is acceptable. But nobody and I don't know
16 of any OBGYN that, you know, knows exactly for them what
17 is gentle downward traction based on pressure. Those
18 studies are just not available to us. But I do know my
19 feel and I stick strictly to my feel.

20 Q And because if you did --

21 A I wouldn't, no, wouldn't do it.

22 Q You are saying, (inaudible).

23 A That mistake, I am, yes.

24 Q So my question, Doctor, if you or another OBGYN is,
25 used excessive traction, more than gentle traction, that

1 would violate your training and the standard of care?

2 A I have never done that. And honestly I don't know,
3 of the multitude of Doctors that I practice with, I don't
4 know any of them that would have done that.

5 Q My question though, Doctor, if it is done it is a
6 violation of the standard of care?

7 A So you are asking a hypothetical question, is that
8 correct.

9 Q Sure.

10 A I would disagree with one part of that and I would
11 agree with Dr. Duboe in that situation. You can reach a
12 certain level of severity or danger that at some point you
13 will do almost anything to get a baby out and even if that
14 means injuring the brachial plexus. Not the case here
15 because she did not have a shoulder dystocia with that
16 left shoulder. But there are extenuating circumstances,
17 you know, doing a Zavarelli; doing a fractioning, a
18 child's clavicle, those things.

19 Q Doctor, when you gave a deposition back in 2011 you
20 were asked about using excessive traction and it being a
21 deviation of the standard of care. You remember that?

22 A Yes.

23 MR. DAVIS: If he is going to refer to his
24 deposition, I believe he needs to reference the page
25 number and line number.

1 THE COURT: Mr. Jordan?

2 Q Page 104, Doctor, you were asked line 7.

3 A Yes, sir.

4 Q And the reference here is more than gentle traction.

5 A You said page 104.

6 Q 104.

7 A Okay.

8 Q And actually start with line 2 and your answer there,
9 and you say, I would say we are not trained to use greater
10 than gentle traction. Is that what you said there?

11 A Yes, I did.

12 Q And the question, in fact you are trained not to,
13 correct. What was your answer.

14 A Yes.

15 Q We are taught not to, right?

16 A We are taught not to.

17 Q And then the question, if a given doctor did anyway
18 that would breach a generally accepted standards of the
19 obstetrical care, true?

20 A And I said, I think that would be a breach of what
21 most reasonably trained obstetricians would do.

22 Q Doctor, you would agree with me, wouldn't you, that,
23 first of all you said you would use nothing other than
24 gentle traction. I understand that is your testimony.

25 But you would agree, wouldn't you, that whatever amount of

1 force you used, you, (inaudible).

2 A I don't quite understand.

3 Q You were there and you had hands on Alexia's head,
4 your testimony here is you used gentle traction, correct?

5 A Yes.

6 Q And whatever amount of force you used, you used that
7 force to help deliver Alexia, correct?

8 A That gentle downward traction, yes.

9 Q And you, (inaudible).

10 A That was my force that I used, yes.

11 Q And, again Doctor, knowing what we know about this
12 case you would do nothing different.

13 MR. DAVIS: Your Honor, again, that has been asked
14 and answered, I believe.

15 THE COURT: I am going to allow it with an adverse
16 witness.

17 MR. DAVIS: Thank you.

18 Q And, Doctor, the shoulder dystocia, and your
19 testimony it was an emergency. If you did your normal
20 routine protocol for shoulder dystocia?

21 A Yes, involving the right shoulder.

22 Q You didn't do anything differently with this case
23 than you would have done on other cases of shoulder
24 dystocia?

25 A Well, each case is a little different and you have to

1 make judgment calls as to what you are going to do in that
2 situation. There is some nuance to what you do.

3 Q So you just said that each case is different. And so
4 each case may require something other than your routine
5 protocol to safely deliver a baby, isn't that true?

6 A No, no, no, no.

7 Q In this case you did a routine protocol?

8 A So my routine protocol is as listed and you can see,
9 you know, how I went, we did the McRoberts, we did the
10 suprapubic, tried to do the posterior shoulder delivery
11 and that is the left one. The right one is the one that
12 stuck toward the top. And my posterior shoulder delivery,
13 the first thing I will do is I will try to get behind the
14 arm. With a posterior shoulder dystocia what you are
15 trying to do is you are trying to lift this arm, you are
16 trying to get this arm down here, that left arm to lift in
17 front of the baby and above the head. And the purpose of
18 that is, again, to take that bisacromial diameter and
19 reduce it, to shrink it so there is more room for that
20 baby to come out. Now, I will often go if I can reach and
21 it depends on what you can reach. I will try to go behind
22 the shoulder first and try to push the arm up. Sometimes
23 when you do your exam you notice that the arm, the arm is
24 back here sometimes I will try to push the arm forward
25 from behind. If the arm is up here, might not even do

1 that because you can either grab the forearm or you can
2 put pressure on the biceps tendon. The biceps tendon will
3 cause the arm to reflex up. So a little bit does depend.
4 And, in fact, even in the last couple of years I have
5 added another step to my posterior shoulder dystocia and
6 that is, it is called a, (inaudible), or an axillary
7 sling. But what it does is you take your fingers and you
8 reach them underneath the baby's axial. And what I think
9 a lot of people believe is that there is a lot of room in
10 the hollow of that sacrum that is not being utilized by
11 the baby. So if you can get in the axial, in the underarm
12 and move that baby down, the shoulder slides under.
13 Because you are on the axial you are not affecting the
14 brachial plexus at all. So that is actually have become
15 my go to first maneuver. So depending on what you find
16 you will do that and then depending on the baby's
17 position, in this case I rotated the shoulder, the left
18 shoulder anteriorly but sometimes you might, if it is
19 easier, you might rotate the anterior shoulder
20 posteriorly. But the maneuvers themselves and my steps
21 remain the same.

22 Q And, Doctor, during this process, when you are doing
23 your routine protocol with shoulder dystocia you are
24 trained to stay calm?

25 A Yes.

1 Q And do the maneuvers. And if they don't work the
2 first time you are to do them again, correct?

3 A So if they don't work the first time, you know, the
4 first thing you want to do is you want to try to get some
5 idea of what the fetal heart rate is. So you can get some
6 idea of what, maybe what your time is in this situation.
7 And so, yes, if the fetal heart rate looks good and I am
8 going to do, and it is actually what Dr. Duboe says, I am
9 going to try a different type of rotational maneuver. If
10 I tried to push the left shoulder around this way chances
11 are I am going to try to take the right shoulder and move
12 in the opposite. So if I try to go counterclockwise, I am
13 going to go clockwise the next time. And if that doesn't
14 work then I will go back to the posterior shoulder because
15 you might have dislodged it enough that one of your
16 posterior shoulder maneuvers works.

17 Q You only did one woodscrew maneuver in this case?

18 A That's correct.

19 Q And, Doctor, your testimony yesterday, we talked a
20 little ago about the --

21 A I didn't testify yesterday.

22 Q You heard testimony --

23 A Okay, I am sorry.

24 Q You heard testimony yesterday about Alexia's
25 injuries, the evulsion injury, we have discussed that.

1 And it is a severe injury, correct?

2 A Yes.

3 Q And that severe injury was diagnosed within minutes
4 of your delivery, correct?

5 A Yes.

6 MR. JORDAN: I beg the Court's indulgence.

7 THE COURT: Yes.

8 MR. JORDAN: Thank you, Doctor.

9 THE COURT: All right, Mr. Davis.

10 MR. DAVIS: I will reserve my rights, Your Honor.

11 THE COURT: Yes, sir. Thank you, Doctor, you can go
12 back to the Counsel table. Counsel, can I see y'all at
13 the bench.

14 (Whereupon, a bench conference was held in the
15 presence of the jury but out of the hearing of the
16 jury.)

17 THE COURT: Call your next witness, Mr. Jordan.

18 MR. JORDAN: I would call Shemica Degraffenreid. It
19 is my understanding she is outside.

20 THE COURT: Yes, sir.

21 Shemica Degraffenreid, being
22 first duly sworn, testified as follows:

23 DIRECT EXAMINATION

24 By Mr. Jordan:

25 Q Good morning.

1 A Good morning.

2 Q Will you please state your full name.

3 A Shemica LaShown Degraffenreid.

4 Q And do you go by Tina?

5 A I do.

6 Q And, Tina, where do you live?

7 A Rock Hill.

8 Q And what relationship are you to Alexia?

9 A Her Aunt.

10 Q And you are Angela's sister, correct?

11 A Yes.

12 Q And were you present when Alexia was born?

13 A Yes, I was.

14 Q Or at the hospital?

15 A I was at the hospital.

16 Q And you and Angela are from a pretty good size
17 family, correct?

18 A Yes, it is eight of us.

19 Q It is six boys and two girls, right?

20 A Yes.

21 Q And, Shemica, did you go to some of the appointments
22 with Angela?

23 A I went to almost all of the appointments, yes.

24 MR. JORDAN: Your Honor, I am having a hard time
25 hearing.

1 THE COURT: Ma'am, if you can pull your mask down,
2 thank you.

3 Q Did you go to some of the appointments with Angela?

4 A Yes, I did.

5 Q And was anything unusual at those appointment or just
6 regular appointments?

7 A They were just regular appointments.

8 Q Were you aware of any problems that Angela had with
9 her pregnancy with Alexia?

10 A No.

11 Q And when she would go to Rock Hill GYNOB, would she
12 see different doctors?

13 A Yes.

14 Q Do you know if she had seen Dr. Miller before?

15 A Yes, I think she seen him once or twice. Like I say,
16 when you go to OBGYN, Rock Hill, you see different
17 doctors.

18 Q Now, did you come to find out that they were going to
19 induce Angela?

20 A Yes.

21 Q And tell me about that. Tell me what you learned or
22 how you learned?

23 A Well, the day before, before she had went to the
24 doctor and she stated that, you know, they said the baby
25 was going to be pretty big and they didn't want her to

1 get, you know, any bigger so they gave her time and said
2 they were going to induce her labor, that day before she
3 was actually born. But when she went there there wasn't
4 any hospital bed so she had to wait a little time.

5 Q And I believe Angela went to the hospital the night
6 of April the 4th?

7 A Yes.

8 Q And when did you go up to the hospital?

9 A I was going to go that day but it wasn't going to be
10 no point because she wasn't going to have the baby. So I
11 went that morning.

12 Q That would have been the morning of April the 5th?

13 A Yes.

14 Q And did anyone go up there with you?

15 A Yes, it was me and one of our best friend's and my
16 sister-n-law.

17 Q And was anyone else up there?

18 A The mother was, the mother and Antwan was already up
19 there when we went.

20 Q When you say the mother --

21 A Antwan's mother.

22 Q Antwan's mother. And what is her name?

23 A Sheila Lumpkin.

24 Q And has she passed away?

25 A Yes, she passed away.

1 Q And so Antwan and Sheila were already there?

2 A Yes, they were there.

3 Q About what time did you get to the hospital that
4 morning?

5 A We got there around, about 7:00 something, no later
6 than 8:00.

7 Q And how was Angela doing?

8 A She was doing good. Because I actually went up there
9 to see if she was going to be in pain or actually pick at
10 her because when I had my child I acted a fool. So this
11 is my time for me to get my laughs in and pick at her but
12 she was calm. I kept asking her, you ain't hurting, you
13 ain't hurting and she was like, no. I was like, okay. So
14 it wasn't nothing unusual.

15 Q And so your friends went up with you that morning and
16 you all went into the room?

17 A Yes.

18 Q And was she progressing quickly or not?

19 A No, it was at a standstill.

20 Q And about what time did you get there that morning, I
21 am sorry?

22 A It may have been early 7:30, 8:00. It was early that
23 morning.

24 Q And then how long did you stay that morning?

25 A We stayed about an hour or two waiting to see if

1 anything was going to happen and basically they was like,
2 she ain't going in no time soon, she is stuck, she had
3 stopped progressing.

4 Q And so what did you and your friends do at that
5 point?

6 A They went to work and I went back home. I did a
7 little shopping, got some food and I decided to come back
8 later on.

9 Q Did you, in fact, come to the hospital later on?

10 A Yes, I came back.

11 Q About what time did you come back?

12 A It may have been around, I would say about 2:00 I
13 came back.

14 Q And did your friends come back at some point as well?

15 A Yes, at some point they came back too.

16 Q Okay. Was that after you?

17 A Yes, that was after me.

18 Q I believe it was Tamara and LaToya were their names?

19 A Yes.

20 Q And about what time did they get back to the
21 hospital?

22 A They got back around 5:00, I would say abut 5:30.

23 Q Okay. And do you ever remember, well, let me ask
24 you; do you remember anyone coming in to check Angela
25 while you were there?

1 A Well, the nurses came in to check but that was it.
2 The nurses were in and out checking.

3 Q And do you remember Dr. Miller coming in at some
4 point?

5 A I can honestly say, no. I don't remember, I remember
6 the nurses coming in but I don't remember him coming in.

7 Q Not initially. Do you remember when she was about to
8 give birth whether or not Dr. Miller was in there, I
9 believe it is a birthing suite at Piedmont, is that
10 correct?

11 A Yes.

12 Q And do you remember the Doctor coming in, when,
13 thought she was going to deliver?

14 A Yes, that is when he came in.

15 Q And, if you would, when, Dr. Miller is sitting here
16 between these two attorneys, correct. And when he came in
17 can you describe his demeanor.

18 A Well, when he came in he was serious but it was like
19 he was, let's get this birth over with so I can get on
20 with my life. It wasn't a friendly when he came in.

21 Q I am sorry, it wasn't what?

22 A It wasn't friendly.

23 Q Friendly, okay. When you say it wasn't friendly,
24 tell me what you mean by that?

25 A Like I done had birth, my daughter gave birth. When

1 the doctor came in, you know, they usually, hey, how are
2 you doing, sit down, you know, joke. He came in like he
3 had an attitude and was just like was ready to get the
4 birth over with.

5 Q And at some point did you observe Dr. Miller
6 interacting or speaking with Angela?

7 A He did tell her to push but --

8 Q How did he tell her to push, tell me what he said?

9 A He was like, push, Angela, push. And then he was
10 telling her, you know, if you don't get the baby out the
11 baby's heart rate can drop and he was like, push, Angela,
12 push. He was yelling and even I said to my friends, we
13 were like, why is he yelling like that. And then I even
14 said at one point said, she is pushing all she can push
15 and then that is when he is like, if you don't push I am
16 going to have to cut you. And she kept pushing and he
17 kept hollering. And he was like, just sign the papers,
18 sign the papers. And that is when she was like, well, I
19 will sign the papers. And that is when, she signed the
20 papers and they wheeled her out quickly to go get cut.

21 Q And by cut, you are referring to a C-section?

22 A A C-section. He told her that he was going to cut
23 her.

24 Q And so did they wheel her out on that bed?

25 A Yes, they wheeled her out on the bed.

1 Q And you and your friends stayed in the birthing
2 suite?

3 A Yes, we stayed in there.

4 Q Did anyone follow Angela toward the operating room?

5 A Yes. Sheila, which is Antwan's mama and Antwan, they
6 went.

7 Q And then after some time did Sheila come back to the
8 birthing suite?

9 A Yes, she came back.

10 Q To your knowledge, did Antwan stay there with Angela?

11 A Antwan stayed the whole time.

12 Q After the birth of Alexia, you remember Angela coming
13 back in?

14 A Yes, she came back in.

15 Q And what did you ask her?

16 A I said, let me see your cut. And she was like, I
17 didn't get cut. And I was like, why didn't you get cut.
18 And then I looked up at her, and I was like, you sure you
19 didn't get cut. And she was like, no, when I got back
20 there they was like, whenever you feel like pushing just
21 push. And she said, I had her naturally. And I was like,
22 for real.

23 Q Do you remember a nurse bringing Alexia in to the
24 birthing suite?

25 A After sometime the nurse brought Alexia in.

1 Q And what did you notice about her?

2 A Alexia was in the little cradle and she lift Alexia
3 up and she had the little white outfit on and she had her
4 arm pinned up with a safety pin like this. And I asked, I
5 was like, what is wrong with her arm? And she was like,
6 oh, it was stretched a little bit, it will go back in
7 place in a couple of days.

8 MR. DAVIS: Objection, Your Honor.

9 THE COURT: Hold on. Counsel, if y'all will approach
10 the bench, please.

11 (Whereupon, a bench conference was held in the
12 presence of the jury but out of the hearing of the
13 jury.)

14 Q Tina, when the nurse came in, you questioned, why is
15 her arm pinned up?

16 A Yes, I did.

17 Q What did she say?

18 A She said it had been, she was like, oh, it was
19 stretched a little bit. It should go back in place in a
20 couple of days. She sounded like it wasn't a big matter.
21 She was like, oh, it was just stretched a little bit. It
22 will go back in place in a couple of days. And that is
23 when she reached the baby to me and I held her and we
24 didn't think anything of it.

25 Q She was a beautiful baby?

1 A Yes, she was.

2 Q And, in fact, you used to babysit Alexia, is that
3 right?

4 A Yes, I babysit her up until she went to school.

5 Q While Angela and Antwan were working?

6 A Yes.

7 Q You were her nanny so to speak?

8 A Yes, I was.

9 Q And so you watched her grow and progress?

10 A I did.

11 Q And after a few days or after a few weeks, did you
12 notice anything about her arm?

13 A Yes, it wasn't getting any better. It was still
14 like, when it wasn't pinned up it just would flop down.
15 And we was like, she said after a couple of days it should
16 be going back in place but it wasn't, if you didn't have
17 it pinned up with a safety pin, if you hold her you have
18 to put the arm so it wouldn't flop. But it didn't get any
19 better after a couple of days, even after a couple of
20 weeks it didn't get any better.

21 Q (Inaudible).

22 A Yes, it would flop.

23 Q Now, Tina did you, Alexia has had to have a lot of
24 treatment including surgery, is that right?

25 A Yes.

1 Q Did you go with the family when she had surgery?

2 A We were told, her first major surgery when she was a
3 couple of months old, it was in Charleston. And they did
4 state it was going to be 17 hours, that no one could be in
5 there with her. So they went a day before us, but me and
6 my daddy and all of us, we came down about the time she
7 come out of the operating room. But we was there.

8 Q I believe you said you were her babysitter up until
9 the time she started school. Is that right?

10 A Until she started kindergarten.

11 Q And you, tell the jury what you noticed about her as
12 she is reaching milestones, as she is trying to crawl and
13 walk and things like that?

14 A It was hard because as a baby, she couldn't use her
15 arm at all. So it took her, when she should have been
16 walking at the age of one, she was learning how to crawl.
17 Because, you know, crawling, the normal, it do take two
18 arms. She only had one. So I mean, it wasn't like she
19 wouldn't try, she would scoot a little bit but she didn't
20 have the support. Seeing her like that was, me as a grown
21 woman, I would cry but it was very hard seeing her trying
22 to crawl or even at the age, you know, two, when she tried
23 to pull up and start walking and stuff. It just, it is
24 hard.

25 Q She would fall down --

1 A She would fall down and pick her back up and her
2 trying again. But she was constantly falling and you
3 didn't want her to keep constantly falling because she may
4 even get hurt more.

5 Q Did she have a hard time getting up if she fell?

6 A She couldn't even get up when she fell. We had to
7 literally pick up and place her where ever she, we wanted
8 her to be in the floor.

9 Q What about feeding herself?

10 A She couldn't feed herself, we had to feed her. I
11 mean, you could put food in front of her and she would try
12 to grab it. But after she get frustrated, we will just
13 get the spoon and feed her.

14 Q As a toddler, when she couldn't feed herself or
15 couldn't do these other things, how would she react, would
16 she be frustrated.

17 A She would get frustrated, I would get frustrated and
18 just cry. But, you know, I just kept on doing the best
19 and trying. Because if she see me cry, what is she going
20 to do.

21 Q What about riding a bicycle, something that all kids
22 learn to do early on. Was she able to do that?

23 A She never rode a bike. And honestly, she still have
24 two bikes that she never even rode.

25 Q Now, Alexia is in the ninth grade now?

1 A She is in the ninth grade.

2 Q So as she has entered high school, middle school,
3 high school, have there been things she has wanted to do
4 there?

5 A Everybody in our family was either, I was a
6 cheerleader, I played softball, basketball, I played
7 everything. Probably would have played golf if I could
8 but we didn't have a golf team. Everybody played sports.
9 So in the seventh grade she wanted to go out for
10 basketball. We practiced a whole summer, she has a
11 basketball goal. We practiced, even I have a daughter
12 that is 12, all of us was out there practicing. We
13 practiced the whole summer. But she went and tried out
14 and she didn't make the team. And she tried. Me,
15 personally, I couldn't shoot with one arm but she
16 literally could shoot with one arm. Like she could play
17 basketball but she didn't make the team. And when she
18 came and told me she didn't make the team I literally
19 wanted to call the coach and ask the coach, why didn't she
20 make the team. Was it she wasn't good enough, but how she
21 felt was because she had one arm. They felt she wouldn't
22 be an access to the team because what if they throw her
23 the ball and she couldn't catch it. So that made her feel
24 like, you know, she only had one arm and that is the
25 reason she didn't make the team. I was like, no, maybe it

1 would be, somebody may have been better than you. She was
2 like, no, they wasn't better than me, I seen who make the
3 team. She was like, I was hitting all of my baskets but I
4 just didn't make the team. And I said, that's fine. So
5 let's, next year we will go out for volley ball. Same
6 thing, we went out for volley ball, we practiced over the
7 fence the whole summer. Same thing. She didn't make the
8 team. And so she got to the point where, she was like, I
9 have one arm, I can't do nothing. She went out for
10 cheerleading, she didn't make the team because she felt
11 like she couldn't hold two pompoms or she couldn't do all
12 the moves that they do. She didn't make the team. It is
13 not like she don't try. But it just like, it is
14 depressing. You keep trying but you keep getting knocked
15 down. Someone is telling you can't, it is just
16 frustration. What more even frustrating is, is 100
17 degrees outside and guess what, she has a hoodie on to
18 hide her arm. 102 and you have got a sweat hoodie all
19 year around, hot, just to hide her arm because she is
20 ashamed of it. But better yet, what about riding the bus.
21 She has never, never rode the bus. You want to know why.
22 Because kids are cruel. They ask her questions about her
23 arm, why she has one arm. So we felt like, we will take
24 her to school, you know. If her mama can't take her to
25 school, I take her to school or somebody will drop her off

1 so she don't have to go through, it has really been hard.
2 And, yes, she tried, she even played the piano. She don't
3 sit like and think, just because I do one arm I can't do
4 anything. She tries. But me being as an adult and seeing
5 what she is going through, it is hard. The Christmas, I
6 asked her, what you want for Christmas. The new Jordans
7 came out. Yeah, that was \$250.00 dollars and I was
8 willing to pay \$250.00 dollars because my daughter got
9 them. I know how kids is, I know how the style is. She
10 told me, Auntie, I just want some crocks and some jogging
11 pants and sweatshirts. And I was like, why. Because she
12 was like, I don't feel like stringing those shoes up or
13 what if they come loose at school and I have to tie and it
14 will take me a long time to tie them. I said, well, tuck
15 the strings in and she was like, they don't look good with
16 them tucked in like that. So I had to go and I bought her
17 two pair of crocks.

18 Q Has she learned to tie her shoes?

19 A Yes, she has learned to tie her shoes. It may take a
20 while but, you know, when you are out in public, in school
21 and somebody says, hey, tie your shoes. She just can't
22 bend down and tie it real quick, you know what I am
23 saying. Like I would do or like you would do. It is
24 going to take her some time but she will get it tied. But
25 instead of going through all of that, why not, I will just

1 slip on some crocks. Something I just put my feet in and
2 don't have to worry about.

3 Q You mentioned sweatpants, why would she wear
4 sweatpants rather than jeans.

5 A Because most jeans have buttons and it takes her a
6 long time to button them up. So with sweatpants she just
7 pull them up. Like I said, I do have a daughter that is
8 getting ready to be a teenager, we go shopping. She wants
9 the cutup jeans that have all the buttons and all of that.
10 She can't get them so we will look for pants that you just
11 pull up with the stretch. But most of the time it is
12 hard. So she will be in the boys section because she
13 likes the boys jogging pants and that is what she gets.
14 So she will just pull them right up.

15 Q What about something like even getting her hair --

16 A -- literally on Thanksgiving I cried. A six-year-old
17 sister had took braids out and blow dry her hair. And
18 when asked her sister to put her hair in a ponytail, and
19 Alexia nearly cried because she couldn't do it. Imagine
20 having a bad hair day, everybody have a bad hair day. And
21 what we do to our hair, we put it in a ponytail. She
22 can't do that so we keep her hair braided down or we keep
23 it done so she don't be frustrated about trying to do
24 something to her hair.

25 Q What about social life or doing things with friends?

1 A What social life. For her to be 15, she don't have
2 one. Or, like I say, I have a daughter. My daughter
3 would do, because they best friends, they do stuff. But
4 they only go to the movies. They don't want to go to the
5 skating ring because she is scared she will fall and get
6 hurt or she got to string up, you know, sometimes they do
7 have the ones that snap, sometimes they have one string.
8 But basically, if they do anything it will be the movies.
9 But she is getting to the point now, she, it is
10 frustrating. But I never let her see me think that she
11 can't do anything because if I am weak she is going to be
12 weak. I will be telling her, let's go here but basically
13 our social life is going to Fusion and paying to eat.

14 Q Does Alexia carry a blanket to school?

15 A Yes, not because she is cold. She carry it to hide
16 her arm.

17 Q Does she ever wear short sleeves in public?

18 A No, no. She is ashamed of her arm.

19 Q Has this affected her self-esteem?

20 A She has the pretty eyes, the prettiest smile and she
21 is the prettiest young lady in the world. But she don't
22 have self-esteem. At 15, you may be thinking about going
23 on dates or doing anything. She don't think no boy, you
24 know, because she has one arm. She don't have a social
25 life, it is depressing. It is even, even for my little

1 daughter it is depressing because my daughter will call
2 her and ask her, let's go here, let's do that. And she
3 was like, no, I don't want to do it. Sometimes she won't
4 tell me but she will tell my daughter. And my daughter
5 come and say, Alexia says she don't want to go here
6 because she can't do this or she can't do that. She don't
7 want people looking at her, she don't want people feeling
8 sorry for her. It has been a long journey and it is going
9 to get worse. Like I constantly ask her if people picking
10 on her at school. She won't say. Or it is, it is just
11 hard.

12 Q And is there a plan at school that she can get help
13 carrying her books or lunch tray or anything like that?

14 A It has been a plan like every school she went
15 through. If she needs someone to open her locker, tote
16 her books, they put in place a long time ago that she can,
17 you know, tell the principal, they can have someone
18 following her to help her. But you are a teenager, you
19 don't want nobody helping you like that. You want to be
20 independent. You got to realize, she is getting ready to
21 be 18, she wants to go off to school. She ain't going to
22 have nobody following her helping her then.

23 Q What about driving an automobile. Is she old enough
24 to get her permit or will be soon?

25 A She is turning 15 and we already had a discussion. I

1 was like, you ready to drive in a little bit. She don't
2 even want to learn how to drive. Because she see me using
3 my one arm, to back up and look back. She was like, how
4 am I going to back up and look back. I only have one arm.
5 How am I going to do this, how am I going to do that. I
6 even told her, we will get you a new car with a backup
7 camera. She is like, don't, ain't it the law, you are
8 suppose to have two arms when you drive. I was like, they
9 will make exceptions for you. But she was like, I don't
10 think I am ready. No, she wants to, that is all they do
11 is talk about driving but she told me she can't.

12 MR. JORDAN: I beg the Court's indulgence.

13 Q Thank you. Please answer any questions that Counsel
14 may have for you.

15 THE COURT: Mr. Traylor?

16 MR. TRAYLOR: No questions, Your Honor.

17 THE COURT: Okay. Thank you, ma'am, you can step
18 down.

19 MS. DEGRAFFENREID: Can I say something?

20 THE COURT: Ma'am, you can answer questions but you
21 are not allowed to just give a statement.

22 MS. DEGRAFFENREID: Okay, thank you.

23 MR. GRAHAM: Your Honor, I think it may well be a
24 good time for a lunch break.

25 THE COURT: If we start back at 1:00, is that

1 agreeable to everybody?

2 MR. DAVIS: Yes, sir.

3 THE COURT: Ladies and gentlemen, we are going to
4 take our lunch break. I remind you of the same rules,
5 please don't do any research, don't discuss the case with
6 each other or anyone else. Thank you very much for your
7 attention, I can tell y'all pay very close attention. We
8 will see you back at 1:00.

9 (Whereupon, the jury was excused from open court for
10 a lunch break.)

11 THE COURT: Anything we need to take up before our
12 break?

13 MR. GRAHAM: No, Your Honor.

14 MR. DAVIS: No sir, Your Honor.

15 THE COURT: Okay. See you back at 1:00.

16 (Whereupon, a lunch break was taken.)

17 MR. GRAHAM: At this time we introduce exhibits.

18 THE COURT: What exhibit numbers will they be, Mr.
19 Graham.

20 (Whereupon, Plaintiff's Exhibits 3 through 6 were
21 introduced into evidence.)

22 THE COURT: Is the Plaintiff ready to proceed?

23 MR. GRAHAM: Yes, sir.

24 THE COURT: Is the Defense ready to proceed?

25 MR. DAVIS: Yes, sir.

1 THE COURT: Let's bring them in.

2 (Whereupon, the jury came into open court at
3 approximately 1:21 p.m.)

4 THE COURT: Mr. Graham, you can call your next
5 witness.

6 MR. GRAHAM: Thank you, Your Honor. Dr. Nelson, we
7 call as our next witness, Dr. Maureen Nelson.

8 DIRECT EXAMINATION

9 By Mr. Graham:

10 Q Dr. Nelson, good afternoon.

11 THE COURT: Can we see her on the monitor, not to be
12 a tiny little box. Let's -- maybe try to move to stage.
13 There we go. Thank you.

14 Q Can you see us?

15 A Yes, I can you.

16 Q For the record please state your full name.

17 A Maureen Nelson.

18 THE COURT: Mr. Graham, the Court needs to swear her.

19 Maureen Nelson, being
20 first duly sworn, testified as follows:

21 (Whereupon, Dr. Nelson's testimony by WebEx.)

22 Q Dr. Nelson, please introduce yourself to the jury in
23 terms of your personal background and a brief summary of
24 education and professional work.

25 A My name is Maureen Nelson. I am a specialist in

1 pediatric in (inaudible.) And what that is is I take care
2 of children that, with physical, (inaudible), including
3 brachial plexus. I have been, for about 30 something
4 years. I did my last -- at the University of Illinois. I
5 did my residency at University, San Antonio. And I did
6 the Fellowship in Pediatric in Institute, (inaudible),
7 Delaware which is at Thomas Jefferson. That is pediatric
8 affiliate. Then I worked in Houston. I was in, we have a
9 Children's Hospital in Charlotte, North Carolina which is
10 where I met Alexia. I have an office now in San Antonio.

11 Q Maybe it is just me, I had a hard time over the video
12 link understanding every word you said. So let me just to
13 ask you to clarify a few things. You said that you are a
14 pediatric physical medicine specialist. Is that correct?

15 A That is correct.

16 Q And please tell me again exactly what that means.

17 A I take care of children with physical disabilities, a
18 lot of specialities in orthopedics and neurosurgery and
19 general pediatrics, developmental pediatrics and with
20 therapist as well. So I have worked with children with
21 disabilities doing things, just like, (inaudible),
22 prescription and I do PMG which is extromyography to test
23 the nerves and muscles to see how the nerves and muscles
24 are working. We do Botox injections for, not for official
25 things but for tight muscles. And can you guys hear me

1 now.

2 MR. GRAHAM: Can everyone hear her?

3 THE COURT: Yes, sir.

4 MR. GRAHAM: It was just me. Go ahead.

5 A That is what I basically specialize in.

6 Q Thank you very much. So you got a BS Degree in
7 Biology at the University of Illinois, correct?

8 A Right.

9 Q And then got your MD at, also at University of
10 Illinois, College of Medicine. And then your, tell us
11 about, after you become a doctor, after you become an MD
12 what speciality training is required after that to become
13 certified in your field?

14 A You have to do one internship and three more years of
15 residency and physical medicine and rehabilitation. So
16 training, taking care of children and adults at that
17 residency. Take care of folks with physical and
18 medications and braces and therapy and different medical
19 problems that go along with these issues. And then I did
20 a Fellowship, (inaudible), special needs.

21 Q From viewing your CV it appears you have done a good
22 bit of your career practicing in the State of Texas. Tell
23 me about your work in Charlotte and in Chappell Hill.

24 A I spent eight years in Charlotte. I was a pediatric
25 med, and then at Children's Hospital. I worked at both of

1 those. From there I saw all kinds of children with
2 physical disabilities and lots of baby's and children with
3 brachial plexus palsy, brain injuries, spinal cord
4 injuries, et cetera.

5 Q In terms of your career what role of rehabilitation
6 of brachial plexus injuries played?

7 A It has been part of my career. I have been
8 interested in it, in my Fellowship. I was very
9 interested, always had a focus, to really concentrate on
10 that and learning everything I could. I am still learning
11 today and then I started to do presentations on it for
12 either people that didn't know too much because it is not
13 that common. I have wrote articles and books, I don't
14 know when I did, (inaudible), my last brachial plexus
15 about a year ago. So it has been amazing. While I was in
16 Houston I spent about half of my time taking care of
17 children with brachial plexus injury between a clinic and
18 doing electric diagnosis, test the nerves. And I was also
19 in the operating room to help guide the surgeons which was
20 really interesting.

21 Q I know you are not a lady that likes to brag, but you
22 have received a number of awards for super doctors and
23 America's top doctors, et cetera, et cetera?

24 A Yes.

25 Q Let me turn, well let me, at this point I would

1 proffer Dr. Nelson as an expert in pediatric
2 rehabilitation physical medicine.

3 THE COURT: Any objection from the Defense?

4 MR. DAVIS: No, Your Honor.

5 THE COURT: Thank you, sir. Ladies and gentlemen,
6 Dr. Nelson has been accepted as an expert in pediatric
7 physical medicine and rehabilitation.

8 Q Let's fast forward to when you first, hold on.

9 MR. GRAHAM: We lost you for a second. Can you hear
10 me now. We are working on a solution as we speak.

11 Q We have introduced into evidence a report from your,
12 what I believe is your visit with Alexia, was the first
13 time you saw her in March 13 of 2010?

14 A Yes.

15 Q Please tell us what you observed and what your
16 impressions were about your visit that day. What was
17 important that you learned that day about this child?

18 A So the key things were she was a big baby, weighed 9
19 pounds, 6 ounces and some abnormalities. She had surgery
20 already when she was about five months old. She started
21 having, no moving in her arm at all and then, (inaudible),
22 after that surgery which hasn't changed too much. When I
23 saw her she had, shoulder on the left arm, the arm itself
24 was very small and the muscles atrophy compared to other,
25 smaller than the other side. And her strength was very

1 minimal, only able to rotate her arm towards her body at
2 the shoulder. And she was able to bend her elbow a little
3 bit and that was about it. And so I suggested getting
4 that EMG done to really plan care for her. Certainly she
5 needed a lot of intervention.

6 Q Let me stop you there, Doctor. Please explain to us
7 what an, the test that you just described, the EMG.

8 A EMG, stands for electromyography. It is studying the
9 activities of muscle. So you think about EKG, (inaudible)
10 showing how the heart, the electrical activity so it is
11 very similar. We look at that in whatever muscle in the
12 arm, leg or where ever that we are interested in. And the
13 nerve conduction, the other part of that is you get little
14 electric shocks on the nerve and measure how fast and how
15 big the response is to muscles that we are interested in
16 with weakness or whatever.

17 Q Before you actually performed the EMG did you learn
18 anything else about the child or was the EMG the next step
19 in figuring out what you needed to know?

20 A Well, you can see just from her exam that clearly she
21 was going to need some sort of intervention. And that her
22 shoulder and her elbow and probably her wrist and fingers.
23 I just wanted the conduction study, would help direct the
24 surgeon to give them some hints on what was available to
25 work with.

1 Q We have introduced your EMG note as our Exhibit 5.
2 Could you please tell us what you did and what you
3 learned.

4 A Like I said, I gave some little electric shocks. I
5 do it on the brachial plexus which is here at the site, I
6 stimulate the nerves there and see what kind of response
7 is and compare the muscles and arm and their nerves. And
8 then, (inaudible), to get, to nerves and muscles at the
9 hand. And then I study the muscles secondarily, the EMG,
10 electrical activity. I do that with a tiny, tiny, little
11 needle into the muscles, sort of like a acupuncture
12 needle, put into each of the muscles that are not working
13 correctly to see what kind of electrical activity that I
14 could see.

15 Q And what did you see?

16 A So looking at the nerve conduction study, the media
17 nerve and almar nerve goes to hand and very, very small
18 responses. Then I, the ones that were higher so that, the
19 upper of the arm, those had fair responses. And then to
20 the forearm, some in between responses. So it shows there
21 is some electrical connections. And then an EMG, very
22 similar response that I got, almost no response to the
23 muscles and the hand. A little bit in the forearm and a
24 little bit more in the upper arm. And all of that
25 together shows that there is, there is electrical

1 connections that the nerves do have some fiber working
2 even though that most of those weren't enough to have,
3 (inaudible), it made us think we had some fibers at least
4 in the upper part that could be a minimal of having
5 further procedures done and having some expectation of
6 recovery.

7 Q Let me take one moment for a technical issue. I made
8 a mistake earlier, when I referred to this as being
9 Exhibit 5, it is actually Exhibit 4. Sorry about that
10 interruption. Let me make sure I understand what you are
11 saying. Is it correct that you had, you saw that there
12 were some nerve fibers that were functioning to a limited
13 extent that you could actually detect them on the machine
14 but they were not strong enough that they would actually
15 be able to move a muscle. Is that what you are telling
16 us?

17 A Yes.

18 Q And which parts of the arm had those nerve fibers
19 firing to some extent?

20 A All of them had some firing. In the hand it was
21 barely any, it was minimal that it was, not very hopeful
22 to have a functioning ability especially at the age of
23 three. In the forearm, it is possible that you could get
24 some response. But unfortunately, where you say, seven or
25 higher, absolutely and we can work; below seven it won't

1 work, it is not that specific testing. It is giving you
2 ideas of more probabilities of things. So that, in the
3 upper arm, above the elbow there was fair probabilitly that
4 we could get some more things working electrically,
5 surgically. Again, and then the forearm, it is possible
6 but not probable that we could get some in there. And
7 very rarely anything could happen surgically, electrically
8 with what was going on in the hands.

9 Q You mentioned, I believe the upper arm as having more
10 of these fibers than the other parts?

11 A Yes.

12 Q Is that the biceps area?

13 A Yes.

14 Q Okay. Did you learn anything else of significance
15 from the EMG studies or the ECT studies?

16 A That was, (inaudible).

17 Q The next report that I have seen, we have introduced
18 into evidence as Exhibit 5 which relates to a visit in
19 December of '18. Do you have that report?

20 A Yes.

21 Q Tell us about that visit, what occurred and what did
22 you learn?

23 A She and her mom came to see me at that point, to see
24 where we were and what was going on. At that point she
25 and her mom, she was 11 years old so she can do a lot more

1 things. But she was minimally in that left arm, for
2 anything, that she ever used that hand, would put her left
3 hand on her shoe to tie her shoes, used holding in place
4 so she could use her right hand to tie her shoes. And so
5 I was wondering if she was having pain, she had just one
6 little noted a couple of days of pain but never anything
7 after that. So that was good. She was in sixth grade,
8 was doing great, getting A's and B's. Like many kids her
9 age, her favorite thing was to play on the phone. She was
10 able to feed herself but could not cut up her food by
11 herself. She could dress herself. She could catch with
12 her left hand and she was able to take a bath but unable
13 to wash her hair, fix her hair. And she didn't have any
14 respiratory problems, was running and skipping well. And
15 then on examination of her, her shoulders were very
16 semi-trial, the left side was smaller than the right. Her
17 scapula, which is the little bone, (inaudible), it was
18 smaller than and just placed in the right thigh. She had
19 really significant size difference of her arms, the right
20 side was so, 9.4 centimeters long, the right was only 16,
21 so it was pretty significant.

22 Q Would you repeat those numbers, please.

23 A It was 71.4 centimeters on the right and 67 on the
24 left. (Inaudible due to WebEx.)

25 Q Thank you. And could you translate that difference

1 into inches?

2 A Let me see. Let me do my math here. So it is about
3 11.4, about five inches indifference in her arm length.
4 And so, it is very obvious when you look at her and see
5 her that that arm was shorter than the other. So that is,
6 the hand was also smaller, the hand was about an inch
7 longer on the left than the right. And she had flexion on
8 her elbow, her elbow is stuck.

9 Q Excuse me just a minute. I promised our jury that I
10 was going to avoid medical jargon. You said, flexing
11 elbow. Can you show us what you are talking about.

12 A So bending her elbow. She could not fully straighten
13 out her elbow. It was bent about this, this was the
14 farthest you could straighten it out. She can bend it
15 but, it could not go, mechanically was stuck there, no
16 matter what her strength was. It was the farthest out,
17 when I tried to straighten it, when she was walking in her
18 elbow was bent and she couldn't straighten.

19 Q Thank you. Please continue.

20 A Then looking at her strength, she again was able to
21 actively bend her elbow but she could not move her
22 shoulder to the side at all. She was able to bend a
23 couple of her fingers just, like this, nothing functional
24 that she could bend them a little bit. And she could, she
25 could not bend like this. She could extend it a little

1 bit, extending or bringing up her wrist. And she was able
2 to turn her hand like this but not like this. This is
3 called supination, she was stuck in supination, she was
4 stuck with her palm facing upward. And so, and she was,
5 move her body, swing her body if she wanted to move her
6 left arm, use momentum, where she didn't have strength for
7 some of it. It was a pretty generic movement. She could
8 catch and throw with her right hand. One time she used
9 the back of her left hand, the ball was right here, she
10 went back one time to catch but generally this was her
11 right hand. And she was able to feel when she, the same
12 on both arms, she was able to walk fine and she was able
13 to speak fine and she was able to answer my questions and
14 follow instructions very well. She would tell me about
15 her school and she had no shortness of breath.

16 Q And then the last time you saw her was very recently?

17 A Right. I saw her like this instead of in person
18 since she is in South Carolina and I am in Texas. And so
19 just like we are seeing, there are some limitations in our
20 interactions similarity. It is tougher to examine
21 somebody, so some things are a little, (inaudible).

22 Q Tell us about the telemedicine exam and what you
23 learned and what you can tell us about.

24 A So it was Alexia and her mom at their home. And I
25 was here in the office. Again, they were saying she

1 really doesn't use her arm for anything except for -- I
2 asked her if she ever tucks anything under her left arm.
3 And she said, yes, I guess sometimes. So I got a little
4 bit of that. She was just really doing pretty much,
5 things right handed. She can do her school work. She has
6 no pain in her arm or leg and occasionally would have a
7 little back pain, it was kind of a new thing, nothing
8 consistent. She is still getting physical therapy every
9 week. She is in ninth grade. She no longer likes school
10 and no longer getting A's and B's; she was getting B's and
11 C's at this point. And Mom told me that she was quieter,
12 she is a lot more subdued; and that she would just wear
13 big baggy clothes to try to hide her arm so that people
14 didn't see the difference. And since you told me, again,
15 she could still feel that arm, she was able to feed
16 herself but could not cut up her own food. She could open
17 up some containers with one hand but she could not open
18 jars by herself. Again, she dresses herself. She can
19 take a bath and now can wash her hair and she can comb her
20 hair but she couldn't brush it or fix it up. She did all
21 of her school work with her right hand only, she could
22 catch with the right hand, occasionally left. She wants
23 to ride a bike, she couldn't hold the handle bars. And
24 also she didn't play video games because she could not use
25 her arm. And I think instead of poorly with one hand she

1 didn't want people to see that she couldn't use both
2 hands. That was my inference, she did not tell me that.
3 She can walk around fine. And, again, we got her elbow,
4 because of that tightness that we noticed in her elbow,
5 she would wear, that keeps it straight as much as possible
6 at night. And she said she is not wearing that anymore,
7 it is too uncomfortable and so she was not using that.

8 Q When that happens is that the end of that type of
9 bracing or do you go up a size or what?

10 A Yes. So when they have to be custom fit, once they
11 are tight like this, actually I ordered that for her when
12 I saw her last month. So I sent in an order and hopefully
13 that got to the right person. So, yes, and then if that
14 is not sufficient sometimes we do Botox, sometimes we do
15 casting which means one cast after another, usually each
16 time trying to get a little straighten, a little
17 straighter, a little straighter. Sometimes you can do
18 that with just casting along, sometimes we do Botox. So
19 we can, relieve the muscle a little bit, so it is weaker,
20 it is easier to stretch it out. But, of course, we don't
21 like to use Botox, it weakens muscle when we haven't
22 already pulled weak arm, we would want to be more useful.
23 And then, if that doesn't work then surgery is done to get
24 in the position.

25 Q So all of those treatments, modalities that you

1 mentioned were either recommended by you or performed by
2 your office with respect to Alexia?

3 A Yes. We talked about those, we talked about the
4 options and that, you know, your family and surgeon and
5 therapist has discussed.

6 Q So is it your understanding that they did go forward
7 with those recommendations?

8 A I have not seen her since so I don't know. She had
9 not gotten (inaudible) and had not gotten any of those,
10 that I am aware of.

11 Q Is it part of your training to observe mood of
12 children and the, facial expressions and mood levels in
13 terms of depression and happiness and that sort of thing.
14 Is that within your training?

15 A Certainly we look at that because we want to take
16 care of the whole child routine. So depending on the
17 physical disability, you have anything that makes you look
18 different than the other kids, there is a potential for
19 impact, just psychologically and socially so. Definitely
20 we are aware of that. When she was little she seemed to
21 not mind and didn't have any impact on her at all. But
22 this time she was, she was different than when I saw her
23 before. Every time I have seen, last month, she was
24 (inaudible), this time she seemed pretty down. And I
25 forgot to mention, when I saw her on telemed, she had this

1 huge sweatshirt on. I couldn't see her body and I had to
2 tell, she needed to go change her clothes so that I needed
3 to see her arm and see her back. And so, yes, so, and so
4 back to your question. Her mood was very different when I
5 saw her this time. I didn't see any smile, I didn't see
6 any change. It wasn't sort of, you know, teenager kind of
7 thing, sometimes we see, just teenager want to rebel. It
8 wasn't that kind of thing. It was definitely a little
9 sad. And I talked to mom about potentially counseling for
10 her, trying to get any kind of, she would meet other kids
11 and talk about maybe find a camp for her with kids who
12 have issues with their arms to see if she can just,
13 socialization. That could make her feel better as well
14 counseling opportunities.

15 Q Have you had occasion to speak with Ms. Darlene
16 Carruthers about your future treatment recommendations for
17 Alexia?

18 A Yes, I spoke to her for a few minutes after I did the
19 telemed with Alexia and her mother.

20 Q And have you made specific recommendations about what
21 she needs and the frequency, et cetera?

22 A Yes, we spoke about that. I told her I was concerned
23 about her and I wanted to make sure counseling and
24 psychological support was available now and all of the
25 other physical things.

1 Q Do you make surgery recommendations or do you defer
2 that to someone else?

3 A I can only give general ideas. The surgeons are the
4 ones who decide what is most appropriate. I worked with
5 over a thousand children who had these surgeries. So I
6 have, you know, a lot of experience, I know some of that
7 but I don't know the specifics that an experienced surgeon
8 would know.

9 Q Have you recommended by seen by a surgeon?

10 A Yes. I recommended that she was seen by an
11 experienced surgeon who I knew and probably gave her some
12 other names too but I think she ended up seeing a person,
13 again, do over a thousand cases, maybe no, maybe 500 or
14 so. I recommended her see Dr. Amenta.

15 Q Dr. Armenta?

16 A Yes.

17 Q Where does he do his work?

18 A In Houston and we have worked together when I was,
19 (inaudible).

20 Q What involvement, if any, did you have in bringing
21 him from Houston to Charlotte when you were working in the
22 Charlotte area?

23 A When I was in Charlotte, I had just come from
24 Houston. And, again, I had this, I was working at the
25 brachial plexus team there and because I ended seeing so

1 many children in Charlotte with brachial plexus injuries,
2 and there were not a lot of experienced surgeons around
3 there; so part of the team who I worked with came a couple
4 of times, once a year for several years to see patients
5 who I saw who I thought would benefit from surgical input
6 so that the families could see that, and have options of
7 ideas of surgery that they might try to find where ever.

8 Q Was Alexia one of the children that Dr. Armenta saw
9 for a surgical consultation?

10 A Yes.

11 Q You mentioned that you had such a busy brachial
12 plexus practice in Charlotte. How does that compare to
13 what you were experiencing in Texas?

14 A Texas was, in Houston we saw so many kids. We have
15 two half day clients a week and we had three surgical days
16 a week. So we had kids coming from all over the country.
17 We had patients coming in from around the world. That is
18 how, nobody was doing any numbers. We were the most
19 experienced. We were the only ones in the, (inaudible).

20 Q Do you know how many brachial plexus centers that are
21 around the Country or approximately how many?

22 A I don't know. Now it is a lot more than it was then.
23 Then it was probably, was four and now it is probably,
24 maybe 15 or 20 in the Country for pediatrics.

25 Q So in Charlotte, your personal work load with

1 brachial plexus is larger than in Texas?

2 A No, it wasn't larger than in Texas. Again, the
3 problem was in Charlotte that there wasn't the rest of the
4 team there so it was just me. We didn't have the rest of
5 the team and that is why I had to bring, didn't have to,
6 but thought it would be an advantage to kids in the area
7 to bring the folks from Houston to speak with more
8 surgeons.

9 Q Was that was one of the reasons you moved back to
10 Texas, there weren't the same facilities in the South
11 Eastern for providing optimal care for children with
12 severe brachial plexus injuries?

13 A I knew that I would have a lot better access in Texas
14 for sure. Certainly there was a lot of more options here.

15 Q Please answer any questions the Defense has for you.

16 THE COURT: Mr. Traylor.

17 CROSS-EXAMINATION

18 By Mr. Traylor:

19 Q Dr. Nelson, can you hear me okay?

20 A Yes, fine, thank you.

21 Q So I think it has been pretty well established
22 already but you are not an OBGYN, correct?

23 A Right.

24 Q And your primary focus is on the treatment and
25 therapy of children post-injury, correct?

1 A Correct.

2 Q So you aren't here today at all for any opinions,
3 standard of care in this case?

4 A No.

5 Q Any specific incident that happened during the labor
6 and delivery of this child?

7 A No.

8 Q Doctor, on page two of your report, down near the
9 bottom?

10 A Which report.

11 Q The original, the first one?

12 A Yes.

13 Q You have selected birth trauma and birth injuries on
14 that report. Now you selected these options because these
15 are options that the computer provides to you, right?

16 A Yes.

17 Q So, again, you are not saying anyone did anything
18 wrong during the delivery of this child?

19 A No, those are the computer options.

20 Q Thank you very much. Doctor, you charge \$500 an
21 hour, or at least you did at the time of your deposition
22 for review, correct?

23 A Yes.

24 Q And \$700 an hour for depositions?

25 A Yes.

1 Q And \$700 an hour for trial?

2 A Yes.

3 Q Doctor, when it comes to any specific instances
4 during labor and delivery, you would defer to an OBGYN's
5 opinion in that matter, correct?

6 A Yes.

7 Q Thank you very much, no further questions.

8 THE COURT: Any redirect?

9 MR. GRAHAM: Yes sir, Your Honor, briefly.

10 REDIRECT EXAMINATION

11 By Mr. Graham:

12 Q Doctor, there was a question about whether you were
13 critical of, I can't remember if he said Dr. Miller or
14 another obstetrician. You are not an obstetrician, are
15 you?

16 A Correct.

17 Q Is it your role to evaluate whether an obstetrician
18 followed the rules of obstetrics or not?

19 A Not my role.

20 Q Have you ever undertaken the role of trying to figure
21 out if an obstetrics met the rules of obstetrics?

22 A No, I have not.

23 Q And there was a reference to computer output, I was
24 not clear what that was about. Are you personally
25 involved in the treatment and recommendations for children

1 like Alexia?

2 A Yes.

3 Q Thank you very much.

4 THE COURT: Any recross, Mr. Traylor?

5 MR. TRAYLOR: None, Your Honor.

6 MR. GRAHAM: May I publish?

7 THE COURT: You may.

8 (Whereupon, Exhibits were handed to the jury.)

9 MR. DAVIS: Your Honor, may I speak?

10 THE COURT: Yes.

11 MR. DAVIS: I have no objection to the report being
12 published but I have never seen this done like this. If
13 they want to read it, if Mr. Graham wants to read it
14 instead of passing it around to the jury. It doesn't
15 matter to me, it is in evidence, they can see it in
16 deliberations.

17 THE COURT: I think Mr. Davis is just saying, is
18 there a quicker way to do it then let each juror read it
19 individually.

20 MR. GRAHAM: I am happy to read them if Your Honor
21 desires.

22 THE COURT: Let's do that.

23 MR. GRAHAM: All right. Thank you.

24 THE COURT: Ladies and gentlemen, these documents are
25 in evidence and if you need to refer to them in your

1 deliberations they will be available to you in the jury
2 room.

3 MR. GRAHAM: Levine Speciality Children's Speciality
4 Center Clinic note on Alexia Lumpkin. And then there is a
5 case number. Date of birth, 4/5/07. Date of visit,
6 3/13/2010. History of present illness. Alexia is an
7 almost three-year-old girl who is here for evaluation of a
8 left brachial plexus palsy. She was reportedly born at 39
9 weeks gestation, mom's fourth child. There were 14 hours
10 of labor. Birth weight was nine pounds, six ounces. She
11 had an MRI which reportedly showed left C7 to 8 nerve root
12 evulsion with some dilated space of left C6 to 7 and 7 and
13 1, I believe. There were appointments with neurosurgery
14 at USC in September of 2007. She had brachial plexus,
15 (inaudible) nerve.

16 Oh, Your Honor, may we log out Dr. Nelson so she
17 doesn't --

18 THE COURT: Certainly.

19 MR. GRAHAM: Thank you.

20 THE COURT: Mr. Graham, will we have any other WebEx
21 witnesses today or can we shut down WebEx?

22 MR. GRAHAM: We have two more, Your Honor.

23 THE COURT: Okay.

24 MR. GRAHAM: There were appointments with
25 neurosurgery at MUSC in September of '07. She had

1 brachial plexus expiration with nerve, she had respiratory
2 difficulties and required steroids. There was a report or
3 thoracic duct injury during the operations. She was
4 discharged home on some type of supplement. She then had
5 a chest xray that showed marked elevation of the left ME
6 diaphragm which was new from prior exam with consideration
7 of phrenic nerve injury. Neurosurgery reported that the
8 thoracic duct injury resolved after several weeks.

9 Instructed her to keep her arm down the side for a month
10 and begin surgery. Reportedly Horner's Syndrome improved
11 after a couple of months and the family had noted improved
12 shoulder shrug. The parents reported that there was no
13 movement of Alexia's arm at birth. They state that there
14 is no improvement until about six months after her
15 surgery. Physical examination. This is an alert active
16 girl who is in distress. She had tightness of internal
17 rotation on the left arm. Her cranial nerves are intact.
18 She had no left biceps reflex. Cerebella function
19 appeared intact. She had normal muscle bulk, tone and
20 strength in the right arm and both legs. She had
21 decreased bulk and tone in the left arm. Strengthen the
22 left arm showed shoulder abduction zero; external
23 rotation, zero; internal rotation, elbow flection two,
24 elbow extension, zero; forearm, supination, zero; wrist
25 extension, trace; wrist flexion, zero; finger extension,

1 zero; finger extension is, the word is cut off. She was
2 recommended for EMG and nerve conduction study for
3 surgical planning. Surgery discussed was internal rotator
4 muscle transfer to the external rotators and nerve
5 grafting. Depending on findings that the nerve conduction
6 study, with her significant deficits she will likely
7 require elbow, hand, wrist and shoulder intervention. She
8 will need imaging to help direct this. She will require
9 significant bracing, electrical stimulation will be used
10 for muscle development and continued therapies.
11 Electronically signed by Maureen R. Nelson, MD.

12 The EMG study that same date. Again, refers to
13 Alexia and the date of October of 11, 2010. History of
14 present illness. This is a three and a half year old
15 African American female child with a left brachial plexus
16 palsy. She reportedly had left C7 avulsion with
17 abnormalities at C6, 7 and C7 to T1. She had nerve
18 grafting at MUSC in September of '07. The family states
19 that about six months after that she started having some
20 elbow flexion. There was reportedly also phrenic nerve
21 damage, the parents report no change recently. Physical
22 examination. She is an alert, smiling, pleasant,
23 interactive African American female child in no distress.
24 She has good muscle bulk, tone and strength in her right
25 arm and both legs. Left arm decreased bulk and tone.

1 Strength shows shoulder abduction and external rotation
2 zero; internal rotation, three out of five; elbow
3 flexion, two out of five; elbow extension, wrist
4 flexion, finger flexion and extension, four; supination,
5 zero; wrist extension is trace. Nerves conduction and EMG
6 were performed. Motor nerve conduction studies were done
7 as follows. Left median nerve was stimulated at a
8 distance of 3.5 centimeters from the wrist to the APB with
9 a distal motor latency of 2.8 milliseconds and an
10 amplitude of 1.6 millivolts. Left ulnar was stimulated at
11 the wrist 5 centimeters to the ADM with a distal motor
12 latency of 3.0, an amplitude of 0.8 millivolts. Left
13 musculocutaneous nerve was stimulated at Erb's point.
14 13.5 centimeters to the biceps. The distal motor-latency
15 of 3.6 milliseconds, an amplitude of 6.5 millivolts. Left
16 axillary nerve was stimulated 12 centimeters from the
17 deltoid from Erb's point with a distal motor-latency of
18 4.3 milliseconds and an amplitude of 2.5 millivolts. Left
19 radial nerve was stimulated from Erb's point 16
20 centimeters to the triceps with a distal motor-latency of
21 2.6 milliseconds, an amplitude of 3.8 millivolts.
22 Summary, there was a very small response in the median and
23 ulnar nerves to her hand. There is a fair response of
24 axillary and radial nerves and musculocutaneous to biceps.
25 Electromyography was performed on the left arm, there is

1 normal insertional and wrist activity throughout the
2 biceps, mixed normal and increased amplitude waves with
3 full recoupment pattern. The deltoid had prolonged large
4 amplitude waves, approximately one-half full recoupment.
5 Triceps, biceps had similar wave forms with approximately
6 two-thirds full recoupment as did wrist extension. At
7 extensor carpi radialis longus flexor radialis showed two
8 to three motor units. In the APB and ADM there was very
9 broad, very small amplitude with one motor unit in each.
10 Summary, EMG showed no positive sharp waves or
11 fibrillations. These would be expected at three years of
12 age. There is good recovery in the proximal muscles, fair
13 in the forearm and trace in the hand. Conclusion. There
14 is electrical activity throughout, minimal in the hand,
15 fair amount in the forearm and good proximally. It was
16 discussed at length with the parents that this indicates
17 there is some electro-electrical continuity though not
18 enough for clinical movement in any muscle that are now
19 already moving. But at a level that would be helpful for
20 further surgical intervention. They will be seeing a
21 surgeon upcoming and will call if there are any questions
22 or concerns. Alexia cried briefly during the studies,
23 stopped the second it was completed. Then we have got
24 signature lines and dates and so forth.

25 In the interest of time and my own certainty about

1 whether I understand all of this, Your Honor, we would
2 propose not to publish any more at this time and do it
3 later.

4 THE COURT: They are all in evidence. Mr. Graham,
5 you can call your next witness.

6 MR. GRAHAM: Your Honor, we would call Dr. John
7 Grossman. Your Honor, can we have just a small break.

8 THE COURT: Ladies and gentlemen, we will take a
9 break, head back to the jury room.

10 Plaintiff's number 7, I believe we are up to number
11 7, Mr. Graham?

12 MR. GRAHAM: Yes, sir. We have introduced number 7,
13 April 7th medical report.

14 THE COURT: All right.

15 MR. GRAHAM: Your Honor, we are introducing number 8
16 by agreement which is on November 13th, 2013 medical
17 report from Dr. Grossman.

18 THE COURT: All right.

19 MR. GRAHAM: And introducing Plaintiff's Exhibit 9
20 which is a follow-up report by Dr. Grossman dated December
21 29, 2021.

22 THE COURT: Mr. Davis, any objection to those three
23 exhibits?

24 MR. DAVIS: No, sir.

25 THE COURT: Plaintiff's 7, 8 and 9 are into evidence

1 without objection. That is an April 2011 report by Dr.
2 Grossman; a November 2013 report by Dr. Grossman; and a
3 December 29th of this past year report, a follow-up into
4 evidence without objection.

5 MR. GRAHAM: Thank you, Judge.

6 THE COURT: Is the Plaintiff ready to proceed?

7 MR. GRAHAM: Yes, sir.

8 THE COURT: Is the Defense ready?

9 MR. DAVIS: Yes, sir.

10 THE COURT: Let's bring them in.

11 (Whereupon, the jury came into open court at
12 approximately 2:40 p.m.

13 (Whereupon, Plaintiff's Exhibits 7, 8 and 9 were
14 admitted into evidence.)

15 (Whereupon, Dr. Grossman's testimony by WebEx.)

16 John Grossman, being
17 first duly sworn, testified as follows:

18 DIRECT EXAMINATION

19 By Mr. Graham:

20 Q Good afternoon, Dr. Grossman.

21 A Good afternoon.

22 Q You, first of all, please state of your name for the
23 record?

24 A Dr. John Grossman.

25 Q And where are you currently located?

1 A Miami, Florida.

2 Q Are you currently retired?

3 A Yes.

4 Q What did you retire from, what was your medical
5 speciality in your career?

6 A Hand and nerve specialist and Director of the
7 Brachial Plexus Program in Miami at Children's Hospital.

8 Q Let me ask you just a few questions about your
9 educational background. You got your AB, your College
10 Degree from Dartmouth University or College. And then
11 your MD in 1978 from the University of Virginia School of
12 Medicine, correct?

13 A Yes.

14 Q Tell us about your post-doctoral training and
15 residencies, that sort of thing.

16 A After I graduated Medical School I started out in
17 training in general surgery at George Washington
18 University including a clinic in Cleveland. And then I
19 continued a year of surgery, hand surgery at Massachusetts
20 General Hospital in Boston. And then I did another year
21 of hand surgery training at the Hand Institute in Paris,
22 France. Then I did a two and a half year program in
23 reconstruction plastic surgery in Virginia Medical School
24 in Norfolk. And then I went into practice.

25 Q Thank you. And in which cities have you practiced?

1 A I started out at Brown University in Providence, Rhode
2 Island where I practiced, hand surgery and some
3 reconstructive plastic surgery. I was Chief of Plastic
4 Surgery at the Veteran's Hospital there. And then in 1990
5 I moved to New York City for reconstructive plastic
6 surgery at the University. And also the brachial plexus
7 program there. And then we were recruited down to Miami
8 Children's Hospital, I moved there at the end of 1996 and
9 I have practiced in Miami ever since.

10 Q And what is the name of that brachial plexus center
11 in Miami?

12 A It is a brachial plexus program at Miami Children's
13 Hospital.

14 Q When they founded that did they honor you as part of
15 that, the establishment of that program?

16 A I basically established it with, (inaudible), a
17 pediatric neurologist. And we continued until about 2017.

18 Q And have you published a number of articles and
19 prereview journals?

20 A I have, over a hundred.

21 Q Tell me, when did you retire?

22 A I stopped doing surgical cases around 2017. I was
23 transitioning to a younger surgeon who was very interested
24 in the same things that I was interested in. And then
25 Dr., (inaudible), who runs the program now in Miami, after

1 I stopped doing surgical cases we saw patients together,
2 doing consultations and surgical planning together and
3 subsequently at the end of 2019 he had taken over the
4 program.

5 Q We have heard prior testimony that there are quite a
6 number of brachial plexus centers in this Country now.
7 Could you identify the ones, prior to your retirement,
8 could you identify the three or so brachial plexus centers
9 that were most well known and most highly regarded, the
10 closest to our State of South Carolina?

11 A When I was still practitionering, Miami Children's,
12 series of primary reconstructions of the brachial plexus
13 nerve grafts and such. It was a very easy program.
14 Cincinnati Children's Hospital and a program at Texas
15 Children's Hospital, a program at Shriner's Hospital in
16 Philadelphia and a program at the Children's Hospital in
17 Boston.

18 Q Thank you. Since you have retired has Miami Brachial
19 Plexus Center retained the same patient population.

20 A I think the numbers have probably gone down, with
21 this COVID and such, it is all too often what is going on
22 these days.

23 Q Right. You mentioned that you had done some study in
24 Paris. Tell us about the source of your patients back
25 when you were, had not yet retired. Were your patients

1 limited to the State of Florida or did they extend beyond
2 that?

3 A In United States and broad, Argentina, Brazil,
4 Israel.

5 Q Including some children of royalty, political
6 leaders?

7 A Not really.

8 Q But you have been called to speak internationally by
9 --

10 A I have spoken around the world on brachial plexus
11 injuries in newborns. And I have written a lot of
12 material on that.

13 MR. GRAHAM: Your Honor, we would tender Dr. Grossman
14 as an expert in reconstructive surgery of the hand and
15 brachial plexus surgery.

16 THE COURT: Any objection from the Defense?

17 MR. DAVIS: No objection.

18 THE COURT: Ladies and gentlemen, this witness has
19 been qualified as an expert in reconstructive surgery of
20 the hand and brachial plexus surgery.

21 Q Dr. Grossman, the first report I have from you is
22 dated the 13th of 2013. Is that when you first saw this
23 child, Alexia?

24 A Yes.

25 Q And where was that visit, where did that visit occur?

1 A In the Children's Hospital.

2 Q Tell us about your examination that day and what you
3 learned and what your impressions were?

4 A I saw the child, the history was done, had a birth
5 rate of nine pounds, six ounces. And she had a brachial
6 plexus palsy at birth, that involved all of the nerves in
7 the brachial plexus. Doctors ordered an MRI for the neck
8 and cervical spine. That revealed that, in fact, at least
9 some of the spinal nerves had come out of the spinal cord
10 and, (inaudible), the hand and the forearm. A couple of
11 those nerves at least been actually disconnected by
12 traction, a pseudo neatusfeel, (phonetic), which is like a
13 little hernia on the spinal cord, spinal fluid leaks out.
14 And she was obviously a candidate for early surgical
15 intervention to try to fix. September 26th of 2007 she
16 underwent excessive surgical procedure. And then therapy
17 subsequent to that.

18 Q What did you determine her condition to be in terms
19 what she could do, what she couldn't do, severity, et
20 cetera?

21 A She had an injury that was severe category and
22 extreme, what we call an extreme global palsy brachial
23 plexus, evulsions and extensive damage. A serious
24 situation to deal with.

25 Q When you first saw her did she have any ability to

1 move any of her muscles in her arm, left arm?

2 A Yes, she had a little 30 degrees of forward flashing
3 in the shoulder which is, full motion is 180. So, you
4 know, traction what someone would need. And she had a
5 little bending of the elbow. And her wrist a little bit
6 up, there was some flickers of finger movement. There was
7 no, (inaudible), it was just a few of the muscles maintain
8 innervation subsequent to the injury and surgery.

9 Q What recommendations did you make at that time?

10 A When I saw her?

11 Q When you saw her the first time, right.

12 A Well, she was four years old, four years since the
13 surgery. I said she would benefit from what we call,
14 stage reconstruction, basically evaluate a child in
15 conjunction with the therapy specialists and determine a
16 series of operations that will add a little bit of
17 improvement to the situation and try to prevent further
18 deterioration.

19 Q When did you next see Alexia?

20 A She was sent back to me November of 2013 for
21 reexamination. At that time she had developed a
22 significant contraction of the shoulder, the shoulder
23 became very stiff and can't move, innervation of the
24 shoulder had been lost and the muscles were paralyzed.
25 And so it doesn't move and gets stuck. And she had

1 deterioration throughout the extremity. (Inaudible),
2 deformity of the forearm which means, she had her hand up.
3 She couldn't turn her hand over, palm down. Her elbow,
4 and her elbow would only flex about 45 degrees so she has
5 this hand, it is, the elbow bent and the palm is up like a
6 beggar's hand.

7 Q So at that point was she getting better, worse or
8 about the same?

9 A Well, she was getting a little worse which is not
10 unusual.

11 Q When did you next see this child and last see this
12 child?

13 A Via telemedicine, December of this past year.

14 Q What did you learn from your examination on that date
15 and what impressions did you have?

16 A Seemed to me, she had deteriorated a little bit more.
17 For example, she could raise her arm up forward, but the
18 deformities in her hand and thumb and wrist was worse and
19 the elbow, the elbow, (inaudible). And obviously her
20 shoulder was extremely stiff and deformed.

21 Q Is there any, you made a distinction earlier about, I
22 believe, it was something about fibers having some sort of
23 ability to create a small amount of movement but not a
24 functional amount of movement. What did you see in that
25 regard on your last visit.

1 A We saw that there was some movement in levels in her
2 extremity but not a great significance. But combined with
3 that, the deformity which occurred in the result of these
4 muscle paralyzes and muscle imbalances. So if you look at
5 her you can see where the shoulder, an internal rotation
6 position. The elbow is bent at 30 degrees and the fingers
7 in the hand are very, (inaudible).

8 Q If she can find some type of improvement though any
9 type of treatment modality, surgery, therapy, Botox or
10 serial casting or anything like that, how much, if any,
11 would you expect?

12 A She can get improvement in the way, (inaudible), so
13 it will look better just visually. And that in and of
14 itself is very valuable because the studies that we have
15 done a significant number of these children have a real
16 self-image problem and it makes, sort of adds to the
17 physical handicap. So it looks a little better so that is
18 a benefit. And then you can get, maybe by repositioning
19 some of the, make a little more motion, better,
20 (inaudible).

21 Q So after optimal improvement what would you expect
22 her condition to be?

23 A Basically a complete impairment, (inaudible).

24 Q What importance, if any, would you place on even
25 slight improvement of Alexia?

1 A Nothing is a little, is a lot. That would be the
2 case would be with her. That every little bit you can
3 give her, at this young age, will be some sort of benefit
4 but it is, you know, pretty slim.

5 Q Slim compared to us with two healthy arms?

6 A Yes. She is basically functioning as a one-armed
7 person.

8 Q Do you have some medical illustrations of the surgery
9 that was performed in Charleston, South Carolina at the
10 Medical University.

11 A I do.

12 Q Excuse me just a moment. Doctor, you have two
13 illustrations there in front of you, correct?

14 A Yes.

15 Q Which one would you like to discuss first.

16 A In terms of describing the surgery that was
17 performed?

18 Q Yes, sir.

19 A The one that says brachial plexus repair, two.

20 Q Okay. Doctor, before I ask you to take us through
21 the steps of the surgery that was performed at MUSC, let
22 me just ask you, so far have all of the opinions and
23 conclusions that you have expressed been conclusions and
24 opinions that you hold to at least a reasonable degree of
25 medical certainty?

1 A I do.

2 Q Please take us, if you would, sir, through your
3 description of, well before we do that. Let me actually
4 put into evidence the three-page surgery note. In the
5 interest of time we will put it in, in just a moment.
6 Will you go ahead of part two of the drawing and just
7 explain, if you would, what we are looking at and what the
8 surgeon did to try to benefit this child.

9 A Well, I describe the brachial plexus is like a group
10 of electrical cables coming out of the spinal cord like is
11 doing on the computer and going through all of these
12 muscles and such. Basically this injury, during the --

13 Q We lost you, hold on just a moment. Can you hear me.

14 A I can hear you okay.

15 Q I think you are back on. Please continue.

16 A For the nerves that are torn, like a bunch of
17 electrical cables get burned out which once you get into
18 the nerves it is just one piece scar and is forcing the
19 injury down into the nerves, damages all of the
20 surrounding structures, the muscles, blood vessels,
21 tissue. It is one big scar which is called a neuroma, all
22 of this damage took place. And so basically in a
23 nutshell, this neuroma to determine what can be repaired
24 and cannot be repaired. That they remove the damage
25 tissue or a portion of it and repair the defect that is

1 left, nerve graft that is taken from the leg, harvest two,
2 (inaudible.) And use those to rebuild the cables in the
3 neck. Those are nerve grafts. What you see cleaning up
4 the neuroma and getting ready to excise it. And the
5 picture in the upper corner is the nerve grafts being
6 placed to build a gap where the cable is cut out.

7 Q Do you, I am sorry, go ahead.

8 A I lost hearing you for a moment.

9 Q Are you finished with your answer?

10 A Yes.

11 Q Okay, thank you. Do you happen to have a copy of
12 that drawing, part two, that you could hold up in front of
13 you or is it on the computer?

14 A I am looking at a copy in my hand. The computer is a
15 copy of the operative report.

16 Q Are you able to hold that up so we can see it?

17 A Can you see that?

18 Q Yes, sir. Very good. Doctor, we know you are there
19 behind, would you hold it up again as best you can and
20 identify what we are looking at and what its importance
21 is?

22 A You can see where the, (audible), that is the
23 neuroma. And the nerve fiber coming from that neuroma and
24 coming out of the other side to go to the extremity. So
25 he is taking out the damage tissue and trying to repair

1 the nerve graft.

2 Q And then what about the picture in the top right-hand
3 corner?

4 A That is just a schematic showing what it looks like
5 if he has the, he has cut out the neuroma and fill in the
6 gap with the nerve graft. It is like replacing a piece of
7 burned out cable. You splice it and splice with a new
8 piece of cable.

9 Q And when you reviewed the operative note does that
10 match up with the way these grafts are pictured here?

11 A The drawings on a, of a reduction of what took place.
12 Obviously it is a long complicated procedure but this
13 shows the general idea of what we done, it tells you what
14 you need to know.

15 Q Now based on your reading of the operative report and
16 based on your clinical examination how many nerves were
17 actually ripped out of the spinal cord completely?

18 A Completely, I think two were.

19 Q Which are the two you are talking about is being
20 clearly avulsed?

21 A C8 and T1. The reason we know that, the doctors
22 reported in the operative note. As we dissected C8 and T1
23 nerve, pathology to see what was there. There were what
24 we call ganglions cells. Ganglion cells are found at the
25 level of the spinal cord. In a brachial plexus most of

1 the nerves have been ripped out and, (inaudible).

2 Q Yes, sir. If you would go up just a few lines from
3 there, do you see a sentence that starts, we then cut the
4 neuroma.

5 A Yes.

6 Q Now what --

7 A What happened was, C7, C8 and T1 were, ganglion in C7
8 but, that would be suspected. And C5 and C6 were ripped,
9 with a neuroma, with a connection to the spinal cord. So
10 they grafted two nerves that were still connected to the
11 spinal cord to remain, as possible to some functioning.

12 Q Who is the MUSC surgeon who was primarily involved in
13 that surgery?

14 A Dr. Tutek.

15 Q Do you happen to know Dr. Tutek?

16 A I have never met him personally but I spoke with him
17 on the phone. He used to practice at Children's Hospital
18 in Tampa, Florida and they would refer out patients in
19 cases from time to time.

20 Q Let me understand this. When the child --

21 A Before he came to South Carolina he practiced in
22 Florida, he would send the, brachial plexus, (inaudible),
23 he would send them over to our program.

24 Q So the surgeon who did the surgery on Alexia refers
25 his brachial plexus patients to you?

1 A At the time he was, he decided that he could do them
2 himself.

3 Q Well, let's, the date of that surgery was back in
4 2007?

5 A Right.

6 Q Was Dr. Tutek referring patients before or after that
7 day?

8 A I don't recall, I think before but I don't recall for
9 sure.

10 Q Let's switch gears here. Sir, do you have an opinion
11 to a reasonable degree of medical certainty as to the most
12 probable cause of this child's brachial plexus nerve
13 damage?

14 A I think I said in my deposition some years ago, it is
15 a mechanism, (inaudible), being manipulated, and the child
16 is stuck with the doctors trying to pull the child out,
17 pulling the child out. And in doing so creates forces on
18 the brachial plexus and depend on how much force it
19 stretches the nerves, breaks them or actually pulls them
20 out of the spinal cord. That is with this child during
21 the delivery, the head and neck to bring out the baby.
22 The nerve damage, (inaudible).

23 Q So to get this type of damage on the left side
24 brachial plexus which way would the head be manipulated?

25 A I am not sure, manipulated in a way that you would

1 somehow put forces on the nerve, probably over to the
2 right and, forward, posterior flexion.

3 Q And twist --

4 A The shoulder is stuck and the forces of them pulling
5 on the nerves so it is like you can imagine, a injury in
6 football. If the player hits the ground with his shoulder
7 first and his head and his arm are flying forward, the
8 shoulder is already impacting on the ground so he is
9 stretching the brachial plexus. This is the same idea on
10 motorcycles. Thrown off the back and the shoulder is
11 stuck there and the head and arm keep moving forward.

12 Q So using your analogies about a football player and a
13 motorcyclist, are we talking about a good amount of speed
14 as they, as they have that impact that stretches the, and
15 bends the neck?

16 A This happens, a whole lot of time. (Inaudible),
17 motorcycle cruising down the highway.

18 Q I am sorry, what?

19 A The speed is quite different in the two analogies I
20 am, to delivery. The shoulder is fixed, one movement can
21 cause the damage.

22 Q One movement with --

23 A With the baby.

24 Q Bending, being manipulated?

25 A Yes, the, is better described, the exact, it is in

1 such a fashion it obviously disconnects the, severely
2 stretches the (inaudible).

3 Q So you talked earlier about manipulation of the
4 baby's head and neck. Were you talking about manipulation
5 applied by an obstetrician?

6 A Whoever is delivering the baby.

7 Q Whoever is delivering the baby?

8 A Right.

9 Q So a midwife or an obstetrician?

10 A Right.

11 Q Whoever it is. Have all the opinions you have
12 expressed, do you hold those opinions to at least a
13 reasonable degree of medical certainty?

14 A Absolutely.

15 Q Thank you, sir. Please answer any questions Defense
16 may have.

17 THE COURT: Mr. Traylor.

18 CROSS-EXAMINATION

19 By Mr. Traylor:

20 Q Can you see me okay?

21 A Yes.

22 Q Dr. Grossman, I think it has been pretty well
23 established that you are not an OB, like my client, Dr.
24 Miller, correct?

25 A I am not.

1 Q You are not qualified to say that Dr. Miller violated
2 the standard of care, correct?

3 A Absolutely not.

4 Q In fact, you are not offering any criticism of any
5 doctor in this case, correct?

6 A Correct.

7 Q Dr. Grossman, you haven't delivered a child since
8 medical school, right?

9 A Yes, that is correct.

10 Q During those deliveries you never encountered a
11 shoulder dystocia?

12 A No. I didn't know what a shoulder dystocia was at
13 that time.

14 Q Well, we are learning. You have a general
15 understanding of what a shoulder dystocia is but you don't
16 have a great one since you are not an OB and you don't
17 handle them on a daily basis, correct?

18 A Right.

19 Q And you are not familiar with the protocol for
20 resolving a shoulder dystocia?

21 A No. And there are different maneuvers that they use
22 but I am not familiar with all of them in any way shape or
23 form.

24 Q You are not familiar with the different degrees of
25 severities of shoulder dystocia, correct?

1 A No.

2 Q Now, Dr. Grossman, you haven't done any personal
3 research on intrauterine forces or on traction applied
4 during delivery, right?

5 A No.

6 Q Have you done any research on maternal forces during
7 delivery, correct?

8 A No.

9 Q Do you know how much force can be generated, you
10 don't know how much force can be generated of a woman's
11 contractions during labor, correct?

12 A I, (inaudible), certainly, during, (inaudible).

13 Q That was going to be my next question. In your
14 opinion these internal forces, maternal forces can't cause
15 brachial plexus injury?

16 A It may cause a mild, but certainly, damage as is
17 depicted in the picture you just seen, see on the MRI.
18 You are saying that maternal forces can tear nerves, rip
19 the, from the spinal cord. And that is absolutely
20 ridiculous.

21 Q And you base that on your common sense, right?

22 A Well established in the medical literature for
23 hundreds of years, the injuries like this, partial,
24 manipulation of the head and neck. You go back 200 years
25 of looking at medical text book and see pictures of the

1 drawing.

2 Q Doctor, do you believe in medical advancements and
3 progress?

4 A What?

5 Q Medical advancements and progress?

6 A I would say so.

7 Q So when a group of well respected doctors and
8 professionals do research that say these very things that
9 I am asking you about, about eternal forces. You feel
10 like that is junk science in your opinion?

11 A Yes, because there is no research that you can show
12 me which shows how eternal forces, uterine forces cause
13 this degree of injury. There is no case, the literature
14 will substantiate that hypothesis, it is just junk
15 science.

16 Q So research done by the American College of
17 Obstetricians and Gynecologists, over a hundred pages,
18 this is just complete junk science in your opinion?

19 A There is some good information in there. For one
20 thing, it doesn't address severe brachial plexus injury
21 anywhere. Two, it doesn't give any reasonable idea about
22 how these forces can cause the kind of damage that we see
23 in the kind of brachial plexus injury that require
24 surgery. It is not there. It is an attempt to offer some
25 sort of defense to, that is fine --

1 MR. GRAHAM: Your Honor, can he finish his answer.

2 THE COURT: Mr. Traylor, please don't talk over the
3 witness.

4 MR. TRAYLOR: My apologies, continue, sir.

5 A Some of the information is still invalid. There is
6 nothing in there that would have a relationship to what
7 happened in this case.

8 Q Thank you. So you feel that any research that has
9 anything about internal forces causing an injury like this
10 is strictly junk science for the benefit of litigation,
11 correct?

12 A No. I didn't say that. You are mixing up my words.
13 I said that he doesn't, that paper, that booklet doesn't
14 say anything that relates to this case. Maybe there is
15 some, some internal force that would cause a mild brachial
16 plexus injury, that we don't know about. It is a nice
17 hypothesis, we can't figure out what happened. This is a
18 different story.

19 Q Doctor, do you have your deposition with you
20 currently?

21 A Yes.

22 MR. TRAYLOR: May I open this original?

23 THE COURT: Yes, sir.

24 A What page?

25 Q Page 25, paragraph 16.

1 A Page 25.

2 Q Line 16, yes sir.

3 A Got it.

4 Q At the very beginning of the whole sequence, we will
5 skip ahead if that is okay with you, go to page 26,
6 paragraph 14. The question is, So how are you so familiar
7 with this literature as being junk.

8 Because it comes up over and over and over again. So
9 Plaintiff's attorneys have given copies of different
10 papers and I have looked at it. The common sense tells
11 you that the theories of what they are proposing is
12 nonsense.

13 Did I read that correctly?

14 A They have no cases to support it. They have all of
15 these great ideas and what is the purpose of the idea.
16 What is the point of the, there are no cases, not a single
17 reported case where they can tie internal forces to the
18 birth canal during delivery to damage nerves like this or
19 to a much less degree. Not a single case. So how can you
20 have medical, not a single case that is suppose to be
21 valid. It is ridiculous.

22 Q Doctor, if you would follow with me a little further
23 down on the same line of questioning. Page 27, chapter 6
24 or paragraph 6.

25 A Line 6?

1 Q Line 6.

2 A Got it.

3 Q And at the end of the day it turned out that all of
4 the literature that was being thrown on the table for
5 these cases is what I termed, what the Defendant termed
6 junk science. Junk science, it was created for the
7 purpose of litigating these cases. And it is the same
8 thing here, this is junk science, it has no basis on
9 anatomy, physiology, it is ridiculous.

10 A That's correct.

11 Q And, again, this is based on your common sense?

12 A If you don't have a single position that speaks to
13 the brachial plexus injury to support that internal
14 forces, would cause, (inaudible), not a single one. You
15 should have an expert, you should have a brachial plexus
16 says, (inaudible). There is not a single qualified person
17 who does brachial plexus who stands behind this.

18 Q Everybody that stands behind --

19 A And there is plenty of literature which you haven't
20 brought up, from John Hopkins, for example; that shows
21 that injuries are caused by forces delivered, by the
22 person delivering the infant. So I mean, that is the
23 facts.

24 Q Every doctor that supports this research, they are
25 frauds?

1 A If there was something else, (inaudible), that was
2 based on research. But in terms of trying to say that
3 this case is caused by internal forces is, I mean that is
4 nonsense.

5 Q Thank you, Doctor. So you haven't done any of your
6 own research or put out any publications in regards to
7 forces involved in a brachial plexus injury, have you?

8 A We have shown that every one of these cases, has a
9 consistent pattern that you are seeing, a large neuroma;
10 MRI shows this and surgery, you find tissue that is
11 consistent with a, (inaudible). These are well
12 established facts.

13 Q Doctor, you are not aware of the amount of force
14 necessary to cause a brachial plexus injury, are you?

15 A No.

16 Q In fact, you mentioned as analogy earlier, a football
17 player stinger as well as a motorcycle accident in lines
18 of a labor and delivery incident?

19 A I think this is, analogy, (inaudible).

20 Q You would defer those opinions to an OB who deals
21 with the birth injuries?

22 A They deal with delivering babies and taking care of
23 prenatal care. They don't take care of brachial plexus
24 injury.

25 Q Doctor, you have been testifying since 1985 on legal

1 matters, correct?

2 A Yes.

3 Q And one of the things that I found interesting, you
4 mentioned earlier that the nerves were almost power cords
5 coming out of a computer. You testified for several huge
6 companies on, Toshiba, Apple, IBM, et cetera, correct.

7 A Yes, I did Defense.

8 Q And when you saw the child in this case you were paid
9 between \$2,500.00 and \$3,000.00 dollars for your first
10 exam report on this child?

11 A Probably, yes.

12 Q Around the same for the second exam and report?

13 A Yes.

14 Q And you are paid \$600.00 dollars an hour to review
15 records?

16 A (Inaudible.)

17 Q At the time of your deposition, Doctor, at \$600.00
18 and then either \$1,100.00 or \$1,200.00 an hour for
19 deposition testimony?

20 A Right.

21 Q The same for trial testimony, correct?

22 A Right.

23 Q Thank you, nothing further, Doctor.

24 THE COURT: Any redirect, Mr. Graham?

25 MR. GRAHAM: Yes, Your Honor.

REDIRECT EXAMINATION

By Mr. Graham:

Q Doctor, there were a lot of questions about literature and junk science. Is one of the reasons why you disrespect the obstetrical literature that Defense refers to is because they don't make a distinction between temporary and permanent injuries?

MR. TRAYLOR: Objection, Your Honor.

A That is a huge --

THE COURT: Hold on one second.

MR. GRAHAM: There is an objection.

THE COURT: I am going to sustain the objection, yes.

Q Let me rephrase that. In terms of much of the literature that you have read from the obstetric community, what distinction do you make between whether those articles refer to temporary injuries, permanent injuries or no comment whether about it is temporary or permanent?

A As a basic complaint, there are a lot of children who, that we see, especially a neurologist sees who have a weak arm or temporary paralysis. You never find out what really, what causes this. We can make guesses based on doing some test and generally recover, 90, 95 percent or 100 percent. So we don't know. The permanent, we know because, uterine forces, forces in the birth canal.

1 Q Of the Defense literature that you have criticized as
2 being junk science, what portion of that identifies
3 whether they are talking about temporary injuries or
4 permanent injuries?

5 A I don't recall any specifics. But I do know
6 basically nothing that is mentioned considers injuries
7 like what we are dealing with today, this child.

8 Q In terms of evaluating whether literature on these
9 issues is valuable or not, what importance would you
10 attribute to knowing whether the injury is permanent or
11 temporary?

12 A The importance?

13 Q Yes, sir.

14 A It is important for the child. It doesn't change.
15 You are going to operate on a number of ones where the
16 injury is permanent, if you get them at the right age.
17 Resolves, the child, (inaudible), and happy.

18 Q I don't think I asked my question very well. In
19 terms of the literature that you were criticizing as being
20 junk science, does that, does much of that literature fail
21 to identify whether they are talking about temporary
22 injuries or permanent injuries?

23 A Many times they don't identify a group of patients at
24 all. It is a hypothesis.

25 Q Counsel raised something about your opinions being

1 based on common sense. Is the basis of your opinions
2 limited to common sense or do they also apply to your
3 professional training and education and experience?

4 A When you see these injuries you know that, one of the
5 ideas that is put forth is that when a child is coming
6 down the birth canal, that is where the forces you put
7 across. It is my understanding the birth canal is a
8 pretty tight, tight spot, tight space. There is not much
9 moving there. So I have never been able to understand how
10 the head and the neck can be manipulated to put the forces
11 on a nerve and cause a brachial plexus injury. It is sort
12 of held there like in a cocoon. That is common sense. I
13 can explain that to someone who is a not a physician or
14 nurse. They understand that.

15 Q But that is not, obviously not the only basis for
16 your opinion?

17 A No, of course not.

18 Q There was a lot of discussion about various
19 literature and what you had read about other causes of
20 brachial plexus damage. Have you actually, you and Dr.
21 Alfonso and some other colleagues written an article about
22 another cause of brachial plexus damage, if there is some
23 kind of deformity with cancer to the fact or something
24 like that?

25 A We have written a number of articles, discussed

1 unusual cases, (inaudible.)

2 Q How would you characterize the relationship between
3 the damaged nerve tissue that we see in this case and the
4 types of forceful bending and pulling on the head and
5 neck?

6 MR. TRAYLOR: Objection, this is an improper question
7 on redirect. He had an opportunity during direct to ask
8 it.

9 THE COURT: All right.

10 Q I am going to repeat the question, Doctor. What does
11 your review of the operative note and its description of
12 the tissue tell you about support for your causation
13 opinion.

14 A The extent of damages --

15 MR. GRAHAM: May I say one thing, Your Honor. The
16 reason I asked the question --

17 MR. TRAYLOR: Your Honor --

18 THE COURT: Y'all approach.

19 (Whereupon, a bench conference was held in the
20 presence of the jury but out of the hearing of the
21 jury.)

22 Q There was a question put to you about whether you
23 would defer to obstetricians on certain issues. Would
24 you, would you defer to all obstetricians or would you
25 limit it in any way?

1 A Depending on what the question was. Brachial plexus
2 injury, I am unaware of any obstetricians, (inaudible).

3 Q In terms of the causation of the type of nerve damage
4 that we see here, would you defer to a --

5 A They have done research on the causation. The
6 Hopkins and others have done research on that, they are
7 involved in this area. But I thought you were speaking of
8 the specifics of a brachial plexus injury, to a injury.

9 Q And all of the opinions you have expressed you do
10 hold to a reasonable degree of medical certainty?

11 A I do.

12 Q Including the junk science that fails to make that
13 distinction about whether they are talking about permanent
14 injuries or temporary injuries, is that right?

15 A Right.

16 Q Thank you, Doctor.

17 THE COURT: Any recross, Mr. Traylor?

18 MR. TRAYLOR: None, Your Honor.

19 THE COURT: Thank you, Doctor. We have one more
20 witness via WebEx?

21 MR. GRAHAM: Yes, sir. May we first disconnect.

22 THE COURT: Disconnect Dr. Grossman. Ladies and
23 gentlemen, we have one more witness for today. Give us a
24 ten minute break to connect the internet for the last
25 witness, please.

1 (Whereupon, the jury was excused from open court for
2 a break.)

3 (Whereupon, a short break was taken.)

4 THE COURT: Mr. Graham, I assume this will be the
5 final witness, I should have asked you.

6 MR. GRAHAM: Your Honor, our next exhibit is an
7 operative note.

8 THE COURT: Okay.

9 MR. GRAHAM: 11 is, (inaudible), letter for Dr.
10 Armenta.

11 THE COURT: Alright.

12 MR. GRAHAM: Exhibit 12 is, (inaudible), December
13 4th.

14 THE COURT: Okay. Any objection, Mr. Davis?

15 MR. DAVIS: No, sir.

16 THE COURT: Plaintiff's 10, 11 and 12 into evidence
17 with objection.

18 (Whereupon, Plaintiff's Exhibits 10, 11 and 12 were
19 admitted into evidence.)

20 THE COURT: Ready to proceed, Mr. Graham?

21 MR. GRAHAM: Yes, sir.

22 THE COURT: Mr. Davis?

23 MR. DAVIS: Yes, sir.

24 (Whereupon, the jury came into open court at
25 approximately 4:04 p.m.)

1 (Whereupon, Dr. Armenta's testimony is by WebEx.)

2 THE COURT: Mr. Graham, call your next witness.

3 MR. GRAHAM: We call Dr. Art Armenta to the stand.

4 Dr. Art Armenta, being

5 first duly sworn, testified as follows:

6 DIRECT EXAMINATION

7 By Mr. Graham:

8 Q Good afternoon, Dr. Armenta. Please state your full
9 name for the record?

10 A Arturo Hernandez Armenta.

11 Q Tell us, please sir, about your personal background,
12 your education and professional experience?

13 A I went to Baylor Medical School and then went to
14 Baylor, (inaudible) for Fellowship and Residency and
15 brachial plexus surgery.

16 Q Very good. How long have you been performing
17 brachial plexus surgeries?

18 A 20 years.

19 Q We are here today about the brachial plexus nerve
20 damage of Alexia Lumpkin. Before I ask you questions
21 about that though, let me tender you as an expert witness
22 on matters relating to brachial plexus.

23 THE COURT: Any objection, Mr. Davis?

24 MR. DAVIS: No, sir.

25 THE COURT: Ladies and gentlemen, this witness is

1 qualified as an expert witness in the field of brachial
2 plexus surgery.

3 Q Doctor, the first record I have of you seeing Alexia
4 Lumpkin indicates that you had seen her back in March of
5 2010. Would you please explain that.

6 A We have an outreach, on cases, when they are not able
7 to visit us here in Texas, to where we make the trip
8 easier for them. I have a medical license in North
9 Carolina, we team up with a group of physical medicine in
10 the rehabilitation, to see our patients there.

11 Q So you do have a North Carolina medical license?

12 A Correct.

13 Q Which States do you have licenses in?

14 A Just Texas and North Carolina.

15 Q So was there a particular doctor who brought you in
16 to see Alexia Lumpkin?

17 A At the time we worked with Maureen Nelson who is a
18 physician that we have a longstanding relationship with,
19 professionally she used to work at Texas Children's
20 Hospital.

21 Q And then was in Charlotte for a while and now just
22 went back in San Antonio?

23 A Correct.

24 Q Have the two of you actually published articles
25 together?

1 A Yes.

2 Q Do you have the report, the letter form report dated
3 July 16 of 2010?

4 A I see that on the screen. And July --

5 Q We will put the correct one up. Excuse me just a
6 moment. Doctor, while we are waiting to solve a technical
7 issue. When is the last time you had an opportunity to
8 see Alexia, either in person or by telemedicine?

9 A We recently saw her by telemedicine and evaluated her
10 progress and continued possible therapies and surgeries.

11 Q Have you had an opportunity to talk to Darlene
12 Carruthers about your recommendations for further
13 surgeries and related treatment?

14 A She is, who?

15 Q Darlene Carruthers, lifecare planner?

16 A Yes I have, yes.

17 Q Tell me, sir. Without having that document in front
18 of you, do you have a specific recollection of your first
19 visit with Alexia in general terms?

20 A Yes. At the time she was a young lady that had
21 suffered a severe left brachial plexus injury. At the
22 time had limited mobility with a severe, no hand mobility
23 for which we had recommended surgery, initial treatments
24 and then possible surgery in the future.

25 Q We finally have the right document on the screen

1 here. Can you read that?

2 A The referenced child was seen on 3/13/10.

3 Q Yes, sir. Could you just summarize what you learned
4 from your examination and what your impressions and
5 recommendations were?

6 A As I said previously, she had suffered a severe
7 injury which would require lots of intensive therapy and
8 possibly need surgery, that we would need to evaluate
9 continual basis depending on progress.

10 Q Thank you. And the next report I have is from
11 Alexia's visit with you on December the 4th of 2018. Can
12 you see that?

13 A Not yet.

14 Q Where did you see her on that occasion, did she
15 actually go to Houston?

16 A That I don't recall.

17 Q At any rate, what did you learn from your examination
18 and what were your impressions and treatment
19 recommendations then?

20 A There is, muscle, shoulder reduction, two out of
21 five, four out of five external, (inaudible), and two out
22 of five, reflection (inaudible). And very severe hand
23 function injury.

24 Q So you have numbers here for right hand and arm.

25 A Right.

1 Q So the ones for the left arm, how did you describe
2 those?

3 A The shoulder AB function or, two out of five which is
4 basically almost no motion. And no motion with gravity.
5 The shoulder is severe with, (inaudible), four out of
6 five. Rotation, two out of five. (Inaudible), out of
7 five. (Inaudible). Extension, three out of five. And
8 then supination and hand function at one out of five.

9 Q Overall that represents what degree of severity of
10 injury?

11 A It is a global injury involving the entire plexus of
12 which she has recovered very little function.

13 Q Thank you. Could you scroll down with the one with
14 the pictures. There we go. What is the name for this
15 type of evaluation?

16 A Mala-classification, (phonetic). And where she is no
17 better than a two.

18 Q And the two, underneath the word, two, on some of
19 these I see the word, impossible, is that correct?

20 A Correct.

21 Q What about the other two.

22 A Those are difficult and the others were easy.

23 Q You are going from across from two, three and four?

24 A Correct.

25 Q Focusing on Alexia under the first column for active

1 abduction it indicates, the same category two, but instead
2 of saying impossible it says less than 30 percent. What
3 is the significance of that?

4 A Just she is unable to lift her arm, less than 30
5 degrees against gravity.

6 Q And in terms of external rotation, instead of saying
7 impossible it says zero percent?

8 A She is unable externally to rotate her arm, internal
9 rotation.

10 Q On the next page, preprinted final assessment and
11 then it has your handwriting. Could you fill us in on
12 what the significance is of this?

13 A Yes. It says patient is an 11-year-old female with a
14 brachial plexus palsy with an internal rotation of
15 deformity, (inaudible), she has an elbow contraction and
16 weak wrist with minimum finger flexion and extension.

17 Q And then in terms of studies or interventions
18 ordered. What have, what findings did you make?

19 A At the time we basically recommended a therapy
20 program, stretching and muscle strengthening. Also due to
21 the severe elbow contraction we were attempting either
22 nighttime, (inaudible), or possible serial casting and we
23 were discussing with the parents any possible types of
24 surgical procedures. And the other modalities that we
25 needed were, neuro-muscle stimulation. And then for home

1 use and, (inaudible), surgical procedure to correct the
2 deficits that she had. But we needed to stretch the,
3 (inaudible), muscle and elbow and shoulder secondary to
4 the tightness.

5 Q Before you could do the mod quad surgery?

6 A Correct.

7 Q Have tried my best to avoid medical jargon. Can you
8 explain to us what a mod quad surgery is?

9 A A mod quad is just a, basically, describing a
10 procedure which we describe as modified quads, four types
11 of procedures within one surgery. And those procedures
12 involve and transfer --

13 Q What is --

14 A A muscle of the shoulder, abduction, to bring the
15 shoulder down and internal rotation. The other one would
16 be a (inaudible), to the nerve which provides function to
17 the delta muscle or the shoulder muscle. The other is
18 where, either perform or release a (inaudible) muscle and
19 or, release the (inaudible).

20 Q And where are those last two muscles you mentioned?

21 A Those are also in the shoulder region. They are
22 internal rotators of the shoulder which she had, severed
23 internal, which we need to balance with transferring,
24 (inaudible), dorsel muscle to posterior of the humerus
25 shoulder to allow external rotation and more balancing the

1 shoulder function.

2 Q Thank you. I have read the lifecare plan prepared by
3 Darlene Carruthers and she mentions a series of surgeries
4 that you had recommended. What, in the series, after the
5 shoulder what do you do next?

6 A Sorry?

7 Q In a series of surgeries for a child with brachial
8 plexus damages as bad as Alexia's, after the original
9 resection and then the mod quad, what is the next
10 procedure?

11 A Well, that is a very good question. As we discussed
12 previously, with the lifecare planner, depending as to the
13 degree of improvement in the elbow contracture or ability
14 to extend the elbow she may or may not need an elbow
15 extension procedure where we have a bicep lengthening and
16 allow her to fully extend her elbow. And then also
17 address the hand, once the elbow is addressed, to possibly
18 perform either tendon transfers to allow for finger
19 flexion and extension and or free muscle transfers,
20 muscles from one area of her body to another to allow for
21 active finger flexion and extension.

22 Q If these surgeries are successful how much
23 improvement is reasonably to be expected?

24 A That is a wonderful question. I cannot give a
25 hundred percent answer on that. And its sort of

1 compounded by the degree of recovery at each --

2 Q Can you tell us to a reasonable degree of medical
3 certainty what is more likely than not the level of
4 improvement you would reasonably expect?

5 A Shoulder, I think I would be able to give her around
6 40 to 50 percent function. Realistically in the elbow and
7 hand would be much reduced. So if I am able to give her,
8 I would consider that a successful surgery.

9 Q In the real world what are the ranges of improvement
10 with children with injuries similar to these we are
11 talking about with Alexia?

12 A You can range from recovery from 90 to 95 percent, to
13 no recovery.

14 Q And a large part of the severity of the injury?

15 A Correct.

16 Q How does Alexia's injury compare to the others?

17 A She is in a severe category due to the fact she
18 suffered avulsions in her plexus injury that limited her
19 reconstruction.

20 Q Let me ask you, sir. To a reasonable degree of
21 medical certainty can you tell me, have you formed an
22 opinion about the most probable cause of her nerve damage?

23 A Well, the most probable cause, a lateral traction
24 injury, has been agreed upon in literature and in our
25 experience, that most likely occurred during birth, a

1 surgical injury.

2 Q What do you mean by lateral traction?

3 A A lateral traction is where you increase the degree
4 of angle between the neck and the shoulder. The further
5 that you increase the angle between these two the higher
6 likely that it is going to cause an injury to the plexus
7 at the level, the spinal cord or distal to, at whatever
8 varying level it can occur to where it causes avulsions or
9 ruptures or a traction injury.

10 Q Have all of the opinions and conclusions you have
11 expressed, expressed to a reasonable degree of medical
12 certainty?

13 A Yes.

14 Q Thank you. Please answer the Defense questions.

15 THE COURT: Mr. Davis?

16 MR. DAVIS: Thank you, Your Honor.

17 CROSS-EXAMINATION

18 By Mr. Davis:

19 Q Can you see and hear me all right, Doctor?

20 A Yes.

21 Q Thank you, sir. Do you have any reason, sir, to
22 believe or suspect that the therapies you recommended back
23 in 2010 and maybe beyond that, were done?

24 A Well, I can see from the lack of progress in the
25 patient's recovery, that more than likely that they were

1 not.

2 Q Would that have been against your recommendations in
3 2010, sir?

4 A Yes, my recommendations were to, take the therapies.

5 Q And did you recommend those therapies, the
6 occupational and physical therapies in hopes that would
7 bring some improvement to Alexia's injury?

8 A Right.

9 Q You didn't just recommend those to just recommend
10 them, right?

11 A Right.

12 Q Doctor, in all fairness and in all due respect to
13 your training, your experience and your field, sir, you
14 are not an OBGYN, correct?

15 A Correct.

16 Q And you are not here to offer to this jury any
17 opinions regarding any obstetrical standards of care in
18 this case, are you?

19 A Right.

20 Q Nothing further.

21 THE COURT: Redirect?

22 MR. GRAHAM: Yes sir, Your Honor.

23 REDIRECT EXAMINATION

24 By Mr. Graham:

25 Q You were asked those questions of performance of

1 therapy. Have you seen the therapy records or the therapy
2 bills in this case?

3 A I have not.

4 Q I know this varies somewhat from State to State, but
5 has, the pandemic, COVID, has that affected the way that
6 your practice and the practice of other doctors have been
7 performing?

8 A Yes.

9 Q Are you aware about the condition of Alexia's arm and
10 muscle functioning and stiffness that you described before
11 COVID?

12 A No, not since I saw her on December 15.

13 Q But between December 15th and when COVID and her
14 therapy stopped, you don't know what, (inaudible)?

15 A No, it seemed the same.

16 Q Is one of the reasons, I presume one of the reasons
17 for therapy is to hope, to improve the situation. But is
18 one of the purposes of therapy also to prevent a child's
19 condition to get worse, the contractions of the
20 complications that would otherwise develop without.

21 A Yes, absolutely.

22 Q Thank you, sir.

23 THE COURT: Mr. Davis, any recross?

24 MR. DAVIS: No sir, thank you.

25 THE COURT: Thank you, Doctor, I appreciate you being

1 here. Counsel, can I see y'all briefly at the bench to
2 talk about scheduling for tomorrow.

3 (Whereupon, a bench conference was held in the
4 presence of the jury but out of the hearing of the
5 jury.)

6 THE COURT: Ladies and gentlemen, thank you for your
7 patience and attention. That will conclude the
8 proceedings for today. I ask you to be back tomorrow at
9 9:30 in the morning.

10 (Whereupon, the jury was excused from open court for
11 the day.)

12 THE COURT: Will be in recess until 9:30 tomorrow.
13 Thank you.

14 (Whereupon, the trial will resume the next morning at
15 9:30 a.m.)

16 THE COURT: I think we are up to Plaintiff's 13, is
17 that correct, Mr. Jordan?

18 MR. JORDAN: Your Honor, I believe so. However, I
19 just brought to the attention of Mr. Graham that during
20 the initial witness, Dr. Duboe, he had essentially
21 introduced two exhibits that have not been marked. It was
22 the fetal heart rate monitor and the handwritten note of
23 Dr. Miller.

24 THE COURT: In that case let's mark those as 13 and
25 14. Any objection, Mr. Davis?

1 MR. DAVIS: No objection, Your Honor.

2 THE COURT: And then we will start with 15 for new
3 ones.

4 THE COURT: Plaintiff's 13 is the note. 14 is the
5 heart rate. And your new three, Plaintiff's 15.

6 MR. JORDAN: The two new ones will be the
7 psychological evaluation, Dr. Margaret Greer-Simmons on
8 July 28th of 2012. And a psychological evaluation from
9 Dr. Margaret Greer-Simmons on November 14th.

10 THE COURT: And that is number 16. Plaintiff's 16.
11 What was the date on that one.

12 MR. JORDAN: November 14th.

13 THE COURT: And the last one which would be
14 Plaintiff's 17 is, handwritten note from Dr. Miller. Mr.
15 Davis, any objection to the admission of those exhibits?

16 MR. DAVIS: No, sir.

17 THE COURT: Thank you, sir. Plaintiff's 13, 14, 15,
18 16 and 17 are into evidence without objection.

19 (Whereupon, Plaintiff's Exhibits 13, 14, 15, 16, 17
20 were admitted into evidence.)

21 THE COURT: Anything else we need to do before we
22 bring the jury in?

23 MR. JORDAN: No, sir.

24 THE COURT: Is our next witness live?

25 MR. JORDAN: Yes, sir.

1 THE COURT: Anything from the Defense?

2 MR. DAVIS: No, sir.

3 THE COURT: Bring them in.

4 (Whereupon, the jury came into open court at
5 approximately 9:46 a.m.)

6 THE COURT: Mr. Graham, Mr. Jordan, call your next
7 witness, please.

8 MR. JORDAN: Yes, Your Honor, the Plaintiff would
9 call Dr. Margaret Greer-Simmons.

10 Dr. Margaret Greer-Simmons, being
11 first duly sworn, testified as follows:

12 DIRECT EXAMINATION

13 By Mr. Jordan:

14 Q Good morning, Dr. Greer-Simmons.

15 A Good morning.

16 Q Would you please state your full name for the record?

17 A It is Margaret, it is one of those long hyphenated
18 last names, Greer-Simmons.

19 Q And where do you live?

20 A I live in Mt. Pleasant, South Carolina.

21 Q And if you would, tell the jury your educational
22 background?

23 A I have three degrees from the University of Georgia.
24 I have a Bachelor's, my Master's and my Doctorate. And I
25 am licensed as a clinical and school psychologist by the

1 South Carolina Board of Examiners in Psychology.

2 Q And your Doctorate was in psychology?

3 A Yes.

4 Q And you hold license in South Carolina?

5 A Yes, I do.

6 Q And tell the jury about any academic or
7 administrative positions that you have held?

8 A I have been on the Faculty with the Citadel right
9 there in Charleston, South Carolina; the University of
10 South Carolina and the Medical University of South
11 Carolina. I spent most of my years at the Medical
12 University.

13 Q And what did you do for the Citadel and the Medical
14 University. Were you teaching?

15 A I was mainly at the Citadel. I was teaching graduate
16 school classes in child development and child assessment
17 which is mainly what I do. And with the Medical
18 University of South Carolina I headed up a division of
19 child, (inaudible), located at the Vince Mosley Center and
20 we did assessment with children and adolescent which is
21 essentially what I do now in private practice.

22 Q So you are in private practice now?

23 A Yes, I am.

24 Q And where is your practice located?

25 A It is right there in Mt. Pleasant, South Carolina.

1 Q And tell the jury, if you would, what your practice
2 consist of, what you do in that practice?

3 A I see approximately 200 children per year. Most of
4 them are referred by local pediatricians and I do
5 assessments. Right now I am booking about four months in
6 advance. I hate for people to wait that long to come see
7 me but I usually have the parent conference or the
8 follow-up conference the very next week when I go over the
9 findings with the parent.

10 Q And do you have any publications?

11 A Thanks to you I counted them this morning. I have
12 about 30 publications, most of them having to do with
13 child assessment and developmental disorders.

14 Q Have you ever been qualified as an expert in the
15 courts of South Carolina?

16 A Yes, I have.

17 MR. JORDAN: Your Honor, at this time I would offer
18 Dr. Greer-Simmons as an expert in neuropsychological
19 assessment and evaluation.

20 THE COURT: Any objection?

21 MR. DAVIS: None, Your Honor.

22 THE COURT: Okay. Ladies and gentlemen, this witness
23 is qualified as an expert, tell me again the field, Mr.
24 Jordan.

25 MR. JORDAN: Neuropsychological assessments and

1 evaluations.

2 THE COURT: Neuropsychological assessments and
3 evaluations. Thank you, sir.

4 Q Dr. Greer-Simmons, during the course of your practice
5 did you have an opportunity to evaluate or access Alexia
6 Lumpkin?

7 A Yes, I did.

8 Q And can you tell the jury when the first time you
9 evaluated Alexia?

10 A Alexia, I saw at age five and a half, and then again
11 at thirteen and a half.

12 Q And so I believe the date of your first assessment
13 was July 28th of 2012?

14 A Correct.

15 Q And if you would, tell the jury what you did in that
16 evaluation? What was the background or the reason for the
17 evaluation?

18 A I was contacted by Mr. Ed Graham and he said that
19 Alexia had sustained an injury at birth and wanted a full
20 assessment as to her level of functioning and emotional
21 and behavioral status.

22 Q Did you review any records prior to your evaluation?

23 A Yes, I did.

24 Q And which records did you review?

25 A Let's see. The records from Piedmont Medical Center

1 in Rock Hill. The records from the Medical University of
2 South Carolina and the records from Maureen Nelson with
3 the Lavine Children's Speciality Center.

4 Q And then, Doctor, what did your evaluation consist
5 of, what was the evaluation procedure?

6 A When I saw Alexia at age five and a half, I did the
7 Wechsler Preschool and Primary Scale of intelligence. And
8 the Wechsler Scales are probably the most widely used
9 intellectual measure. And they look at verbal problem
10 solving, visual problem solving, how fast you problem
11 solve and your memory scales. I also did the NEPSY which
12 is a neuropsychological measure to look a little more
13 finitely at language processing, attention, motor skills,
14 et cetera. Then I interviewed both of the parents about
15 Alexia's every day kind of skills to complete the final
16 adaptive behavior scales which looks at communication,
17 socialization, daily living and motor skills.

18 Q Doctor, before we go further and you talk about your
19 findings or opinions, are all of your opinions here today
20 to a reasonable degree of psychological certainty?

21 A Yes, they are.

22 Q So, Doctor, if you would, just take us through these
23 tests and the results that you found for Alexia.

24 A With the first assessment, when she was five and a
25 half years of age, I found that she was functioning

1 intellectually within the average range with verbal and
2 non-verbal skills, easily developed. Processing speed and
3 general language skills were also within the average
4 range. Receptive vocabulary was at five years, ten months
5 and expressive at four years, ten months. She had
6 weakness in impulse control, motor intervention
7 persistence, finger dexterity, fine motor movements and
8 motor planning. Behaviorally, her mother didn't note any
9 significant elevations. And adaptively, she was within
10 average limits with moderate delays in motor skills.

11 Q And so, Doctor, was one of the concerns here for the
12 parents, the lack of ability to use her left arm?

13 A Yes, it was. That was their only concern.

14 Q And so, Doctor, with a child of that age, with regard
15 to any anxiety or depression, can a child of that age
16 self-report?

17 A No. The self-report measures start at age six and
18 become much more extensive at age eight and even more
19 extensive when I last saw Alexia when she was 13 and a
20 half. She was at the adolescent self-report version.

21 Q So after the interviews of the parents with Alexia
22 and the testing that you did, did you have any
23 recommendations or conclusions with regard to Alexia?

24 A Well, with my second evaluation when she was 13 and a
25 half --

1 Q First let me ask you about your first and then we
2 will go into the, and ask you about that. So your summary
3 and recommendations for her, from the first time you saw
4 her when she was five?

5 A Five and a half, yes.

6 Q Five and a half. Do you have a copy of your --

7 A Yes, and I also have one on the screen. I suggested
8 continued occupational therapy to address her fine motor
9 skills which would impact her learning and self-help
10 skills. I also suggested that her development be closely
11 monitored because she was at risk for delays there as far
12 as her motor skills were concerned. I also thought there
13 should be periodic assessment of her eye/hand
14 coordination. And that counseling at certain intervals
15 would be appropriate depending on emotional status. And
16 also some supportive family counseling, mainly thinking of
17 the stress and strain that it would put on the family.
18 And I found her to be quite impulsive so I suggested that
19 that continued to be monitored.

20 Q And when you say impulsive, what do you mean?

21 A She wasn't a child to stop, think and act. She went
22 straight to act.

23 Q And you mentioned supportive family counseling.

24 A Yes.

25 Q With, and do you see a lot of children with

1 disabilities in your practice?

2 A Almost all of the children I see are somehow
3 disabled. It is very rare that I get to come back to a
4 parent and say, nothing is wrong.

5 Q And does that cause stress on the family?

6 A Yes, it does.

7 Q And if you could, with the supportive counseling
8 recommendation that you had, what are you looking to
9 address there in particular?

10 A Mainly her emotional and behavioral status and also
11 to support her mother and father during stressful times or
12 times of development.

13 Q Dr. Greer-Simmons, after July 28th of 2012, did you
14 evaluate or treat Alexia Lumpkin after that?

15 A Yes, I saw her again in November of 2020 at 13 and a
16 half years of age. At that time she had progressed to the
17 Wechsler Intelligence Scale for children, the Fifth
18 Edition of that.

19 Q And what does that mean, progress?

20 A She had gotten older. Also that instrument had just
21 been re-normed or updated. They are updated about every
22 15 years or so. And it looks at the same kinds of thing,
23 obviously she would be in a different realm. But it also
24 looks at verbal problem solving, visual problem solving,
25 how fast she problem solves and her memory skills.

1 Q And what were the concerns when you evaluated Alexia
2 in 2020?

3 A I found her to be functioning within the low average
4 range. So a little bit behind her peers as far as her
5 problem solving skills go. That would probably be a
6 function of progressing from the preschool version to the
7 intelligence scale for children, also the re-norming. IQ
8 test to be more difficult when they are re-normed.

9 Q And do the parents have a concern about self-esteem
10 for Alexia?

11 A Yes. They were concerned that self-esteem would be
12 impacted by her brachial plexus injury.

13 Q And how was Alexia adjusting to school?

14 A School, she had some variable skills as far as her
15 academics. But I did the Woodcock Johnson test for
16 achievement which looks at reading, math and language.
17 And with that I did find some definite gaps with her
18 reading comprehension and her math calculation.

19 Q Now, what other test did you run. Just take us
20 through the evaluation process and procedure, if you
21 would, back in November of 2020?

22 A I also did the NEPSY. Again, it is
23 neurophysiological measure to look a little more finitely
24 at language processing, impulse control, language
25 processing, motor skills. I also did the behavioral

1 assessment system for children and of course she had the
2 adolescent version. That is a self-report measure. It
3 has about 180 different descriptors of how she feels about
4 school, friendships, socializations, those kinds of
5 issues. And she is told from the getgo, no right or wrong
6 answer, just how you feel. With that she is compared to
7 other girls her age, so it is in comparison. Did the same
8 thing with the child behavior checklist would be in
9 comparison to other girls her age. And then I also, like
10 I said, the Woodcock Johnson test for achievement which
11 looks naturally, how she would rank.

12 Q With regard to communication domain, how is her
13 performance there?

14 A Communication. Well I found a weakness in verbal
15 inhibition and her ability to comprehend really complex
16 directions. The parents were describing adequate
17 communication skills but I was finding some weaknesses
18 there.

19 Q What about daily living skills?

20 A Daily living skills were mainly impacted by her motor
21 skills.

22 Q Meaning her left arm?

23 A Her left arm, yes.

24 Q And so, I believe your report indicates that is
25 moderately delayed in relation to personal skills?

1 A Yes.

2 Q And what does that mean, it is moderately delayed?

3 A What I usually do with the adaptative behavioral
4 skills is, I do it as an interview and at that time it was
5 with the mom, about Alexia's every day kind of skills. I
6 don't try to phrase it, whether it is right or wrong. For
7 instance, it could be something like, is everybody her
8 buddy or does she have some special friends. So you don't
9 know exactly where the right answer is. But it is more
10 appropriate at her age to have special friends. I did
11 find a weakness in her daily living skills mainly in
12 relation to motor skills. I am sorry, I am trying to get
13 to that page. Daily living skills were moderately low
14 with personal skills or her daily living skills, more
15 about a seven year level. And, again, she was 13 at the
16 time. Skills around the house, more at 11 so closer to
17 her age. And community skills at 10 years, 10 months,
18 those would be awareness of what is expected in the
19 community.

20 Q With regard to the emotional behavior evaluation,
21 were there any school problems.

22 A The emotional behavior evaluation, it can come out
23 average for her age, at risk, a little bit of a caution
24 flag, keep an eye on it; or clinically significant, this
25 is a big issue, this needs to be addressed. As far as

1 school, did come up at risk. That would be kind of a
2 residence or a wall built up against school work. She
3 thought well of teachers, didn't tend to be more of a risk
4 taker than other girls her age. But internalizing or
5 bottling things up inside, that did come up at risk.

6 Q When you say at risk, what does that really mean?

7 A That means that it is kind of a caution flag, kind of
8 a red flag or yellow flag, is you think of it like a stop
9 light, it would be caution. And clinically significant
10 would be the red.

11 Q And did you find that she was internalizing her
12 problems?

13 A Yes, I did find that. She feels like she has limited
14 control over what happens in her life and occasional gets
15 blamed for things she didn't do. May not be accurate but
16 it is how she perceives things. She had typically levels
17 of difficulty establishing and maintaining friendships.
18 But anxiety was clinically significant. That was actually
19 at the 96 percentile. And that, again, in comparison to
20 other girls her age. So she is much more anxious than
21 most children her age.

22 Q When we are talking about anxiety. If you could,
23 explain a little more to the jury about this score of
24 anxiety and clinically significant?

25 A Well, each score loads anywhere from 10 to 15 items.

1 So it wouldn't be something like, are you anxious. And
2 she said yes or no. It would be, I worry a lot of the
3 time. I feel that I may not be doing things correctly. I
4 worry about what is going to happen. Those kinds of
5 issues. And again, in comparison to other girls age she
6 did come up with a 96 percentile. And I did find that is
7 causing at least risk depression. So she is worrying so
8 much about what is going to happen it is pulling her down.
9 Also her confidence level was kind of low as well. So she
10 feels like she is putting forth a lot of effort and it is
11 just not working out the way she would like. No elevated
12 physical complaints. She feels like she has some
13 difficulty maintaining her attention and impulse control.
14 A lot of strain at home and some strain with friendships
15 feeling isolated and lonely. Also, as I mentioned before,
16 her confidence level was low. Past anxiety was also
17 elevated, that was at risk. A little bit of anxiety on a
18 test and we actually do better. But as the anxiety goes
19 up test performance goes down.

20 Q Did you find that with her?

21 A Yes, I did.

22 Q With regard to the depression being an at risk, does
23 that indicate that she feels sad or misunderstood?

24 A Yes, it does.

25 Q And what about her score on the sense of inadequacy?

1 I am referring to page 10 of your report.

2 A Okay. Sense of inadequacy, they come up at risk. So
3 that was when I was explaining that she feels like she is
4 putting a lot of effort but it is not working out well.

5 Q Does that indicate that she is not satisfied with her
6 level of ability to perform certain tasks or functions?

7 A That's correct.

8 Q And what about in attention or hyperactivity scale?

9 A Both of those were at risk. So she feels like she
10 has a lot of difficulty her attention and impulse control.
11 And I did find out when I evaluated her at age five, not
12 as much so as age thirteen and a half.

13 Q Now, with regard to going back to the anxiety and
14 depression. How is that affecting her?

15 A Well, it would affect, it is a little bit different
16 with children than it is with adults. We, as adults,
17 think of an anxious person kind of sitting in the corner
18 all kind of bottled up and not able to relax. Children
19 often lash out, they don't know how to handle the anxiety.
20 So they explode and that can cause some difficulty at
21 school and at home as well. But it is to the point that
22 it is pulling her down some.

23 Q And with regard, well first let me ask you, the
24 anxiety and depression you say pulling her down. Does
25 that cause or can cause the conflicting relationships with

1 friends, family, when she lashes out?

2 A Yes, it can.

3 Q Did you find that with her?

4 A Yes, I did.

5 Q And with regard to Alexia and her frustration over
6 inability to perform task, given her left arm. How does
7 that play into your evaluation of her?

8 A Mainly that would be the adaptive measure, how she
9 performs different daily tasks. As far as the anxiety,
10 that can be multi-facet, it is certainly the frustration
11 level is there, her confidence level is low, she, again,
12 feels like she is putting forth the effort but it is not
13 working out well.

14 Q And after the evaluation and reviewing the records,
15 let me ask you, I don't believe I asked you. What records
16 did you review this time as well, this report?

17 A This report, I reviewed mainly her school records,
18 her academic performance up until that time.

19 Q And how was she doing in school at that point?

20 A It was quite variable. She was receiving what is
21 called a 504 Plan which is accommodations within the
22 classroom or especially at her age, since she was changing
23 classes she could have an assistant help her if she needed
24 them to carry books or whatever, supplies. But
25 academically she was everything from the midrange to the

1 high range. Language and arts, she was approaching
2 expectation. She had A's in chorus and physical
3 education; B's in history, science, language, arts, social
4 studies and math; and a C in Spanish. So some
5 variability.

6 Q After reviewing records and your evaluation of her,
7 what was your summary and recommendations?

8 A I found her to be functioning in the low average
9 range with verbal skills and non-verbal skills evenly
10 developed. She had deficits in her verbal inhibition, her
11 ability to respond and accurately process verbal
12 instructions; finger dexterity and visual special
13 processing. Emotionally a lot of concerns; some at risk
14 attitude towards school; atypicality or not feeling like
15 she fits in; locus of control, not being able to control
16 the environment; some depression; some sense of
17 inadequacy; some attention problems; some hyperactivity;
18 some relations with others; some self-confidence; test
19 anxiety and ego strength. And clinically high with
20 anxiety, relations with her parents and mania or inability
21 to relax or calm down. With her mother's report she was a
22 little low on the activities but, again, this was during
23 COVID, I think we are all a little low on activities. She
24 was average with her social contacts; achieving in an
25 average rate in school; and nothing came up clinically

1 significant as far as behavioral elevations. She was
2 functioning within average limits in her reading
3 recognition, her with reading; her math reasoning, her
4 speed with math; her spelling and her ability to express
5 herself in writing. But reading comprehension and math
6 calculation were delayed. So I did diagnose a generalized
7 anxiety disorder; a moderate impairment with her reading;
8 mainly reading affecting reading comprehension. And that,
9 of course, affects everything. So your science, your
10 history, so forth. And when I did measure mathematical
11 reasoning I actually read those to her, that is the way
12 the test is designed. So it did take reading out of the
13 component. And I did diagnose a moderate impairment with
14 her math, mainly the arithmetic facts. And should I
15 continue with recommendations?

16 Q Let me make sure I understand your diagnosis.
17 Generalized anxiety disorder. And if you would, explain
18 to the jury, what is a generalized anxiety disorder?

19 A It means that her level of anxiety or worrisome,
20 being a worry wart is permeating multiple environments.
21 So it is at home, it is at school, it is with her
22 friendships, et cetera. So, again, anxiety is at the 96
23 percentile so it is also pulling her down and she is
24 unable to relax or calm down from that.

25 Q And did she, anxiety related to her left arm and her

1 inability to use that left arm?

2 A Well, it doesn't really, her self-confidence would be
3 affected but it doesn't specifically address --

4 Q Your test doesn't?

5 A Right, yes.

6 Q But certainly her self-confidence is a result of the
7 left arm?

8 A Yes.

9 Q Was diminished?

10 A Yes, that is correct.

11 Q And so your diagnosis, are they to a reasonable
12 degree of psychological certainty?

13 A Yes, they are.

14 Q So the first was generalized anxiety and then if you
15 would just go through the other few for us and explain
16 those?

17 A I did diagnose a moderate learning impairment in her
18 reading comprehension. It can be called dyslexia,
19 unfortunately the media portrays letter reversals, it does
20 not have to be that at all. It is any learning disorder
21 or learning disability in reading. And, again, that
22 affects her reading comprehension which in turn affects so
23 many other subjects. And a moderate impairment with her
24 math or a specific learning disorder with the moderate
25 impairment of math, mainly her number sense and math

1 facts.

2 Q And did you have some recommendations?

3 A Yes. Her, first of all her mother mentioned she had
4 a lot of difficulty falling asleep. So I recommended a
5 trial of melatonin. It is a natural substance, it is even
6 used with preschoolers. Then I also suggested some
7 individual counseling to help her through the anxiety, to
8 lower that anxiety. And I did suggest that that would be
9 face to face. There are a lot of people during COVID that
10 are only doing telemedicine. And I don't find that very
11 effective with adolescent.

12 Q Would that be a hinderance to her being able, during
13 COVID?

14 A It would, unfortunately so. There are a lot of
15 people even in my office building are doing telemedicine.
16 It is pretty effective with adults but not so with
17 children and adolescents. So I did suggest that she be
18 involved in small groups where she would experience some
19 success. That would help boost that self-confidence level
20 up. Different activities to elicit her participation.
21 Stressing attempt rather than final outcomes. So she sees
22 the glass is half full instead of half empty. Being real
23 consistent in helping her develop positive comments,
24 identifying roll models that have similar attributes.
25 Again, emphasizing the positives. Also make sure that she

1 is not blowing things out of proportion. So if you say to
2 her, Alexia on a scale of one to five, is this really a
3 five. No, maybe a three. So I won't get as upset about
4 it. And make sure that she is setting the appropriate
5 expectations or goals. She may be setting them up here
6 and nobody can get there. So and then I did give some
7 websites that have to do with anxiety and depression.
8 They also have some activities for adolescents. So that
9 would be helpful as well. I also suggested that she be
10 referred to her school's special education committee to
11 address her reading and math. With that she is a great
12 candidate, if there is a summary at the end, read the
13 summary first before you read the chapter. That way you
14 know the basis of what you are looking for. Maybe there
15 are questions at the end, read the questions first and
16 then go back and read the chapters so you know, again,
17 what you are looking for. I also suggested maintaining
18 her good knowledge base. So if she is reading, for
19 instance, in Charleston, about South Carolina birds, go to
20 the aquarium that weekend, see the South Carolina bird
21 exhibit and that would help build on her knowledge base.
22 Having her make predictions. What do you think might
23 happen to this character. And certainly reading every day
24 would be a commitment and have her visualize a picture of
25 what she is reading about, have her close her eyes and

1 visualize it. Also there is some great computer software
2 programs that address reading comprehension. As far as
3 her math skills, I said look for the key terminology,
4 definitely do each step on paper. She is not a candidate
5 for doing it in her head. Go back and check the results.
6 And I gave some websites that have to do with learning
7 disabilities.

8 Q And you haven't seen Alexia since November of 2020,
9 is that correct?

10 A That is correct.

11 Q That was last your report?

12 A Yes.

13 Q Thank you, please answer any questions that Counsel
14 might have for you.

15 THE COURT: Mr. Traylor?

16 MR. TRAYLOR: No questions, Your Honor.

17 THE COURT: Thank you, Ma'am. Mr. Graham, you can
18 call your next witness.

19 MR. GRAHAM: Thank you, Your Honor. Our next witness
20 will be Darlene Carruthers. And she will be by video
21 hookup.

22 THE COURT: Ladies and gentlemen, it takes a few
23 minutes to get everyone logged on. If y'all want to take
24 a short five minute break.

25 (Whereupon, the jury was excused for a short break.)

1 THE COURT: Let's bring them in.

2 (Whereupon, the jury came into open court at
3 approximately 10:30 a.m.)

4 (Whereupon, Darlene Carruthers is testifying through
5 WebEx.)

6 Darlene Carruthers, being
7 first duly sworn, testified as follows:

8 DIRECT EXAMINATION

9 By Mr. Graham:

10 Q Good morning.

11 A Good morning.

12 Q Let me get you to state your full name for the
13 record, please.

14 A Darlene M. Carruthers.

15 Q And tell me about your educational background?

16 A Certainly. I have an undergrad degree from George
17 Peabody College which is now part of Vanderbilt
18 University. And that was in exceptional student
19 education, working with folks who are developmentally
20 delayed, learning disabled, emotionally handicapped,
21 impaired and multiple handicapped, deaf and blind. I then
22 have a Master's Degree from (inaudible) University in
23 Vocational rehabilitation and Habilitation and
24 Administration and Supervision.

25 Q Tell us about your professional background.

1 A So initially I started in therapy, so I worked with
2 people with various disabilities from very young and all
3 the way up to close to their 70's and 80's. I did that
4 for approximately eight summers while I was in
5 undergraduate school. I then worked, after graduate
6 school, in a school for individuals with developmental
7 delays and emotional handicaps, in community and
8 functional academics. Then taught for two years in the
9 public school system with children who has learning
10 disabilities and emotional handicaps in the middle school.
11 And then finally in 1984 I started working in the Company
12 that I am employed by now, Comprehensive Rehabilitation
13 Consulting, Inc. So this June will be 38 years that I
14 have been with the Company.

15 Q Let me ask you your background within qualifications
16 with respect to projecting future healthcare needs and
17 other needs for a child with disabilities of some sort?

18 A Certainly. I have a Certified Rehabilitation
19 Counselor. I am Certified Disability Management
20 Specialist. I am Certified Case Manager. I can testify
21 as a vocational expert for social security administration.
22 I can work as a rehabilitation provider and case manager
23 for Worker's Comp. And finally I am a Fellow of the
24 International Academy of lifecare Planning. I believe
25 there are 17 of us now. I have had all of those

1 certifications continuously since I sat for the test and
2 qualified. So for the certification since the late 80's,
3 and for the Fellow which is a peer review process, I have
4 had since 2007.

5 Q Very good. Let me ask you, well you have mentioned
6 vocational work experience. Does your educational
7 background cover vocational aspect as well?

8 A Yes. When I obtained my Master's Degree that was
9 specifically in vocational rehabilitation so I had
10 experience doing vocational assessment, developing
11 rehabilitation plans; doing job training, job counseling
12 and job placement.

13 MR. GRAHAM: Your Honor, at this time we offer Ms.
14 Carruthers as an expert in lifecare planning and
15 vocational evaluation.

16 THE COURT: Any objection, Mr. Davis, Mr. Traylor?

17 MR. DAVIS: None, Your Honor.

18 THE COURT: Ladies and gentlemen, this witness is
19 qualified as an expert again. What that means is she is
20 allowed to give her opinion, unlike other witnesses, but
21 it does not mean you have to believe her testimony, you
22 should evaluate her testimony the same way you should any
23 other witness in the case.

24 Q At my request, have you performed a lifecare plan
25 evaluation for Alexia Lumpkin?

1 A Yes, I have.

2 Q And have you also prepared a vocational evaluation
3 for her?

4 A Yes, I have.

5 Q Let's talk first then about the lifecare plan. First
6 of all, please explain what a lifecare plan is?

7 A That is a dynamic document which outlines all of the
8 medical therapeutic equipment support care needs of an
9 individual who has some type of limitations or disability
10 or illness. And the methodology is based upon standards
11 of practice which I follow and includes review of records
12 of medical and therapeutic as well as occupational meeting
13 with and continuously staying in contact with the client
14 and their family; obtaining input from treaters and
15 evaluators. And incorporating all of that information
16 with a precise plan which lays out a item, the duration,
17 for so how long it is needed, the frequency, how often and
18 a cost range.

19 Q So have you prepared a report containing the lifecare
20 plan for Alexia Lumpkin?

21 A Yes, I have.

22 Q Can we pull that up, please. In the beginning you
23 have some definitions. I think those cover various
24 phrases. Annual evaluation, medical evaluation, household
25 services and level. Let me get you, first of all, I think

1 the medical evaluations and care are fairly
2 self-explanatory. But let me get you to define what you
3 mean, explain what you mean by household service.

4 A Yes. Those are services that are needed in
5 maintaining a household. So that includes light
6 day-to-day tasks, such as laundry, vacuuming, maybe
7 cleaning the bathroom, kitchen, changing bed linens, food
8 preparation, cleanup meal planning; grocery shopping,
9 shopping for the household. All of those types of
10 activities.

11 Q And then is a housekeeper, what do you mean by
12 housekeeper in this context?

13 A In this context a housekeeper is the person who
14 performs what I would call heavy cleaning. So the person
15 who cleans the floors, cleans the bathroom, cleans behind
16 the toilet, maybe getting up on a ladder, cleaning fan
17 blades; taking down curtains to be cleaned; cleaning out
18 refrigerator; cleaning out cabinets. So heavy activities.

19 Q Thank you. And now on page one of your report, after
20 those definitions you have, you have a format here that I
21 want to ask you about but first could you clarify exactly
22 what you do in terms of preparing the various treatment
23 modalities, ages, frequency and the cost. What does that
24 general process involve?

25 A So as I said, I review all of the records, medical,

1 therapeutic, educationally and extract out what services
2 an individual is receiving and look at the recommendations
3 from all of the providers and evaluate. I also speak with
4 the client and family to find out how frequently they are
5 attending medical appointments, therapy sessions. And all
6 of that information is incorporated into the document that
7 you see whereby I take into account those recommendations
8 and lay out what an individual needs by age category and
9 then how often they need them. With respect to the cost,
10 a survey is done of the provider that the client currently
11 treats with as well as other providers in the geographical
12 area in which they reside. So I am looking at where they
13 reside, and I am coming up with a middle range. So kind
14 of a medium of the cost range of what providers will be
15 charging for those various services.

16 Q And in evaluating what future treatment needs there
17 are, have you spoken with some of Alexia's physicians and
18 surgeons.

19 A Yes, I have. I have spoken with Dr. Nelson, Dr.
20 Armenta, we have obtained information and spoken with Dr.
21 Grossman and also have obtained input from her treating
22 therapist in the way of forms that they have completed
23 outlining their recommendations.

24 Q Very good. Did you also have access to some
25 information and recommendations from a specialized

1 occupational therapist in Miami?

2 A Yes, that was Yvette Alliance who gave us input and
3 then also reviewed the report.

4 Q And you mentioned getting therapy reports, the
5 treating therapist. Tell us whether those therapists are
6 general practice type therapists or whether they have any
7 special abilities and training with respect to brachial
8 plexus injury.

9 A From what I can see those are general pediatric
10 therapists that provide therapy to a wide range of
11 children who have various needs requiring therapy. So she
12 has had both occupational and physical therapy pretty
13 consistently from a very early age up until most recently,
14 a couple of months ago. So she has been attending therapy
15 as much as two times per week for sixty minute sessions
16 from those therapists. But, again, that is on a general
17 therapeutic basis. So they work with her on activities of
18 daily living, finding ways to accommodate her limitations
19 and caring out those activities. They do stretching,
20 range of motion, they also help her with obtaining and
21 fitting, devices for her elbow and wrist.

22 Q How do their capabilities and training for brachial
23 plexus therapy compare with those of a specialist
24 therapist in brachial plexus?

25 A There are, what I would call, centers of excellence

1 or places where individuals who have a particular
2 disability go because the folks that are there have years
3 of experience, specialized training and working with that
4 particular disability. For example, (inaudible), one of
5 those centers in Miami. There are centers in Houston,
6 Cincinnati and at Boston Children's. And those centers
7 have people who spend a tremendous amount of time or all
8 of their time working with individuals with brachial
9 plexus type injuries from evaluating them, performing
10 surgeries, surgeons and therapists who utilize all of the
11 modalities to work with individuals with that particular
12 disability.

13 Q We have the first page of your report here with the
14 format that you have described. Did you just basically,
15 take us through, the first heading that I see is Medical
16 Evaluations and Routine Care. And the first one
17 references neurosurgical reconstructive surgery and
18 orthopedic evaluation. Are those, what are those
19 specifying, are those actually talking about surgeries or
20 something else and, if so, what?

21 A Those are actually the medical evaluations. So on
22 the first page there are two types of care, the
23 evaluations and the routine follow-up. So the evaluations
24 are a visit where there is a comprehensive assessment done
25 and where there is an item, for example, care; that is for

1 the follow-up in between the evaluations. So these are
2 with visits with those particular specialists or for
3 treatment by those specialists.

4 Q The next column is age over which services will be
5 provided. Explain what that means.

6 A That is what I would call the duration. So how long
7 or over what time period that particular recommendation
8 will be needed. So in some cases it is over life, some it
9 is broken down now, to life and the bottom two to now to
10 18. And that is the age of 18.

11 Q And you have got the frequency listed. I guess, that
12 is self-explanatory. But can you just summarize what that
13 means.

14 A I will make a distinction on what I think is
15 important. On the first line you will five to ten times.
16 So that is not five to ten times a year, that is five to
17 ten times through their life. Now the next item, or the
18 one after that is a one time year. So the frequency would
19 be for an annual visit or if you will see further one,
20 every two to five years, so that would be a range. And
21 the rest of them are a certain set amount, either after an
22 evaluation or over a particular time period.

23 Q Then we have got the cost sections from a certain
24 dollar amount to a certain dollar amount. How did you
25 come up with those figures.

1 A So, again, doing a survey of what her current
2 providers are charging as well as other providers in the
3 area, making phone calls, assessing transparency data
4 bases from hospitals or other medical practices. And then
5 using a range. So that is a medium range. So kind of the
6 middle of what that price range would be.

7 Q Thank you. Let's turn to the next page, please. One
8 with diagnostic test. We have got the same format, just
9 explain generally what is involved with these
10 recommendations?

11 A Certainly. The first three are Xrays and the left
12 shoulder would be two to five times over life; the left
13 elbow and hand wrist one time or more as needed; and
14 finally the last item, magnetic MRI of the shoulder, she
15 would need one of those at least and perhaps more as
16 needed. And that, of course, would have the cost range.

17 Q Let's move down to the following page, therapeutic
18 evaluations and care. The same format. Give us an
19 overview of what is involved here in terms of these
20 evaluations and care?

21 A Yes. So this is the various therapeutic modalities,
22 these are occupational therapy which should include
23 electrical stimulation which she has been recommended by a
24 therapist and her physicians. And then there is physical
25 therapy, a more intensive therapy program after any

1 surgeries, recreational therapy and a psychological
2 evaluation. So there is a therapy evaluation periodically
3 once a year, every six months. And then there is therapy
4 in between those evaluations. So we have occupational
5 therapy, and physical therapy. Occupational therapy is
6 two hours a week, physical therapy two hours a month. And
7 then there would be additional therapy as she gets a
8 little older for a short period of time but a much
9 frequency to help her maintain any progress she has made
10 and help provide a program that she can do at home. And
11 finally, the intensive therapy program is after she has
12 surgery, she will need therapy more intensively to include
13 various modalities such as electrical stimulation. And
14 then recreational therapy three to five times over her
15 life to help come up with various accommodations so that
16 she can participate in leisure activities, also increase
17 physical abilities. And finally a psychological
18 evaluation periodically to kind of get a baseline and to
19 determine how this is impacting her from a psychological
20 standpoint and helping make recommendations for treatment.

21 Q While we are on this page, that includes occupational
22 therapy and physical therapy; have you had an opportunity
23 to obtain information from the general therapist that had
24 been providing care to Alexia?

25 A I guess I have. Not only have I reviewed all of her

1 records to date from those therapists but I have also sent
2 out questionnaires to them periodically over the years to
3 receive their input both in the goals they are working
4 with her on her level of participation, recommendations
5 for modalities, pieces of equipment and what they see as
6 far as future needs. So all of those have been
7 incorporated into the recommendations in this report.

8 Q In obtaining that information were you able to access
9 how the therapists perceived the corporation to be from
10 the family and from Alexia in terms of complying with the
11 therapy recommendations and the therapy?

12 A Yes. In all of the records there were indications of
13 slow but steady progress. Her level of participation was
14 excellent within any given time period for the last couple
15 of years. She only missed one or two therapy sessions
16 within a whole time period that was generally three to
17 four months. So she was a regular participant and she
18 would follow the recommendations and work as much as she
19 could in reaching her goals. Varying degrees of progress
20 would be made but most of the goals, as I said, were
21 designed around activities of daily living; accommodations
22 and visual and motor integration.

23 Q The next page continues therapeutic evaluations and
24 care. Would you comment on these evaluations?

25 A Yes. And here we have, the first couple of them are

1 for individual counseling, family counseling. The records
2 indicate that there is some emotional response to her
3 limitations, issues with self-esteem, issues with social
4 participation. They have worked very hard to try to
5 educate her about her condition but find that she is
6 somewhat remised about sharing that information and kind
7 of hides the effective limb by putting it in a pocket of a
8 sweatshirt or a jacket. So she doesn't share a lot about
9 it but there is indications in the records of social
10 anxiety and some difficulty with the perception of peers
11 and embarrassment and shame at her limitation. So the
12 individual family counseling is designed to try to help
13 her develop of kind of a healthier response to look at
14 ways that she has been successful and to help her improve
15 her self-esteem and social interactions. There is a
16 vocational assessment there and an ergonomic work site,
17 evaluation, so that she can have some guidance in what
18 areas of employment would accommodate her limitations and
19 how those in the work environment can be accommodating.
20 And finally an adaptive evaluation and some training so
21 that she can have some adaptive equipment to enable her to
22 drive safely and accommodate her limitations.

23 Q Turning to the next page we have surgical procedures.
24 If you don't mind, would you please give us an overview of
25 surgical procedures that are listed here?

1 A Yes. There are several procedures there, we have
2 the, not necessarily in the order which they would be
3 performed. But a shoulder surgery that they call mod
4 quad, this is all outlined by Dr. Armenta. And elbow
5 surgery and the hand/wrist surgery which would be done one
6 to two times. Each of the, they include the surgery, the
7 surgeon's fees, the anesthesiologist fees, the assistant's
8 fees, recovery, hospitalization, meds; everything that
9 happens while you are at the hospital from when you step
10 in the door until you leave. So that is an all inclusive
11 cost. I have also put in some ancillary expenses related
12 to visiting Houston for those surgeries. So the air-fair
13 for Alexia and a parent, lodging while she is there and
14 transportation to and from the airport, hotel, hospital
15 and meals while they are there.

16 Q Next, well continue down, if you would, with the
17 other items that you have recommended?

18 A So, again, what we see there is the air-fair and
19 transportation, meals, so all the cost associated with
20 Alexia and her parent going down to Houston.

21 Q What about the Botox injections?

22 A Those Botox injections are specifically needed to
23 loosen up the affected area and followed up by rigorous
24 therapies so she can benefit from those procedures. So
25 Dr. Armenta recommends Botox followed by what is called

1 serial casting which is actually loosening up the limb with
2 the Botox and a series of casts are applied to increase
3 the range of motion. And the more rigorous therapy would
4 be used during that time period to help prepare her for
5 the next level or phase of the surgery.

6 Q Are those kind of surgery preparation techniques,
7 Botox, serial casting, et cetera; has Alexia received any
8 of those to date?

9 A No. Again, those are done by the more specialized
10 centers and usually following a program by a surgeon such
11 as Dr. Armenta where a particular sequence would occur and
12 follow-up with the physician in between so that they can
13 determine when she is ready for the next surgical
14 procedure.

15 Q And moving on down, I see references to elbow
16 surgery, hand/wrist surgery and a variety of other
17 evaluations that seem, therapies that seem to be related
18 to those surgeries. You mentioned a series of surgeries,
19 I believe, and you also said something in the beginning
20 about these not necessarily being in the order in which
21 they would be performed. But of the mod quad, elbow and
22 the hand/wrist, is it the mod quad that would be first?

23 A Yes. My understanding from Dr. Armenta is that would
24 be first and then following that would be the Botox,
25 serial casting and then the elbow surgery. In between

1 there would be follow-ups with the physicians to monitor
2 her progress. And then once those procedures are
3 completed she would then go to the next surgery which
4 would be the elbow surgery, which includes kind of a
5 biceps tendon lengthening. And, again, follow-up visits
6 with the surgeon, more intensive therapy and then
7 hand/wrist surgery following that intensive therapy
8 period. Again, medical follow-up. But in all of those
9 would be kind of a stage from one step to the other with
10 medical follow-up and therapy in between.

11 Q And you mentioned various procedures to prepare her
12 for the next surgery. What about the very first surgery
13 on the shoulder, with regard to the preparation that she
14 would need for that mod quad, is that something that she
15 can get from her current therapist or does she need that
16 from specialist?

17 A She would need, by a specialist, kind of the
18 direction or supervision of the medical doctor so that
19 they know exactly what it is, the areas he wants targeted
20 and how frequently she has it. So it would be a more
21 intensive level of therapy prior to that first surgery.

22 Q I am going to skip the page about travel expenses. I
23 believe that is self-explanatory. On the following page
24 it addresses education, training and experience. Would
25 you just, and equipment, could you basically summarize

1 briefly what is involved there and why?

2 A Yes. To accommodate her inability to perform
3 by-manual work and still be able to be an active
4 participant and keep up with class, I recommended a few
5 items that would enable her to be able to work more
6 efficiently. She does have a 504 plan for school which
7 does give her a few accommodations. In other words,
8 somebody is to help her with her locker, carrying her
9 lunch tray, she gets a slight bit of more time to take
10 tests or for assignments. But to help her to be able to
11 be more efficient I have given her a digital voice
12 recorder, a tablet computer that she can use to help
13 organize and keep her assignments. A one-handed key board
14 because she cannot use the left hand to type. So there is
15 a special keyboard that has everything set for one, for a
16 person to use this with the one hand. I have also put in
17 Dragon Natural Speaking software, that is a voice
18 recognition software and some educational software on top
19 of that to include word prediction so that, that relieves
20 her from having to type the whole word. Sometimes we see
21 this in text messaging where you start typing a word and
22 then it will try to guess what you want. Just hit it
23 instead of having to type. So that would be an example of
24 the piece of software. Finally a very minimal amount of
25 job placement assistance. Really, that is to help her

1 understand the American's Disabilities Act and the
2 accommodations that she can ask for and to help her get
3 settled into a new job. That person might help her know
4 what to ask for in terms of accommodations, may help
5 meeting with potential employers, to be able to help them
6 understand what she will be able to do or what she would
7 need help with.

8 Q The next page is entitled support care. Take us
9 through that and explain briefly what those are for?

10 A Sure. So Alexia does not have, for the most part,
11 the use of her left hand except for a helper or as a
12 weight. And, weight, w-e-i-g-h-t, so it holds something
13 down. So she requires a great amount of assistance with
14 activities that require both hands and fine motor. For
15 example, her mother has to help her wash her hair and
16 style her hair. Her mom takes her to have, currently
17 right now, braids put in every three weeks at the cost of
18 \$120.00 dollars so that she can be able to care for her
19 hair in between. But her mom has to do the washing and
20 help her. She has to have clothes that she can pull on
21 over her head or stretching that don't have zippers or
22 buttons or she needs assistance with them. Her mom helps
23 with meal preparation. She can't even fasten a necklace
24 unless it goes over and puts backs on earrings. There are
25 many activities that we think about on a daily basis that

1 we use both hands for. She certainly couldn't carry a big
2 heavy pot like one you might use to boil pasta, she would
3 have to do things to accommodate. So what I have done,
4 now to 21, basically while she is in the family home, I
5 have just given her a minimum assistance with anything
6 over and above family has been provided. But once she is
7 in her own home as an adult she will need more help. So I
8 envision that person would help with household tasks, some
9 of which we have already outlined. Whether it is getting
10 on a ladder and cleaning or pulling something from
11 shelves, some food preparation, come in and doing some
12 cutting, getting it in a bag so she can bake her meals;
13 heavy housekeeping, changing sheets; carrying heavy
14 laundry baskets. All of the various activities that we
15 use both hands for. She does and will be able to do
16 certain things with accommodations but some of them take
17 so much longer that it is inefficient for her to do all of
18 them without some preparation or assistance. So that is
19 basically what we have here. If and when she has children
20 she would need a little additional help. Bathing a
21 slippery, soapy baby could be very dangerous without
22 assistance. If she has her own home, anything like that
23 would require to use two hands, like a screwdriver to make
24 a small repair, carrying, planting materials or doing
25 hedging or carrying certain hand tools. She would not be

1 able to use both hands and therefore would have difficulty
2 with. So in order for her to be able to work, to be
3 efficient in completing her activities of daily living
4 this gives her some support. So she still has a level of
5 independence but has folks to help her so that she can
6 continue to work and have activities that we all do on a
7 daily basis.

8 Q I am going to skip the next page about a free
9 magazine. Going to the page about home modifications.

10 Please explain those briefly if you would?

11 A So I have in there a shower grab bar, really that is
12 just for safety so when she is getting in and out of the
13 tub because she does have some balance issues due to her
14 inability to catch herself or to control that side of her
15 upper extremity. So this is for safety. The next item,
16 modify a closet. She cannot do, with that left arm, up
17 over her head or carry anything. So this is just a modify
18 it so that all the shelves are lower and she will be able
19 to do everything as far as getting in and out and some
20 shelving that can be pulled own. And then finally in the
21 kitchen, a pull down shelving so that she can keep things
22 up above her shoulder height and move shelving at waist
23 height so that she will be able to reach everything with
24 just the one hand instead of needing both hands or
25 climbing up on something to get it. So this, again, very

1 minor accommodations that will enable her to maintain some
2 level of independence.

3 Q Thank you. Let's move to the next page entitled
4 equipment for activities of daily living. Please take us
5 through those, please.

6 A Okay. So this section actually is two pages. The
7 first was, the purpose of it, there are various pieces of
8 equipment, again, so that she can make some accommodations
9 for the lack of the ability to use that one hand. So
10 whether it is one-handed devices that, for example, to
11 hold a piece of fruit or vegetable that she is trying to
12 cut; whether it is a knife that, by rocking it, you cut
13 the meat; let me go back to the second item, silicone
14 shoulder pads. Those have been recommended by both Dr.
15 Nelson and several of her therapists that will help even
16 out her shoulder height and help elevate some of the pull
17 on her shoulder. And we have in there suction plates,
18 soup bowls. So when she is using them they don't slide,
19 not having both hands. Disseum, (phonetic) is something
20 that her therapist has actually given her and it is
21 something that sticks to both, what you put it on. For
22 example, a table top or a counter top and the object that
23 you put on it to keep things from moving. There is a
24 one-handed can opener, jar opener, self-opening scissors.
25 The lazy-susan can be used both on, at a job site, on a

1 desk or on a table or a cabinet. Again, the one-handed
2 paring board which is kind of a cutting board with a, to
3 put the fruit on and an edge to put stuff up against
4 because she is not able to hold it. So all of these
5 things are items that she will need throughout her life to
6 supplement the assistance that you have to enable her on a
7 day-to-day basis to get through what she needs to get
8 through. You can see on the next page, if you go there.
9 There is a pan holder, a food prep board, a revolving desk
10 organizer, some other items that, a book holder, a
11 telephone headset, all of these items are to accommodate
12 her limitation of having only one hand and arm to perform
13 all of these activities.

14 Q Let me stop you right there because we weren't
15 coordinated on the screen. All right. Thank you.

16 A That is the second page where you see the pan holder,
17 the food prep board, the revolving desk organizer and
18 electric stapler, book holder, telephone headset. Again,
19 all of the things that are needed. And I am going to say
20 the telephone headset, I am going to give you an example
21 of that. Many of us hold the phone with one hand and then
22 we work on the keyboard or we use the mouse with the other
23 to look up something on the computer while we are working.
24 She can't hold the phone up to her, with the left hand.
25 So by giving her a headset she is free to be able to use

1 that right hand to do whatever she needs to be able to do.
2 This is an example of an accommodation that's necessary
3 for her to be able to do what she needs to do whether it
4 is school, work or home.

5 Q On the next page we have orthopedic equipment. Would
6 you please, once we get that on the screen, would you
7 please go through those items.

8 A Yes. These are all items that, as part of her home
9 therapy program and to maintain whatever range she has
10 been able to achieve either by therapy or service. So
11 theraban resistance van kits are exercise van, there is
12 theraplast for strengthening, soft weighed balls, dumb
13 bells, all of those are part of the home therapy program.
14 So when she goes to therapy, the therapist works with her,
15 teaches her how to do the certain exercises and then she
16 will be following those types of exercises on the days she
17 is not in therapy. The next few items, the electrical
18 stem unit, electros, lead wires; that is specifically,
19 again, recommended by both Dr. Armenta and Dr. Nelson as
20 well as her current physical occupational therapist all to
21 be used to help reduce some of the tightness, increase
22 muscles and help with range of motion. And finally, the
23 last two items are splints that she uses both when she
24 sleeps and one is during the day to help with her range
25 and to help to support the elbow and the wrist throughout

1 the day and night. And, again, that will help keep
2 whatever progress with range of motion either by way of
3 therapy or surgery or Botox or serial cast.

4 Q Let's turn to the next page, transportation. Tell us
5 about that.

6 A Yes. So the first items is just emergency roadside
7 assistance such as Triple A. If she were to have a
8 breakdown she would not be able to change a tire or do
9 anything with that one hand. In case of emergency she
10 will be able to get help. The next two items are two
11 small items actually were recommended by her therapist
12 that will help her to be able to drive. So if you think
13 about when you back up and turn your body, usually you put
14 your right arm back on the seat or to help turn your body
15 and then use your left to use the steering wheel. She
16 won't be able to do that. So that gives her a panoramic
17 mirror to help with visibility and the spinner knob, again,
18 is a device to be put on the steering wheel that she can
19 use to help her turn the steering wheel with one hand.
20 Small items are very important for safety, and again,
21 recommended by her therapist.

22 Q The next page is leisure and recreation and exercise
23 equipment. Tell us about that, please.

24 A These are just a few items that, again, to help her
25 continue to exercise and the first two areas, to improve

1 her range of motion and coordination by providing her with
2 activities when she is doing with therapy. Again,
3 recommended by the therapist. The first one is leisure
4 time community activity programs. And the second one,
5 physical positioning. So that she can continue to have
6 someone assist her in participating in or performing these
7 exercises with respect to the physical position to have
8 someone there to facilitate whether it is adaptive
9 aquatics or using equipment but being supervised in a safe
10 environment. The last two items are exactly what you
11 think they would be, a way of shuffling a deck of cards
12 and holding the cards so that she can participate in that
13 activity. These also are very important because there has
14 been some issues unfortunately with socialization. She is
15 very self-conscious and giving her an opportunity and
16 encouraging her to develop these skills will help her
17 improve her self-concept and self-esteem and help
18 facilitate socialization.

19 Q So is that similar to the recreational therapy that
20 you said was so important?

21 A Yes, exactly. That very brief evaluation, a few
22 sessions will help find some other types of equipment to
23 accommodate. And there are a great number of them, I
24 haven't listed them there. But there are other types of
25 equipment that could, she can use, depending upon the

1 activity she is in. But it is very important for her to
2 be able to physically be accommodate so that, again, she
3 is able to keep her range of motion and her flexibility,
4 whatever she is in therapy on a lifelong basis because she
5 is not going to be having regular therapy as an adult,
6 just intermittent with the maintenance program. So this
7 helps her to be able to keep that.

8 Q That appears to conclude your lifecare plan. Before
9 we move on to the vocational evaluation, let me just ask
10 you. Has everything that you have presented so far, does
11 it represent your opinions held to at least a reasonable
12 degree of certainty in your field as a lifecare planner?

13 A Yes, it does.

14 Q And in terms of some of the specific, in terms of the
15 specific surgeries and other medical treatment modalities,
16 have you only included those which have been recommended
17 by various physicians and surgeons as being reasonably
18 certain more likely than not to be needed and to occur.

19 A Yes, I have. They are in there based upon my
20 discussions with them, their recommendations in the
21 records and then ultimately their review of my report and
22 approval of it.

23 Q Thank you. I am getting ready to turn to your
24 vocational report. But before we do, are all of the
25 opinions and conclusions that you have set forth in the

1 vocational report also opinions and conclusions that you
2 hold to at least a reasonable degree of vocational
3 certainty?

4 A Yes, they are.

5 Q Rather than me go through item by item, could you
6 just explain to us what the process is for evaluating
7 one's occupational options and the effect on earning
8 capacity for a child with injuries like this?

9 A Yes. So the methodology that I use is the
10 occupational access system which is based upon using
11 government statistics, Dictionary of Occupational Title,
12 the Bureau of Labor Statistics; and the Occupational
13 Employment Statistics. In other word, all from government
14 publication, government statistics and accepted
15 methodology within my field and also used by the Social
16 Security Administration and governmental agencies and comp
17 agencies to determine this. So we use that methodology,
18 it is called the Labor Market Analysis. And basically
19 what we do is we come up with a profile, had she not had
20 the brachial plexus injury which is based upon parents,
21 education and background, at least average levels and
22 abilities to perform physical activities, to complete at
23 least high school and perhaps some college, Associates
24 type of degree. And be able to be trained in a skilled
25 occupation. So we develop a profile in a number of

1 different categories. We look at flexibility,
2 coordination, bimanual dexterity, ability to crawl and
3 climb and crouch; all of the physical characteristics and
4 we come up with a profile. And that would be had she not,
5 (inaudible), the brachial plexus. We then come up with
6 another profile that compares to that profile. So we
7 reduce the strength, we, the characteristic of not having
8 bimanual dexterity, not being able to do a lot of
9 activities that require fine motor flexibility. But we
10 keep everything with respect to ability level,
11 intelligence, training because none of that has been
12 impaired. So for her, it is just the loss of use of that
13 left arm and hand and how that impacts each of her
14 characteristics. And in this particular case I also got
15 some input from Dr. Nelson. And so if we look at it, you
16 know, things like crawling, climbing up on a ladder; doing
17 a lot of fingering. Those are all characteristics that
18 have been impacted by the loss, the use of that left arm.
19 So we have taken all of those variables and then use an
20 approach, again, that is accepted by the Social Security
21 Administration to help compare and contrast all of the,
22 the Dictionary of Occupational Titles that she could
23 obtain using the non-brachial plexus profile. And then we
24 compare them with what her limitations are now and all of
25 the jobs, occupational title that she would be able to

1 meet. And then we come up with a loss of both access in
2 the labor market. In other words, a loss, job categories
3 and actual jobs that she no longer would be able to do as
4 well as the percentage of jobs in the labor market that
5 that represents.

6 Q Let me interrupt right there. How much has she lost
7 in terms of career options?

8 A Well, basically she has lost 96 percent of an
9 opportunity for the job market which translates to about
10 \$15,321.00 per year. And that is with the most up-to-date
11 wages that we have available. So basically if we compare
12 all of the jobs she could have done before having, not
13 having the brachial plexus injury versus what she can do
14 now, she has a loss of access of the labor market of 96
15 percent. And that corresponds by way of that list of all
16 of those jobs to a loss of \$15,321.00 dollars per year.
17 There you go, and that is the first paragraph there. And
18 then I also do have some additional opinion I think we all
19 need to take into consideration. What I have in the
20 second paragraph of that page which is, for an individual
21 who is only using one arm, there is going to be some
22 increased wear and tear on that one arm. There is a
23 higher rate of bursitis and tinnitus tunnel, muscle
24 injury, all of this, these types of things to the
25 non-impaired arm because of what we call overuse. So that

1 is an issue that she is going to have to think about. And
2 as I already said before, she does have some difficulties
3 with self-esteem, self-image. That is going to create a
4 little bit of extra anxiety when applying for jobs and
5 working in the public. All of those may additionally
6 impact her ability to secure employment and keep
7 employment.

8 Q Thank you. Thank you very much.

9 MR. GRAHAM: Your Honor, we would offer her report
10 into evidence.

11 THE COURT: Any objection, Mr. Davis?

12 MR. DAVIS: No, sir.

13 THE COURT: Into evidence. Number 18.

14 (Whereupon, Plaintiff's Exhibit 18 was admitted into
15 evidence.)

16 THE COURT: Mr. Traylor?

17 CROSS-EXAMINATION

18 By Mr. Traylor:

19 Q Ms. Carruthers, just for the record, you are not a
20 medical doctor, correct?

21 A Correct.

22 Q So you are not offering any opinions about the
23 standard of care causation, correct?

24 A That's correct.

25 Q You don't have any criticisms of anything Dr. Miller

1 did?

2 A I have no knowledge about anything he did or did not
3 do. So I have no opinions.

4 Q Ms. Carruthers, how much do you charge per hour in a
5 case like this?

6 A I don't personally charge because I am a salaried
7 employee but my company does charge, I think on this case,
8 it was \$250.00 per hour.

9 Q And how many hours would you say you have put in this
10 case so far?

11 A I don't know, I don't keep track all together but
12 probably certainly in excess 40 to 50 hours all together.

13 Q Thank you, Ma'am, that will be all.

14 THE COURT: Any redirect?

15 MR. GRAHAM: No, Your Honor.

16 THE COURT: Thank you, Ma'am. Ms. Carruthers, you
17 can go ahead and disconnect. Counsel, can I see y'all
18 briefly.

19 (Whereupon, a bench conference was held in the
20 presence of the jury but out of the hearing of the
21 jury.)

22 THE COURT: Mr. Graham, you can call your next
23 witness, please.

24 MR. GRAHAM: We would call Dr. Oliver Wood.

25 DR. OLIVER WOOD, being

1 first duly sworn, testified as follows:

2 DIRECT EXAMINATION

3 By Mr. Graham:

4 Q Please state your name and address?

5 A Oliver G. Wood, Jr.; Columbia, South Carolina.

6 Q Thank you. Where are you from originally?

7 A I grew up in Greer, South Carolina.

8 Q How long did you live there?

9 A 18 years.

10 Q Tell us about your educational background, please?

11 A I have a Bachelor's of Science in Business from the
12 University of South Carolina. I have a Master's Degree in
13 Economics, University of South Carolina. And a PhD in
14 Economics from the University of Florida.

15 Q Please describe your professional background?

16 A I was hired by the University of South Carolina to
17 teach economics in banking and finance courses. Taught at
18 the University for 29 years. I now am a distinguished
19 Professor Emeritus, translated, that means I am retired
20 from teaching.

21 Q Did you serve in the military?

22 A Yes, I served on active duty in the United States
23 Navy from 1959 to 1961.

24 Q After then did you serve in the reserves?

25 A Yes, I served in the Naval reserve from 1961 to 1987

1 when I retired from the Navy.

2 Q What was your rank at retirement?

3 A Captain.

4 Q What practical experience have you had in the
5 business world?

6 A I have helped start nine banks, two savings and loan
7 associations; serve on the Board of Directors or Advisory
8 Board for Republic National Bank until we sold it; BB&T
9 until it was sold; I went to the Lexington State Bank and
10 then we sold that to BB&T; and I was on BB&T's Board for a
11 while and then Greer South's Advisory Board and Bank
12 Meridian's Board, I served on the Board of Directors of
13 Edisto Farm Credit in Orangeburg. We made farm loans in
14 the lower part of the State. And I also own a farm in
15 Tennessee which is a business.

16 Q What special experience have you had in the field of
17 investments?

18 A Graduate course on money and capital markets. For
19 about 27 years I taught bank management for 27 years. I
20 directed MBA field studies in the summer for 20 years. I
21 taught the South Carolina Banker's School for 25 years.
22 And let's see, I served on various investment committees
23 at the banks that I was involved with.

24 Q Have you written any books in the field of economics
25 or finance?

1 A Yes. I have authored or coauthored seven books or
2 monographs.

3 Q What experience have you had in estimating economic
4 losses in personal injury cases, wrongful death and
5 business loss cases?

6 A For approximately 53 years I have made studies of
7 cases where someone has been killed, injured; a business
8 has had a loss; or someone has been terminated from their
9 employment due to age, race or sexual discrimination and
10 reported on the results of those studies.

11 Q Have you instructed lawyers in the areas of economic
12 loss and what experience do you have with that type of
13 activity.

14 A The various Bar Associations have asked me to appear
15 at their seminars about 25 times since 1972; aspects of
16 damages and economics. From 1970 to 2004 I was a guest
17 lecture in the damages course at the University of South
18 Carolina Law School. 2004 the Professor in charge of
19 damages, retired and went down to Charleston to open the
20 new Charleston School of Law. Since then I have been
21 involved with them as a guest lecturer and several years
22 ago they made me their economist in residence.

23 Q In terms of the methodology that you use, evaluate
24 economic loss, is that methodology accepted among
25 economist?

1 A Yes.

2 MR. GRAHAM: Your Honor, we submit Dr. Wood as an
3 economic expert in the evaluation of economic loss and
4 personal injury cases.

5 THE COURT: Any objection, Mr. Davis?

6 MR. DAVIS: No, sir.

7 THE COURT: The witness is so qualified.

8 Q Dr. Wood, were you hired by my firm to make a study
9 of the economic loss in this case?

10 A Yes.

11 Q What facts did you consider in that regard?

12 A In the case of Alexia Lumpkin, she was born on April
13 the 5th of 2007. The assumed date of injury was April 5th
14 of 2007. Her life expectancy was an additional 80.84
15 years which would be to the year of 2088.10. And that
16 data comes from South Carolina Code Section, 19-1-150
17 which is the mortality tables in the statutes that we are
18 suppose to use in determining life expectancy in cases
19 such as this. 19-1-150 is assumed that before Alexia was
20 injured she had no reason to expect less than a normal
21 life expectancy. Ms. Darlene Carruthers was the lifecare
22 planner and she evaluated Alexia's before injury and after
23 injury earning capacity. The loss and earning capacity is
24 evaluated from this child's age 21 to her age 67. Right
25 now the normal social security retirement age for a person

1 is 67. It is crept up from 65. I assume that at age 21
2 she could have started earning \$10.00 dollars an hour.
3 Minimum wage is \$7.25 an hour but we all know it is out of
4 date. And beginning hourly wages for people in the market
5 place are \$10, \$12, up to \$15 dollars an hour. We all see
6 that on signs. I assume her's would be \$10.00 dollars an
7 hour. According to Ms. Carruthers, her before injury
8 earning capacity, \$61,053 and we assumed after ten years
9 of work. According to Ms. Carruthers her after injury
10 earning capacity is \$45,732.00. Again, we assume after
11 ten years of work starting at \$10.00 dollars an hour. Ms.
12 Carruthers prepared also a lifecare plan for Alexia which
13 I have taken into account.

14 Q Based on those facts, have you formed an opinion to a
15 reasonable degree of economic certainty as to the future
16 economic loss to Alexia?

17 A Yes.

18 Q Have you prepared any charts to illustrate these?

19 A Yes.

20 Q Would you, do you have those charts with you?

21 A Yes.

22 Q Would you kindly step down and explain those to the
23 jury? And I will sit down and get out of your way.

24 A I have projected that to age 67. I assume that over
25 her lifetime she, her income would increase at three

1 percent a year. That is what the wages in America has
2 increased that from 1992 through 2020. At three percent a
3 year we know inflation and consumer pricing the, has been
4 2.25. So that means wages have increased at .75 above the
5 inflation rate. That is a measure of productivity, if you
6 will. Now my job as the economist is to reduce all future
7 sums to what is known as the present cash value. All
8 courts in America require that, we have to look at money
9 flows now, those money flows are going to occur in the
10 future, they have to be discounted. So I discounted her
11 earning capacity every year at the rate of five percent
12 compounded annually. So that at the present earning
13 capacity, the present value is, (\$1,393), one million,
14 three ninety three, through 64. That is the discounted
15 amount. Now I have done the same thing to her mitigating
16 earning capacity which is \$45,000.00, again not reaching
17 that until ten years after she enters the labor force. I
18 will use this number later in a chart. This case has a
19 lifecare plan prepared by Ms. Carruthers. Therefore we
20 have to look at medical inflation. I have taken the
21 consumer price index for medical care items, going back to
22 1960. In 1960 that index was 22.3. In order to give it
23 some realism I set that equal to \$100.00 dollars to tract
24 medical inflation for the last 60 years. What cost
25 \$100.00 dollars in 1960, by the year of 2000 cost

1 \$1,169.00 dollars and by the year of 2020 cost \$2,327.00.
2 You don't need to be a professional economist to know that
3 we have had medical inflation, we live with it. The rate
4 of this medical inflation is 5.39 percent compounded for
5 60 years, 5.39. It has been relentless, as you can see.
6 The Federal Agency that collects this data is the Bureaus
7 of Labor Statistics. Within that medical index there are
8 some subsections that we are interested in for this
9 lifecare plan. By way of reference, the general CPI is
10 2.21. We can live with that. The medical CPI, 3.65,
11 higher than the general CPI. Within the medical CPI,
12 professional services, meaning doctors, 2.89 percent per
13 year. Then the services provided by doctors, 2.77. I
14 like to say doctors are good economists, they mark up
15 their services in line with their fees, almost equal.
16 Medical care commodities, that is the stuff you see in
17 drug stores, 2.57; services by other medical
18 professionals, 2.20; and then prescription medications,
19 3.29. Slightly under the general CPI. What is pulling
20 this guy up right here are hospital charges. They are
21 higher than even the medication. We are going to use
22 these rates right here to project the elements in that
23 lifecare plan. Ms. Carruthers, I think testified as to
24 what is needed in a lifecare plan. A lifecare plan is
25 really just a game plan for the future medical needs of a

1 person. And a lifecare plan has four dimensions. Number
2 one, the element. The number two, how often do you need
3 it, the frequency. Number three, the cost; and then four,
4 the duration. I have taken her lifecare plan and reduced
5 it to a couple of three sheets. I am not going over this
6 line by line again because you have already heard it.
7 Just look at it in terms of groups. Medical evaluations,
8 she has got the frequency, the cost and the duration. A
9 lot of these are from age 21 to life. Some of them are
10 from now, 2022 to life. Diagnostic test, therapeutic
11 evaluations, you can see how often you need them, current
12 cost. That is all under therapeutic evaluations.
13 Surgical procedures. The most expensive items in this
14 lifecare plan are these procedures. One, here is a
15 shoulder surgery, \$156,000.00 dollars. Here is another
16 one which is elbow surgery, \$93,000.00. And then down the
17 list is another one, I don't see it right now. Anyway, it
18 is in there. All of these are surgical procedures. This
19 category is education, training and equipment. Here are
20 the items, here is support care. This is help she will
21 need throughout her life to function. Ancillary services.
22 It is, had got a zero, I didn't evaluate it. Home
23 modifications, these are one timers. Equipment, a whole
24 bunch of equipment here and didn't cost very much. It is
25 the stuff that will make her life easier. Orthopedic

1 equipment. Again, not very expensive but needed.
2 Transportation. Emergency assistance and so forth. I
3 didn't evaluate that, if needed. If you function out
4 there in the world, you got to buy it anyway. So I just
5 said, I waived it off. Leisure and recreation equipment.
6 Several there. That is Ms. Carruthers' plan reduced to
7 four sheets. Here is what I do as an economist. I take
8 all of those numbers and the duration, how long you need
9 it, and I project that for the period needed. If it is
10 now, it is not a projected, I just accept that number.
11 Again, I am not going to go over each one of these with
12 you because you can read. Medical evaluations,
13 \$10,646.00. Now this is the present value of these things
14 over her lifetime reduced to present value. This number
15 plus interest will produce the money to pay for the item
16 in this lifecare plan. All we are concerned about is the
17 present value. Diagnostic test, \$13,000.00; therapeutic
18 evaluations, \$94,000.00; and then surgical procedures, as
19 I told you, the most expensive one is this surgery right
20 here, \$156,000.00. And then the elbow surgery and then
21 the deconstructive, the elbow surgery and then the
22 hand/wrist surgery, \$84,000.00. So there are three
23 surgical procedures. The \$156, the \$88 and the \$84. Those
24 are the most expensive items in this plan right there.
25 Okay. Total of all of those surgical procedures is \$361.

1 Education and training, \$12,000.00; support care, \$381.
2 She will need assistance throughout her life in
3 functioning. Ancillary services, I have got a zero on
4 that. Home modifications, \$3,139.00 dollars. Equipment,
5 \$5,806. Orthopedic equipment, \$5,969. And then all of
6 the transportation stuff, I didn't evaluate it. So there
7 is nothing in this plan for that. When we add all of this
8 stuff up, what do we get, \$948,716.00. This is the
9 present value of the future medical needs. This sum plus
10 interest will produce all of the dollars needed in that
11 lifecare plan. Now, let me show you how you can use this
12 lifecare plan if you want to make any changes. Well, here
13 is a for instance. Let's suppose that this item right
14 here, you say, I don't think she needs it. You take that
15 number right there, \$14,901 and subtract it from that and
16 that adjusts, if you don't like that item. On the other
17 hand, you can do the reverse. Let's suppose you say, I
18 think she needs twice as much as in the lifecare plan.
19 You can take that \$14,000 and add it to that right there.
20 And adjust the plan to fit your assessment of the needs.
21 You can go back to any item in here because they are all
22 in present value terms. Pull the number out and subtract
23 it or add it. Okay. Confucius said the longest journey
24 begins with the first step, is the last step, the last
25 chart. Her present earning capacity. Present value is

1 \$1,393,064.00. However, she can do something, according
2 to Ms. Carruthers, she can earn a rate of \$45,000.00 after
3 10 years, which is like \$20.00 dollars an hour. The
4 present value of her offset or mitigating earning capacity
5 is \$1,073.636.00. You subtract what she can do from what
6 she could have done and that forces out the present value
7 of the loss and earning capacity. Before, minus after
8 equals that loss. Okay. Present value of the medical
9 plan we just looked at, \$948,716.00, makes the total,
10 economic loss, \$1,268,144.00. That is my estimate of the
11 economic loss to Alexia. Okay. That is it.

12 Q Dr. Wood, I have just a few follow-up questions. Do
13 your figures include anything for pain and suffering?

14 A No. That is a non-economic loss and I don't value or
15 measure non-economic sums.

16 Q That is just not the job of an economist?

17 A No, I am a numbers person.

18 Q Do your numbers include anything for loss of
19 enjoyment of life?

20 A Same answer. That is a non-economic damage or a loss
21 and I don't evaluate that.

22 Q Thank you. Now, we have got these big flip charts.
23 Did you happen to bring with you any 8x10 copies that
24 would be suitable for introduction as an exhibit?

25 MR. GRAHAM: Your Honor, at this time we would

1 introduce these charts as our next exhibit?

2 THE COURT: Any objection, Mr. Davis?

3 MR. DAVIS: No, sir.

4 THE COURT: All right. Plaintiff's exhibit 19.

5 (Whereupon, Plaintiff's Exhibit 19 was admitted into
6 evidence.)

7 Q Dr. Woods, please answer any questions that the
8 Defense may have.

9 THE COURT: Mr. Davis.

10 CROSS-EXAMINATION

11 By Mr. Davis:

12 Q Dr. Wood, it is good to see you again.

13 A Good to see you, Mr. Davis.

14 Q I just want to start with this. You mentioned you,
15 you were active duty Navy?

16 A I was.

17 Q And then you stayed in the reserve?

18 A I did.

19 Q And you retired as a Captain?

20 A I did.

21 Q Well, now a Captain in the Navy is an 06, not like a
22 Captain in the Army who is an 03?

23 A You are right.

24 Q Because my brother was in the Navy for a while and he
25 was a Lieutenant 03 and I was a Captain 03 and I happened

1 to call him one day and said, this is Captain Davis, can I
2 speak to Lieutenant Davis. And he said, fell all over and
3 said, Eye, Eye, sir. I love that he thought I was an 06.

4 A He was pulling rank on you.

5 Q He tried. Congratulations on your retirement, both
6 in the Navy and to your service to our Country.

7 A Thank you.

8 Q And your Americanus Status?

9 A Thank you.

10 Q Well deserved. Doctor, I know you don't work for
11 free. Just tell the jury what your fees are in this case
12 for doing the work that you have done, sir.

13 A I think the total fee for all the work from the
14 beginning was \$7,200.00 dollars.

15 Q And does that include your time today and testifying
16 for the Court?

17 A No. My hourly rate is \$425.00 and that's for today.

18 Q All right, sir. I want to be sure that I understand
19 what you do and what you told the jury. You take the
20 lifecare plan from Ms. Carruthers and you don't
21 cross-examine the need, you don't cross-examine as an
22 economist whether it is really indicating or not. You
23 take your report, all due respect to you and to her, and
24 you take those numbers and then you go through the
25 calculations that you explained?

1 A Correct.

2 Q And the same with surgeries?

3 A Right. Sometimes I get a little aggressive, like I
4 threw out a computer. I took that on myself because
5 today's world you have to have a computer, you have to
6 have one anyway. So out.

7 Q Okay.

8 A And I think the transportation, I did an out. So I
9 marked that out.

10 Q All right, sir. So you are not, in all fairness, Dr.
11 Wood, you are not making any comment by your report or the
12 work that you have done in this case on the validity of
13 the lifecare plan or the need for the surgery or medical
14 things. Is that fair to say?

15 A Exactly. I am four years short of finishing medical
16 school.

17 Q Now, you are a PhD, we call you, Doctor, rightly so?

18 A Yes.

19 Q Your earned PhD and economics?

20 A Correct.

21 Q In all fairness, you are not a medical doctor, you
22 are not here to offer any opinions on the standard of
23 care, my client, Dr. Miller; whether you think or whether
24 he did anything wrong to cause any of the injuries?

25 A Absolutely, three years short of finishing law

1 school.

2 Q Sir?

3 A Three years short of finishing law school.

4 Q Doctor, it is great to see you again.

5 A Good to see you.

6 THE COURT: Any redirect, Mr. Graham?

7 MR. GRAHAM: Only, Your Honor, just to introduce --
8 (inaudible).

9 MR. DAVIS: No objection, Your Honor.

10 THE COURT: In evidence, without objection, that is
11 Plaintiff's 20.

12 (Whereupon, Plaintiff's Exhibit 20 was admitted into
13 evidence.)

14 MR. GRAHAM: Let me ask one question.

15 REDIRECT EXAMINATION

16 By Mr. Graham:

17 Q Doctor, I know this on your report is titled revised
18 preliminary appraisal of Alexia Lumpkin.

19 A Correct.

20 Q Did you have to do this before this trial,
21 (inaudible)?

22 A Yes, yes. And you try to have it as up to date as
23 you can on the day of the trial. And that is what we do.

24 Q Thank you.

25 A Thank you.

1 THE COURT: Anything else, Mr. Davis?

2 MR. DAVIS: No, Your Honor.

3 THE COURT: Thank you, Dr. Wood, you are excused.

4 Counsel, this seems to be a pretty good time to take a
5 break. Is there a reason to push forward, for scheduling
6 purposes.

7 MR. GRAHAM: I agree with taking a break, Your Honor.

8 THE COURT: Mr. Davis, is that good from your
9 perspective.

10 MR. DAVIS: Yes, sir.

11 THE COURT: Ladies and gentlemen, thank you for your
12 attention this morning. I really appreciate it. It is
13 ten after 12:00, I am going to ask you to be back here at
14 1:30. Please remember the rules I have given you and have
15 a great lunch.

16 (Whereupon, the jury was excused from open court for
17 a lunch break.)

18 THE COURT: We will see you back at 1:30.

19 (Whereupon, a lunch break was taken.)

20 MR. GRAHAM: Done with Webex witnesses.

21 THE COURT: All right. Anything before we get
22 started?

23 MR. GRAHAM: No, Your Honor.

24 THE COURT: From the Defense?

25 MR. DAVIS: No, Your Honor.

1 THE COURT: Let's bring them in.

2 (Whereupon, the jury came into open court at
3 approximately 1:42 pm.)

4 THE COURT: Mr. Jordan, call your next witness.

5 MR. JORDAN: Thank you, Your Honor. The Plaintiff
6 calls George Lumpkin.

7 George Lumpkin, being
8 first duly sworn, testified as follows:

9 DIRECT EXAMINATION

10 By Mr. Jordan:

11 Q Good afternoon, Mr. Lumpkin?

12 A Good afternoon.

13 MR. JORDAN: Your Honor, can he take his mask off
14 while he testifies?

15 THE COURT: Yes, sir. So everyone can hear you, if
16 you don't mind just pull your mask down.

17 Q State your full name for me, please.

18 A George R. Lumpkin.

19 Q And, Mr. Lumpkin, where do you live?

20 A 870 Finley Road, Rock Hill.

21 Q And how long have you lived there?

22 A About 40, 48, 49 years.

23 Q Okay. And what relationship are you to Alexia?

24 A That is my granddaughter.

25 Q So you are Antwan's father?

1 A That's correct.

2 Q And where are you employed?

3 A T&T Hauling.

4 Q What do you do for them?

5 A Truck driver.

6 Q And how long have you worked for them?

7 A About 11 years.

8 Q Is that long haul, regional?

9 A Short.

10 Q Short. And how long have you been a truck driver?

11 A I don't know, about 35 years.

12 Q A long time?

13 A Long time.

14 Q And you are not married currently, you are a widower,
15 is that right?

16 A Right.

17 Q And your wife, Alexia's grandmother, passed away not
18 too long ago, is that right?

19 A That's right.

20 Q And she was pretty close to Alexia, is that right?

21 A Yes, she was.

22 Q I believe she was actually present when Alexia was
23 born, wasn't she?

24 A That's right.

25 Q Now, you were not actually at the hospital when she

1 was born, were you?

2 A No, I was at home.

3 Q Okay. And, Mr. Lumpkin, are you a member of any
4 church organizations here in York County?

5 A Excuse me?

6 Q Are you a member of any church or other
7 organizations?

8 A Nazareth Baptist Church, Rock Hill.

9 Q And you hold in any positions in that church?

10 A I am a Deacon.

11 Q Now, you were not present at the hospital but do you
12 remember the first time you saw Alexia?

13 A Yes, I do.

14 Q Tell the jury about that.

15 A Are you sure you want me to tell them.

16 Q Yes sir, I do.

17 THE COURT: Yes sir, please.

18 A Daman, she looked good. That is what I said. Just
19 like that.

20 Q Pretty baby.

21 A Pretty baby. To myself, not really out loud.

22 Q And you spent a lot of time with Alexia, correct,
23 when she was --

24 A Coming up, yes.

25 Q And Antwan and Angela work a good bit and Alexia,

1 your wife kept her sometimes, you and your wife?

2 A Yes.

3 Q And Shemica would keep her some too, right?

4 A Yes.

5 Q But your wife, you and your wife would help out?

6 A Yes.

7 Q Let's talk a little bit about Alexia when she was
8 young. Tell me what problems she had with not being able
9 to use her left arm. Tell me a little bit about that.

10 A First of all, I don't call her Alexia, I call her
11 Boo.

12 Q Or Boo.

13 A Boo, when she was coming up, you know, she was real
14 small. And she would always want to move her arm but she
15 really couldn't. So as she grew older than all of a
16 sudden you could see her try even more. And me and my
17 wife, we would always encourage her and we would tell her,
18 put your arm on the table. She would put her arm out. I
19 would say, can you move your fingers. And she would do
20 like that. And I would say, is that all you can do. She
21 said, yes sir. Put it down. And I would say, can you
22 raise your arm like this. And would say, is that the best
23 you can do, Boo. Yes, sir. That was it. I never would
24 mess with her that much but every once in a while, I would
25 try to encourage her to use it.

1 Q What about doing something as simple as tieing her
2 shoes. Do you remember working with her on that?

3 A Yes, I do.

4 Q Tell the jury about that.

5 A Me and my wife, we would encourage her to try to do
6 it. She would get frustrated and start crying but we
7 would keep on after her. And then she got to the place
8 where she could make the bow and when she made it, I mean
9 she thought that was something. And we had to make out,
10 you know, oh, that is real good, that is good. We had to
11 do that to encourage her to keep doing it because that is
12 the only way because we knew, we wasn't going to be there
13 with her all the time. So we kept on doing it and she
14 learned how to do it but it never was tight.

15 Q When Alexia was young would you take her out in the
16 stroller, take her with you places?

17 A Yes, I did. Me and wife. We went to the Mall in
18 Spartanburg.

19 Q Tell me about that?

20 A We went to the Mall in Spartanburg and I was pushing
21 the stroller and she would sit there with her arm folded
22 like this. And like I say, she couldn't move it. And
23 people would ride by and they would look at her and she
24 would look at them. Like I say, she was small and she had
25 a way of looking at you, she would stare at you, you could

1 make a face, sometimes she wouldn't make one. She would
2 just look at you like you are crazy. So I would push her
3 in the stroller and these people would walk by and they
4 saw her and it was like, man, she is a pretty baby. And I
5 would say, thank you.

6 Q Would you, when she was young and taking a bottle,
7 and learning, trying to hold the bottle. She would
8 struggle with that one hand?

9 A She did.

10 Q What did y'all have to do?

11 A We would have to prop either a pillow or towels under
12 her. And if she was sitting up we would have to hold it
13 for her. The best way to do it, when she lay down, she
14 could lay on her side and you lay the bottle down and she
15 would get it that way. But as she got older, she was able
16 to hold it with her good hand.

17 Q And when she was learning to crawl and learning to
18 walk, did she have any issues with falling?

19 A Yes. She never really crawled that much because we
20 was always try to be there for her. She didn't, and we
21 would always hold her up trying to get her to take that
22 step. And she was always scared. And her Grandma stayed
23 on her all the time about trying to walk, because her
24 Grandma was very protective of her too. So we just walk
25 her along a little bit at a time. She was scared but she

1 tried.

2 Q Is it fair to say that Alexia has always tried to do
3 things?

4 A Always.

5 Q She has tried not to let that hold her back?

6 A Right. She didn't really start, sort of a drawback
7 until she got older, when she realized, you know, I am not
8 going to be able to use my arm. Then all of a sudden you
9 could see a change in her.

10 Q How did that affect her?

11 A Well, she just wouldn't do things, you know, like
12 other kids be out playing and stuff or walking around.
13 Not her, she would sit there and watch you or go to the
14 Mall or something like that. But she never was outgoing a
15 whole lot.

16 Q And you still spend a lot of time with her?

17 A I do, not as much as I used to since my wife passed.
18 She stay with her mom and dad more now. But I still see
19 her a lot.

20 Q And is it fair to say she has got you wrapped her,
21 your little finger?

22 A Yes, sir.

23 Q Tell me about, when your wife was still living and
24 she would be over there. Would you order pizza sometimes,
25 tell me about that?

1 A She, my wife done cooked. And as a mother you know,
2 if you cook you expect for everybody to eat. Well, that
3 girl, she called Yang. She didn't call me granddaddy, she
4 called me Yang. And she would come in the bedroom and she
5 would say, I don't want that, I want pizza. And her
6 Grandma would hear her. You are not getting pizza, we are
7 eating what I cook. So, she would come in, you want to
8 get a pizza. I said, yes, we will get a pizza. And my
9 nickname was Jim. So my wife would say, Jim, now you know
10 that ain't right. I done cooked and you are ordering
11 pizza. Well, the only thing that saved me is that I am
12 grown. That is the only thing that saved me. Baby girl,
13 she got me in a lot of trouble sometimes, she did.

14 Q Did she ever learn to ride a bike. She has been
15 given several bikes, hasn't she?

16 A One of them is in the storage building now at home.
17 It is, my wife bought it, it is an eletric bike. But if
18 you look at it, it is small like for a four-year old or
19 five-year-old. Believe you me, a grown person can ride
20 this bike. I know, I got on it in the house. And she
21 never got a chance to ride it. She never would, because,
22 I wonder, why did you get this for her, she can't use it
23 because of her arm. Maybe you know something I don't
24 know. But I never see her get on it.

25 Q And when Alexia started school would your wife take

1 her to school sometimes?

2 A Every day.

3 Q And is that because she didn't want to ride the bus?

4 A No, my wife, I don't know, my wife just started doing
5 it on her own. I don't know, and it never stopped.

6 Q Did she use her left arm much now at all?

7 A No.

8 Q How does that affect her now?

9 A She just doesn't use it, she just don't, she don't
10 even try. As a matter of fact, she was over to the house
11 two days ago and she come to pick up some mail for my son.
12 And I said, give me hug. She had her hand in her pocket,
13 she had a hand in her pocket like that, that jacket thing
14 you wear that you put on your head. She had that on. And
15 I said, give me a hug, Boo. And she went to hug me with
16 the good arm and I reached, pulled that arm out, give me a
17 hug, girl. And she hugged me, tried to hug me like that.
18 You could feel and I was holding her arm so she hugged me
19 like that and that was it. She just grinned, she thinks
20 the world of that kind of stuff, when you encourage her.

21 Q And are there certain things, you said she doesn't
22 use it now. Are there things that she can't do that she
23 has tried to do. What about sports or cheerleading?

24 A No, no sports, no sports. I have never seen her
25 bounce a ball, nothing like that.

1 Q And I think, she did try, or you may not know, did
2 she try out for sports at school?

3 A My son told me she was trying out for sports but that
4 is the last I heard of that.

5 Q You like to cut up with her a good bit. Is that
6 right?

7 A Yes.

8 Q And how do you do that with her?

9 A Baby girl is a soft spoken person. You don't just
10 yell at her. I know you are saying, that is your
11 granddaughter, that is why you are talking, but it is
12 true, it doesn't work that way with her. So when you talk
13 to her, if you can't understand what she is saying, speak
14 up. So and then she don't do it, you have got to be
15 creative and do something crazy, make her laugh or
16 something. Then she kind of like open up to you then.
17 And then you can tell, she is a different person.

18 Q Does she get frustrated because she can't use that
19 arm?

20 A Yes. She do. I seen her, like I say, she try to do
21 it and she just do that. I can't do it, I can't do it.
22 So you just leave her alone.

23 Q Thank you, sir. Please answer any questions for
24 other Counsel.

25 A Okay.

1 THE COURT: Mr. Traylor.

2 MR. TRAYLOR: No questions, Your Honor.

3 THE COURT: Okay. Any objection to excusing this
4 witness?

5 MR. JORDAN: No, Your Honor.

6 THE COURT: Thank you, sir, you can step down. Call
7 your next witness, Mr. Jordan.

8 MR. JORDAN: Yes, Your Honor, we would call Antwan
9 Lumpkin.

10 DIRECT EXAMINATION

11 By Mr. Jordan:

12 Q Antwan, if you would, remove your mask, I want to
13 make sure the jurors can hear you. Okay. Good afternoon?

14 A Good afternoon.

15 Q Will you please state your full name?

16 A Jimmy Antwan Lumpkin.

17 Q And you go by Antwan?

18 A Yes, I go by Antwan, most people call me Twan.

19 Q Twan?

20 A Yes.

21 Q Where do you live?

22 A I live in Rock Hill, South Carolina, down on 460
23 Redwood, it is out in the country.

24 Q And who do you live there with?

25 A I live there with Angela, Alexia's mama, and Alexia

1 and my other daughter, Arie (ph).

2 Q And Alexia is how old now?

3 A She is 14, she will be 15 April 5th of this year.

4 Q And how old is your other daughter?

5 A She is eight years old.

6 Q And was Alexia your first child?

7 A Yes, she was. She was my first born.

8 Q And Alexia and your other daughter, where do they go
9 to school?

10 A Alexia goes to Rocky High; my youngest, Arie goes to
11 Belview.

12 Q And what grade are they in?

13 A Alexia is a freshman at Rocky High and my baby is in
14 the fourth grade.

15 Q Where are you employed?

16 A Currently I am employed at Stevenson Weir and
17 Company, it is a concrete company, ready mix.

18 Q What do you do for them?

19 A I am a truck driver.

20 Q And before working, you said Stevenson Weir?

21 A Yes.

22 Q Before working Stevenson Weir, where were you
23 working?

24 A Previously I worked at 7 Star Construction for about
25 eight years; Bell for about three years; and TNT Hauling

1 for about 13 years.

2 Q And were you a truck driver at those places as well?

3 A Yes, I have been a truck driver for over 21 years.

4 Q And where did you go to school?

5 A Right down the road at the good ole Northwestern
6 High, best school in York County.

7 Q What year did you finish?

8 A I graduated in '95.

9 Q And did you start college at all?

10 A Yes, I did make one semester at Claftin University
11 down in Orangeburg, South Carolina.

12 Q You decided to continue driving trucks?

13 A Yes, I decided to fall in my dad's and my uncle's
14 footsteps. They are both truck drivers so I decided to
15 pick up the family tradition and just start driving
16 trucks. I always been around trucks, grew up on a farm,
17 always around tractors and big stuff. I was always
18 fascinated with stuff like that so I just, kind of took
19 that up.

20 Q Where do you go to church?

21 A Nazareth Baptist Church.

22 Q And Angela and the girls go with you there?

23 A Yes, sir.

24 Q Antwan, did you go to any of the appointments with
25 Angela, the prenatal visits?

1 A No, I did not.

2 Q Were you aware of any issues with Alexia's pregnancy?

3 A No issues but prior to Angela delivering Alexia, I
4 was made aware on her last doctor's visit that Alexia was
5 going to be a big baby. So they were thinking about
6 inducing her.

7 Q You found out she was going to be induced?

8 A Yes.

9 Q And did you go with her when she was induced?

10 A Yes, I did.

11 Q I think she went, it was on the evening of April 4th,
12 maybe?

13 A Yes, sir.

14 Q When did they induce her, do you remember?

15 A I think it was the following morning.

16 Q Okay. And who was present the following morning or
17 who came the following morning?

18 A Well, it was me and Angela, my mother and my sister,
19 both of my sister-n-laws and a close friend of Angela's.

20 Q And I think Shemica?

21 A Yes, Shemica and Latoya.

22 Q Latoya, Tamara?

23 A Tamara.

24 Q And your mother?

25 A My mother.

1 Q Was that in one of the birthing suites there at
2 Piedmont?

3 A Yes, it was.

4 Q And did you stay with her pretty much the whole time?

5 A Yes, I was there the whole time.

6 Q You would walk out of the birthing suite?

7 A Yes occasionally I would go out and get a snack but,
8 yes, I never left, I stayed the whole time.

9 Q Okay. Do you remember at some point Dr. Miller
10 coming into the birthing suite?

11 A Yes, I remember him coming in.

12 Q Describe your impression of Dr. Miller when he first
13 came into the birthing suite?

14 A Well, I mean, never experiencing a child being born
15 before, I did take the time like to watch it on TV, see
16 what it was like. And I didn't quite get the professional
17 attitude that I saw on TV, from Dr. Miller. He seemed a
18 little uptight, you know, a little anxious maybe. I knew
19 it had been a long day for him. He was more ready to just
20 get the birth over and I guess I was, and we were too.

21 Q Did Dr. Miller, did he appear to be tired?

22 A No, not really.

23 Q Tell me, do you remember any interaction between Dr.
24 Miller and Angela in that labor and delivery room, the
25 birthing suite?

1 A Well, beginning into labor, yes. Trying to get her
2 to push as well as I was.

3 Q So you all were trying to get her to push?

4 A Yes.

5 Q What specifically did Dr. Miller say?

6 A Well, you know, he was like, push, Angela, push, you
7 know. Push, mom, you are not pushing, you got to push
8 harder than that. And at some point, you know, it was
9 said, you know, mom, you got to push. You don't push any
10 harder I am going to have to cut you, I am just going to
11 have to cut you if you don't, if you can't have this baby
12 I am going to have to cut you.

13 Q And did you think he was talking about a C-section?

14 A Yes, I knew what he was talking about.

15 Q Was that his tone?

16 A Yes, his tone, it wasn't one that I was expecting,
17 no.

18 Q And at some point did Dr. Miller make the decision to
19 go to the operating or send her to the operating room for
20 a C-section?

21 A Yes, after trying, I think, one more time to get her
22 to have her naturally and it just wasn't happening. He
23 just decided, I am just going to cut you. And so, you
24 know, Angela was like, well, I will just go ahead on and
25 sign the papers and y'all can take me back and cut me.

1 And I was, me, I was just standing there helpless looking.
2 I am like, oh well, you know, they are going to cut her.
3 And so they came and just wheeled her off in the bed that
4 she was in.

5 Q When that decision was made, tell me how Dr. Miller
6 said, I am going to cut you. What did he say?

7 A His exact words were, if you can't have this baby I
8 am just going to have to cut you, I am going to cut you.

9 Q And then he asked her to sign some papers?

10 A Yes, she signed the paper work and they wheeled her
11 off.

12 Q And initially were you allowed to go back in the
13 operating room?

14 A No, I wasn't.

15 Q After a period of time were you allowed to go back in
16 the operating room?

17 A Yes, I was.

18 Q About how long?

19 A I say about 20, 25 minutes.

20 Q And so, did someone bring you back, a nurse, or
21 someone bring you back?

22 A Yes, I was actually getting ready to go out to the
23 lounge and grab me a snack and one of the nurses came
24 through and it was like, Mr. Lumpkin, we are going to let
25 you come on back. And so they gave me a little, you know,

1 the little thing they let you put on when they send you
2 back. And I went on back with her.

3 Q Describe what you had to put on?

4 A Like the little operating gown that they put on you
5 when you are going to surgery and a little mask and then
6 she took me on to the back.

7 Q And so you went back to the operating room, is that
8 right?

9 A Yes.

10 Q Antwan, if you would, I would like you to step down
11 here, I would kind of like to set the scene and you show
12 me where people were in that operating room, if you could.
13 And do you mind if I use this little table as a reference
14 or a bed.

15 THE COURT: Mr Lumpkin, if you don't mind, just grab
16 one of the microphones, if you are not at the witness
17 stand, it is important that we still be able to hear you.

18 Q Can we use this as a reference for a bed?

19 A Yes.

20 Q And let's, so this end is Angela's head?

21 A Yes.

22 Q Okay. Where is the door, that is Angela's head,
23 where would be the door where you came in?

24 A The door would be to my right.

25 Q You came in the door, is that right?

1 A That's right.

2 Q Tell me what you see?

3 A I see Dr. Miller; I see Angela on the bed.

4 Q Tell me where Dr. Miller is?

5 A Dr. Miller is at the foot of the bed. Angela is
6 laying on the bed, head, feet that way.

7 Q Are her legs up and back?

8 A Yes, they are in a upward position. A nurse on that
9 side.

10 Q A nurse on this side?

11 A A little table that they use to use the surgical
12 equipment on this side.

13 Q Table here, just to the left of Dr. Miller?

14 A Yes, sir.

15 Q And is there anyone on that side?

16 A Yes. There actually was another nurse over here and
17 me.

18 Q And tell me what the room looks like?

19 A Not as big as the first room we were in. It is
20 lightly dim and like, smell of, you know how hospitals
21 smells, had a hospital smell to it. That was pretty much
22 it.

23 Q Was there any lights in the room?

24 A Yes, actually there was one light kind of over
25 Angela. But over all the room was lightly dim.

1 Q And when you come in, I want you to describe for me
2 what you observed Dr. Miller doing?

3 A Okay.

4 Q When you first came in. Well, first of all, let me
5 ask you, before that; did you have any interaction with
6 Angela?

7 A Yes. I sure did. Because when I came in I was
8 surprised to see her in a position with her legs up to get
9 ready to give birth.

10 Q You thought she was going to have a C-section?

11 A Yes. When they took her out of the room, that is
12 what they said that she was going to get a C-section. So
13 when I came in I asked her, you know, I leaned over and
14 asked her, why haven't you had a C-section. And she was
15 like, they decided to go ahead and give, let me have it
16 naturally. Dr. Miller said the baby's heart rate was
17 normal now. So I was like, okay. And I just kind of
18 stood back and watched to see what was going to happen.

19 Q And as you were watching to see what was going to
20 happen, tell me what you observed?

21 A Okay. I observed Dr. Miller, he --

22 Q Dr. Miller is here?

23 A He is between Angela's leg. They start trying to get
24 her to push again. And he is telling her to push, I am
25 trying to encourage her to push but she still having

1 trouble. Dr. Miller has his hands, you know, inside of
2 Angela trying to deliver the baby.

3 Q Did, at the time his hands were inside, do you know
4 whether he turned the baby then or not?

5 A No, I do not.

6 Q And he is encouraging her to push, tell me what else.

7 A After a few minutes of encouraging her to push, she
8 still was having trouble. So at that point one of the
9 nurses got up on her and started to push down on her
10 stomach.

11 Q Which nurse, from which side?

12 A The nurse from this side.

13 Q The nurse over here?

14 A Yes.

15 Q Got up and is --

16 A Pushing on Angela's stomach.

17 Q Pushing?

18 A Yes. And as well as Dr. Miller still trying to give
19 birth, deliver it through the vagina.

20 Q Now, at some point did you see Alexia's head?

21 A Yes, I did.

22 Q And tell me what you observed?

23 A Well, I observed like, part of one shoulder and the
24 baby's head, Alexia's head. And, you know, at that point
25 Dr. Miller had her by the head and was actually pulling on

1 her head trying to get her to come out.

2 Q I want you to reverse rolls here, I want you to be
3 Dr. Miller and demonstrate to the jury what was happening.

4 A Okay.

5 Q I am going to stand over her and I am going to be
6 you. I am in your position. Is this where you were
7 standing?

8 A I was more like to the side here.

9 Q To the side back here. Go ahead.

10 A So Dr. Miller is here, Angela's legs are up, in up
11 position. Dr. Miller is down here and he is pulling on
12 Alexia's head trying to get her to come out. It was
13 evident to me that she was stuck.

14 Q Let's reverse rolls now. I am going to be Dr.
15 Miller. I am right here and I am pulling. And then what?

16 A I am a nervous wreck not knowing what is going on and
17 after, I see a few seconds of him, you know, kind of
18 pulling on her head. I asked him, I was like hey, don't
19 you think you are pulling on my baby's head a little too
20 hard.

21 Q Now, I want you to reverse roles, I want you to be
22 Dr. Miller again. I am going to be Antwan.

23 Hey, don't you think you are pulling on my baby's head a
24 little too hard.

25 A And his response was --

1 Q Well, you are Dr. Miller.

2 A Okay. Yes, I am pulling on the head. My response
3 is, I only have a certain amount of time to deliver this
4 baby or it is going to be retarded or brain dead.

5 Q Let's reverse roles. I am Dr. Miller now, you are
6 Antwan. Tell me what you said to Dr. Miller?

7 A Hey man, don't you think you are pulling on my baby's
8 head a little too hard.

9 Q I have only got a certain amount of time to deliver
10 this baby or she is going to be brain dead or retarded.

11 A That is basically what happened.

12 Q Antwan, you are no longer Dr. Miller and I am no
13 longer Dr. Miller. How long after that statement was
14 Alexia born?

15 A Maybe a minute or two after, shortly after.

16 Q And Dr. Miller continued to pull?

17 A The whole time.

18 Q And some point Alexia was born?

19 A Yes.

20 Q Describe what you saw?

21 A You know, she came out, you know, she was pretty
22 little baby just like my daddy said.

23 Q Did Dr. Miller continue to pull the whole time?

24 A Yes, once he continued to pulling they got her out,
25 as they, I think he was walking away to give her to the

1 nurse. I noticed her arm was dangling down by her side.
2 And as they were taking her back to clean her up, I asked
3 the nurse, I said, what is going on with her arm, why is
4 her arm down like that. And the nurse said, well, that
5 happens sometimes during birth. It will get better in a
6 day or two or maybe a week or two.

7 Q Antwan, you can go back and have a seat.

8 A All right.

9 Q And so, Antwan, I am understanding, you actually saw,
10 right after the birth Alexia's arm flop?

11 A Yes.

12 Q And you asked the nurse?

13 A Yes.

14 Q And what was that explanation?

15 A That sometimes those things happen during child birth
16 and, you know, maybe the nerves or the arm had been
17 stretched. At first she said it would come back normally
18 in a few hours, and then she said, well, maybe a few hours
19 to a week or two. It may take a week or two at most. And
20 so, you know, me not knowing, I just, I just took her for
21 her word and said, okay. The next time I saw her, when
22 they brought her back up wrapped up in a blanket and her
23 arm was pinned to her chest.

24 Q Was your impression of Dr. Miller at the time of
25 Alexia's birth, was it he was calm?

1 A No, I wouldn't say he was calm.

2 Q Would you say, would you describe his action as
3 gentle?

4 A No.

5 Q Now, you take Alexia home, she has got the problems
6 with the arm, right? First of all, let me ask you, did
7 you ever speak with Dr. Miller any more after that?

8 A No.

9 Q Did Dr. Miller ever explain to you what had taken
10 place?

11 A No, he didn't.

12 Q So you take Alexia home, and are you and Angela
13 expecting this issue with the arm to clear up?

14 A Yes. I mean we were watching her closely and it
15 just, it seemed to not get better.

16 Q And what did y'all do at that point?

17 A Well, I think, actually a relative of Angela's who
18 works in baby care was one of the first people to actually
19 speak anything to us about brachial plexus. And she said,
20 you know, y'all need to get somebody to look at her child
21 because I think she may have a brachial plexus injury.

22 MR. DAVIS: Objection, hearsay.

23 THE COURT: I am going to sustain the objection.

24 Q Did Alexia have to have surgery?

25 A Yes, she did.

1 Q And I believe that was in September of 2007?

2 A Yes, sir.

3 Q And where was that surgery?

4 A At MUSC in Charleston.

5 Q And did you go down for the surgery?

6 A Yes sir, I was there every day.

7 Q That was a long surgery?

8 A Yes, sir.

9 Q How many hours was it?

10 A Seven or eight hours.

11 Q And when holding Alexia, what would you have to do to
12 make sure that arm wouldn't flop?

13 A Well, you never could just hold her, you always had
14 to kind of like hold that arm and hold her. She never had
15 the normal stability that a normal baby would have where
16 you could just pick them up and just hold them behind the
17 head, you know, give them a little pressure. You had
18 always be mindful of her arm as well as her head.

19 Q Do you remember who else went down for that surgery?

20 A Yes. Actually it was me, Angela, my mom and my dad,
21 we all rode down together.

22 Q Tell me about Alexia as she was growing up and trying
23 to use the arm. What about crawling or walking, falling?

24 A Like my dad said, she never done any of that. She
25 never crawled. She would try but, I mean, in the position

1 that her arm was in, there was no way that she was going
2 to be able to crawl. And at some point, you know, I would
3 tell Angela, just not to let her try because I was fearful
4 that she may break something, she may hurt herself
5 actually more because her arm was in the position that she
6 couldn't move and it was so stiff.

7 Q And was Alexia a happy child?

8 A Oh, yes. She was a wonderful baby. She wouldn't cry
9 a lot at night, most babies do but she was a good baby
10 yes.

11 Q And as Alexia got older, did she start to realize
12 that she was not going to be able to do things with the
13 arm.

14 A Yes, I guess about the time she started kindergarten,
15 about the age of five or six years old, that I noticed
16 that she knew that something was different from her and
17 other kids.

18 Q Would she get frustrated?

19 A Yes, she would get very frustrated.

20 Q When she was small could she feed herself?

21 A No, she couldn't feed herself.

22 Q What would y'all have to do?

23 A Well, you know, a lot of times I would just, I would
24 let her sit down in the floor and just make a mess of
25 herself because she couldn't really feed herself. But

1 just to let her try because she wanted to try. But most
2 of the time we always had to feed her.

3 Q And growing up, your dad was here just a little bit
4 ago. Did she ever ride a bike?

5 A No, she never, the only time I actually remember her
6 riding a bike is, I think one year for Christmas, when she
7 did get a bike I did put her on it and ride her through
8 the house on it. But she never actually, she has never
9 ridden a bike, not on her own.

10 Q Now, as she got older and into middle school, did she
11 want to try out for sports or for cheer?

12 A Yes, she did.

13 Q Did she try out for those things?

14 A Yes, she did.

15 Q How did that turn out?

16 A Not good. She didn't make the team, she was upset, I
17 was upset. I think the whole house was upset about it.
18 They couldn't give us a good reason why but, you know, as
19 parents we knew the reason why she didn't make the team.
20 I felt like me, as a person, that played sports in school;
21 I felt that they felt that she was going to get hurt and
22 they didn't want to be responsible.

23 Q What does Alexia wear now?

24 A Mostly sweat pants, hoodies, pullovers. Anything
25 that she can wear that is loose that, where she can put

1 her arm, in like another sleeve. Mostly hoodies and if
2 you catch her walking around anywhere that is the position
3 you will see her. She will have a hoodie on, sometimes
4 she will even have it over her head. I will get on her
5 and tell her don't, don't cover your face, you have got a
6 beautiful face. No reason to cover your face. But she
7 will slide the injured arm into the pocket of the hoodie
8 or even sometimes she will just have it, the sleeve pulled
9 down because her other arm is significantly shorter. She
10 will make sure she has it pulled down far enough where it
11 is covered and in the sleeve, to hide it when she is out
12 in public.

13 Q What about in the summer time?

14 A Even during the summer time.

15 Q Does she have trouble still tieing her shoes?

16 A Yes, she does have trouble. She can tie them but she
17 cannot tie them right.

18 Q Was that a learning process?

19 A She taught herself how to.

20 Q And what about buttoning her clothing, shirt or
21 pants?

22 A She can but it is difficult, it takes her a while.
23 So I think that is another reason why she likes the
24 tights, the pull up with elasticity in the waist,
25 something that doesn't have a button.

1 Q And does she wear a lot of shoes without shoe
2 strings?

3 A Yes, she does. She just got about four new pair for
4 Christmas.

5 Q Can she pull her hair up in a ponytail?

6 A No, she can't do that.

7 Q What about social interaction with friends. How has
8 that affected her?

9 A Well she doesn't really socialize. She just kind of
10 keeps to herself.

11 Q I think Shemica's daughter is her best friend?

12 A Yes, yes. And her sister. But, you know, they are
13 not, there is an age gap there so more with Shemica's
14 daughter than her sister.

15 Q Something as simple like playing a play station, is
16 she able to do that?

17 A She has never been able to do that.

18 Q Does she carry a blanket to school?

19 A I think so, yes.

20 Q Why does she carry that blanket?

21 A To hide herself.

22 Q Does she wear short sleeves out in public?

23 A No, you, honestly I can't remember when the last time
24 I saw my child with a short sleeve shirt on.

25 Q Did Alexia also, I think you said, did she try out

1 for basketball?

2 A Yes.

3 Q Did she also try out for volley ball and cheer?

4 A Yes. I didn't know about the cheer but I knew about
5 the volley ball.

6 Q And she didn't make the team?

7 A She didn't make the team.

8 Q Tell me what movements you know that she currently
9 has with that arm?

10 A Very little and most of it is just side to side.
11 There is not much, there is not any range of motion of,
12 like this because her arm now is just in about a fixed
13 position like this. So there is just very little movement
14 at all.

15 Q Does it take her longer to shower, get dressed, do
16 those things?

17 A Yes, it does.

18 Q But she does it herself?

19 A Yes. She makes do, she makes do.

20 Q And what about her hair. Does Angela take her
21 somewhere to have her hair done now.

22 A We keep her braided down. She has someone that
23 braids her hair down every two or three weeks.

24 Q Does she have a brace that the therapist described
25 for her?

1 A Yes. She has one or two braces, maybe three.

2 Q Does she like wearing that to school?

3 A No, I have tried to encourage her to wear them to
4 school but she may wear them one time but she won't wear
5 them.

6 Q What does she like to do, what are some of the things
7 that she does like to do?

8 A Well, before her grandmother passed away she was
9 really, really in the church. With all of the COVID going
10 on we haven't been inside the churches as much as were
11 before. She mostly just stays in the house and on her
12 phone.

13 Q Would she sing in the choir before?

14 A Yes. She has been in chorus in high school, yes.

15 Q In chorus in high school?

16 A Yes.

17 Q Does she like to roller skate or would she try to
18 roller skate?

19 A She likes roller skating but she won't try.

20 Q Is she afraid of falling?

21 A Afraid of falling, yes.

22 Q What about the movies, does she like to go to the
23 movies?

24 A Yes, she likes to go to the movies.

25 Q And does she have a plan where the school will help

1 her out carrying a lunch tray or books?

2 A Yes. She has had a plan in place since she first
3 started school. But she prefers to try to make do
4 herself.

5 Q Even though there is a plan for someone to help her,
6 she doesn't want to take advantage of that?

7 A She always tries to make do. We even bought her a
8 book-bag with wheels but she wants to be normal like the
9 rest of the kids. She carries a normal book-bag.

10 Q Now, are there certain tools that she uses at home to
11 help prepare food or things?

12 A Yes. She has a cutting board. Recently, I think the
13 therapist that she goes to got her a knife that is made
14 specifically where she can hold, where she don't have to
15 hold the stuff down, I think it is a knife and a cutting
16 board.

17 Q I think I may have a cutting board. Antwan, are
18 these special tools to help her prepare her own food?

19 A Yes.

20 Q And the first one you mentioned is a cutting board?

21 A Yes, sir.

22 Q Is this it?

23 A Yes, sir.

24 Q And attaches --

25 A To the table.

1 Q To the table or counter. And then what does this do?

2 A That holds the food in place where she doesn't have
3 to use her hand, where she can prop it up against and use
4 her good hand.

5 Q And this is, plastic that rolls out. What is that
6 used with?

7 A I think that is used for putting the food down and
8 hold it in place. Yes.

9 Q You put that down on the counter?

10 A Yes, sir.

11 Q And is this the knife that she uses with one hand and
12 rotates?

13 A Yes, sir.

14 Q She doesn't have to, non-slip surface for food and
15 then the cutting board stays in place; and then she can
16 use the knife to cut?

17 A Yes, sir. And she uses it.

18 Q Have you all tried to provide her with tools that
19 will enable her to do the things she needs to do with one
20 hand?

21 A Yes, sir. I have tried to give her the best care
22 that I possibly can.

23 Q When, let me ask you this. Does she ride the bus to
24 school?

25 A No, she doesn't ride the bus.

1 Q And why does she not like to ride the bus?

2 A As my dad said, that was something that my mom
3 started. The reason that started with my mom is, her
4 first school my mom actually worked there. But since she
5 has gotten older now, she doesn't want to ride the bus
6 with the other kids. She is so secluded and so withdrawn
7 now that she has gotten older, we didn't have these issues
8 when she was young. But now she is a teenager she knows
9 she is not like the other kids and I think she just shy's
10 away.

11 Q Do you ever talk with her about her frustration with
12 not being able to use her arm?

13 A All the time.

14 Q And does she ever cry about it?

15 A She does, she does cry, yes.

16 Q Seeing your daughter struggle, how does that make you
17 feel as a father?

18 A Helpless, it makes me feel helpless. It is
19 frustrating for me sometime. Like I mention, I was always
20 an athlete in high school. I played on a State
21 Championship foot ball team at Northwest and I lettered in
22 track for four years. And I was there at Northwestern and
23 All State twice. I still hold several records at
24 Northwestern. For my child not to be able to participate
25 and do some of the things that I felt that she would do

1 that I did, especially running track, it is a hurting
2 feeling. Like I said, it is a sense of helplessness. I
3 have no control over her condition. No matter how I work,
4 I can work from sunup to sundown seven days a week but I
5 can't, you know, go back and change what happened to my
6 child at birth.

7 Q A few more questions. Just before Dr. Miller made
8 the decision to go back to the operating room, did he ever
9 tell you all that there was an issue with the fetal heart
10 rate?

11 A No, he did not.

12 Q And you told us a little bit ago that Dr. Miller,
13 your impression was, he was not calm?

14 A No, he was not.

15 Q How would you describe him during this process?

16 A A little fidgety, a little uneasy about the whole
17 situation. I mean, like I said, to me he just didn't come
18 across as being that professional. I mean, I don't know,
19 I haven't witnessed but two child births and that was my
20 first one. But I mean I didn't think he put out a good
21 first impression.

22 Q And you told us that you would not characterize him
23 as gentle? How would you describe him during this, when
24 he was delivering Alexia?

25 A The delivery was rough. I mean, make no mistake

1 about that. It was rough. And it was hard to watch.
2 Like I said, not ever seeing that before in my life
3 besides watching it on TV, I really didn't know what to
4 expect. But at some point, the light did go off in my
5 head and was like, hey, this is not right, what he is
6 doing is not right.

7 Q Thank you, Antwan, please answer any questions that
8 Counsel might have.

9 THE COURT: Mr. Traylor.

10 CROSS-EXAMINATION

11 By Mr. Traylor:

12 Q Mr. Lumpkin, my name is Drew Traylor. I am
13 representing Dr. Miller.

14 A Yes.

15 Q I know you have mentioned several times but your only
16 experience prior to Alexia's birth was, of child labor and
17 delivery was the video that you saw on Lifetime, correct?

18 A Watched it on Lifetime about a week before Angela
19 went into labor, yes.

20 Q As any good that would do, curious what was going to
21 happen?

22 A Trying to see what the deal is.

23 Q Once you got up to the hospital and everything is
24 going along, she has been in labor and delivery for a
25 little while, Dr. Miller comes in and senses something is

1 off. Now you mentioned that he never directly told you
2 that her heart rate was dropping. But with that being the
3 case, don't you think that he would be on a timer and be
4 aware that this is almost an emergency like situation?

5 A Well, yes, he should have been. That is his job.

6 Q And that is why he is trying to help get her to push
7 and get the baby out so nothing happens to her. And why
8 he decided, we may have to do a C-section, we may have to
9 cut her.

10 A Yes.

11 Q So he made that call after enough time went by to go
12 back to the operating room and start to perform the
13 C-section?

14 A Yes.

15 Q Now, once he got back there, fortunately her heart
16 rate had elevated to the point where they thought it was
17 safe to proceed with a natural delivery, correct?

18 A Correct.

19 Q And that is when they brought you back there because,
20 you know, dad needs to be there to help the mom get
21 through it?

22 A Yes, that's right.

23 Q Now, when you first walked into the operating room
24 you had mentioned that you came in from Dr. Miller's
25 right. There were a few nurses in there with them?

1 A Yes.

2 Q Now, were you in between the nurse over here and Dr.
3 Miller?

4 A Yes, just the way I was standing just a minute ago.

5 Q Thank you. Had you ever been in an operating room
6 before this occurrence?

7 A No.

8 Q Are you aware of what a sterile section is or a
9 sterile area is in an operating room?

10 A No.

11 Q When a doctor is operating on a patient, do you feel
12 that it is important that his utensils and his hands and
13 everything that could potentially be inside of a patient
14 be sterile?

15 A Yes.

16 Q Thank you. Now, do you remember Dr. Miller having
17 cut Angela any where during this procedure?

18 A I think she did get a little slit down at the bottom,
19 yes.

20 Q Okay. Now, when you walked into the operating room,
21 sorry to back up a little bit, did the nurses, was Ms.
22 Patton up in stirrups or were the nurses pulling on her
23 legs at that point in time?

24 A I think she was up in stirrups.

25 Q Okay. And during the delivery, you mentioned that

1 you could see a shoulder, which shoulder do you remember
2 seeing?

3 A The right shoulder.

4 Q Now, around the time of the delivery, did you make
5 any notes or any journals about what happened?

6 A No, I did not.

7 Q You mentioned briefly that one of the nurses, gotten
8 on top of Ms. Patton and started pressing on her stomach.
9 You mentioned the word, straddle. Would you mind
10 clarifying that for me? How was she straddling, if you
11 don't mind.

12 A Mid-ways of Angela's stomach, to her waistline.

13 Q Was she leaning over?

14 A Yes.

15 Q Okay. Thank you. No further questions, Mr. Lumpkin.
16 Thank you for your time.

17 THE COURT: Any redirect, Mr. Jordan?

18 MR. JORDAN: Yes, Your Honor.

19 THE COURT: Okay.

20 REDIRECT EXAMINATION

21 By Mr. Jordan:

22 Q Antwan, you mentioned that you saw the head and part
23 of the shoulder, is that right?

24 A Right.

25 Q And I believe you said the right shoulder, is that

1 correct?

2 A Yes, sir.

3 Q The right shoulder. So when you saw that right
4 shoulder, was it down like that?

5 A In a down position.

6 Q Right side?

7 A Right side was down.

8 Q Thank you.

9 THE COURT: Mr. Traylor?

10 MR. TRAYLOR: Nothing further, Your Honor.

11 THE COURT: Thank you, sir, you can step down.

12 Ladies and gentlemen, we will take a ten minute recess.

13 (Whereupon, the jury was excused from open court for
14 a break.)

15 (Whereupon, a short break was taken.)

16 (Whereupon, the jury came into open court at
17 approximately 2:40.)

18 THE COURT: Ladies and gentlemen, we are done for the
19 day. As attorneys and me as a Judge, we do our best to
20 make sure we fill every day and we don't waste time. We
21 will try to estimate how long witnesses will take and
22 today went faster than we thought it would. Remember what
23 I explained to you, don't discuss the case with anyone,
24 don't do any outside research. Have a wonderful weekend,
25 we will see you back at 9:30 Monday morning. I had heard

1 a couple of y'all were asking about child care. I would
2 plan on child care the whole week next week. I do not
3 think the case will take that long. But I think it is
4 better to be prepared to go through Friday than have to be
5 scrambling. I think that, just to be safe I would make
6 childcare arrangements for the whole week. Thank you very
7 much, have a great weekend.

8 (Whereupon, the jury was excused for the day, to
9 start back on Monday, January 10, 2022.)

10 THE COURT: Anything we need to do from the
11 Plaintiff's perspective before we break for the week?

12 MR. GRAHAM: No, Your Honor.

13 THE COURT: Mr. Davis?

14 MR. DAVIS: No sir, thank you.

15 THE COURT: We will be in recess until Monday at
16 9:30.

17 (Whereupon, the trial will resume on Monday, January
18 10, 2022.)

19 January 10, 2022.

20 (Whereupon, the jury came into open court at
21 approximately 9:48 a.m.)

22 THE COURT: Welcome back, ladies and gentlemen, I
23 hope everyone had a good weekend. Was everyone able to
24 follow the rules I have given you over the weekend.

25 Thank you very much. Mr. Graham, you can call your

1 next witness, Mr. Jordan.

2 MR. JORDAN: The Plaintiff would call Kimberly Coker.

3 Kimberly Coker, being

4 first duly sworn, testified as follows:

5 DIRECT EXAMINATION

6 By Mr. Jordan:

7 Q Good morning, Ms. Coker.

8 A Good morning.

9 Q If it is more comfortable for you while you are
10 testifying, Your Honor, is it okay if she removes the
11 mask.

12 THE COURT: It would help the Court Reporter and
13 everybody to hear you.

14 Q Thank you. Please state your full name?

15 A Kimberly Coker.

16 Q And where do you live?

17 A I live in Charlotte, North Carolina.

18 Q And are you married?

19 A Yes, I am.

20 Q What is your husband's name?

21 A Anthony Coker.

22 Q What does he do?

23 A He is a machinist for Duff Norton Company.

24 Q You all have any children?

25 A No children.

1 Q Where are you employed?

2 A I am employed at Nazareth Baptist Church, Rock Hill,
3 South Carolina.

4 Q What do you do for Nazareth Baptist Church?

5 A I am the Minister of music for Nazareth Baptist
6 Church.

7 Q And tell me a little bit about your educational
8 background?

9 A Okay. I am a Graduate of Winthrop University where I
10 received my Bachelor's Degree; and I also have graduate
11 studies at Liberty University where I obtained my Master's
12 Degree and my Degree at Winthrop was in music and my
13 degree at Liberty University was in worship studies.

14 Q And how did you come to have the job there at
15 Nazareth, Minister of Music, is that your title?

16 A Yes, it is.

17 Q How did you end up working there?

18 A As a student at Winthrop University, the church was
19 in need of a musician and upon graduating from Winthrop
20 they offered me the position full-time as minister of
21 music.

22 Q Do you know Alexia?

23 A Yes, I do.

24 Q Tell the jury how you know Alexia?

25 A I have known Alexia since infancy. Her grandmother

1 was a devoted member of Nazareth Baptist Church and her
2 grandmother worked very closely with me in the music
3 ministry. And as a baby, well her grandmother would bring
4 her to church on a regular basis so I got to know Alexia
5 very, very well through her grandmother.

6 Q And grandmother's name?

7 A Her name was Sheila Lumpkin.

8 Q And that would have been George's wife, correct?

9 A Yes, correct.

10 Q I believe she passed away recently?

11 A She did.

12 Q And do you know Angela and Antwan?

13 A Yes, I do.

14 Q Now, through the years have you had the opportunity
15 to work with Alexia as, in your role of ministered music?

16 A Absolutely. Alexia, again, being a young, a youth
17 within the church, her grandmother, again, would bring her
18 on a regular basis to the church. And she became involved
19 in the music ministry by participating in the various
20 choirs, the youth choirs. She began with the sunbeam
21 ministry which is a choir for youth under the age of five.
22 So I have been working with Alexia since early childhood
23 age.

24 Q And so she would sing in the choir, youth choir?

25 A Yes.

1 Q Were there several youth choirs there?

2 A It was two, it was a sunbeam choir and a youth choir.
3 The sunbeam were the youth that were under the ages of
4 five. And then once they turn the age of five then they
5 matriculate to the youth choir.

6 Q And have you also had an opportunity to teach Alexia?

7 A Yes.

8 Q What did you teach Alexia?

9 A I taught Alexia piano instructions because I do teach
10 privately piano instruction to youth within the church.
11 And so I have had an opportunity to work with Alexia on
12 the piano as well.

13 Q How many years did she take piano from you?

14 A I would say, I worked with Alexia between five to six
15 years.

16 Q And did that sort of end when COVID started?

17 A Absolutely.

18 Q And haven't started back yet?

19 A No.

20 Q How would you describe Alexia?

21 A Alexia was an inspiration to me because although
22 Alexia was only able to utilize one hand to play the
23 music, she did her very best at doing so. We would find
24 ways to revamp the music, if I could just say that, so
25 that she would be able to utilize that one hand to do what

1 she needed to do. Alexia, sometimes we would work
2 together and like I said, to find different ways to
3 accomplish the goal. Sometimes she would get a little
4 frustrated about things but we would work it out together
5 to make sure that she was able to accomplish the goal.
6 And I am proud to say that she definitely did accomplish
7 the goals because we would have recitals twice a year and
8 Alexia performed on those recitals and did very well.

9 Q And you mentioned that sometimes she would get
10 frustrated. What do you mean by that?

11 A Because, I think sometimes she, you know, she would
12 want to accomplish certain things right away and because
13 she had that disability to not being able to utilize that
14 left hand, so it make it a little more challenging to
15 cover some of the material but she still would not allow
16 that to stop her from completing the goal. So we just
17 have to find different ways to go about doing so. But she
18 definitely put in the work and the goals were
19 accomplished.

20 Q And you mentioned revamping the music. Is that
21 rewriting. Explain to the jury what you would have to do?

22 A So sometimes I would have to take musical scores and
23 because, you know, a lot of times with piano music you are
24 utilizing both hands. The music scores are written for a
25 left and right hand with specific pieces. So sometimes I

1 would have to take those pieces and recognize them so
2 that, that the bulk of the work would be done with the
3 right hand. Now, sometimes, of course, like when we would
4 do performances at recitals, if it is was something that
5 was very extensive in the left hand I would handle that
6 portion where she would handle whatever needed to be
7 played with the right hand. But, again, she did
8 everything she needed to do to accomplish the goal. We
9 worked together.

10 Q And while you were teaching Alexia, was she
11 respectful?

12 A Very much so, very much so.

13 Q Attentive?

14 A Very much so.

15 Q Would you describe her as shy?

16 A Yes, somewhat shy, yes.

17 Q Would you have to sometimes try to get her out of her
18 shell?

19 A Yes, very much so.

20 Q Tell me a little bit about that, what would you do?

21 A Well, one thing about Alexia, again, she doesn't talk
22 a lot or, but she is a good listener. So from time to
23 time I would have to kind of talk with her, to kind of
24 encourage her to speak up sometimes, like if I provide
25 some type of instruction and it would response to things.

1 Like for instance, when we would do recitals each of the
2 students would have to give like a small verbal report on
3 the composer on what they were studying at the time. And
4 so with Alexia being really shy, she never really wanted
5 to, really wanted to speak up on those things. But we
6 worked on those fields. And once again she accomplished
7 the goals.

8 Q Was she ever able to utilize her left hand playing
9 the piano?

10 A Not really.

11 Q And how would you determine what music you would
12 teach her?

13 A At the beginning of our term, when we get together we
14 would come up with a list of things that she was
15 interested in playing. Sometimes we would do an activity
16 in our lesson time, what we call kind of like a listening
17 party where I would present different pieces that I
18 thought would be really good for her to accomplish for
19 that particular term. And we would have like listening
20 parties and she would just kind of develop a list of the
21 things that she was interested in playing and we would
22 kind of work things from there.

23 Q Was there a certain composer that Alexia was
24 studying?

25 A She was a big fan of Beethoven. One of the pieces

1 that we were able to, like one of the last pieces we
2 worked on was Fur Elysée by Beethoven. And let's say she
3 did an excellent job with performing that.

4 Q It is a pretty difficult piece.

5 A It is not an easy piece.

6 Q Did you ever observe Alexia hide her arm when she was
7 around other youth?

8 A Not really because, I think she was comfortable, you
9 know, in the skin she was in. So, yes, so I never really
10 saw her do that.

11 Q She was comfortable around the people that she was
12 with?

13 A Absolutely.

14 Q And you were teaching her?

15 A Yes.

16 Q Let me ask you, the people she was around, other
17 youth in the church, is that correct?

18 A Yes, it was.

19 Q And I believe she started piano lessons around age
20 five or six?

21 A Yes, about five.

22 Q Thank you. Please answer any questions that Counsel
23 has for you.

24 THE COURT: Mr. Davis.

25 MR. DAVIS: Thank you.

CROSS-EXAMINATION

By Mr. Davis:

Q You first got to meet Alexia when she was how old,
when you first met her?

A As an infant. Because, again, her grandmother would
bring her as an infant to church on a regular basis.

Q Six, seven, eight months old, do you have any idea?

A I have no idea but I know she was an infant, was not
walking.

Q And you taught her piano for five or six years?

A Yes, sir.

Q And you graduated from, you say Liberty?

A I graduated from Winthrop University with a degree in
music; and my graduate studies was at Liberty University.

Q Is that the school up in Virginia?

A Yes, it is. Yes, sir.

Q You mentioned Beethoven?

A Yes.

Q He had a disability, didn't he?

A Yes, he did.

Q He was deaf?

A Yes.

Q Thank you.

THE COURT: Any follow-up, Mr. Jordan?

MR. JORDAN: No, Your Honor.

1 THE COURT: Any objection to excusing this witness?

2 MR. DAVIS: Not at all, Your Honor.

3 THE COURT: Thank you, you are excused. Call your
4 next witness.

5 MR. GRAHAM: Your Honor, may we approach?

6 THE COURT: Yes, sir.

7 (Whereupon, a bench conference was held in the
8 presence of the jury but out of the hearing of the
9 jury.)

10 THE COURT: Ladies and gentlemen, what is going to
11 happen now is the attorneys have asked someone to read for
12 you the deposition of another witness. A deposition is a
13 sworn statement taken out of court. So the person who is
14 going to read the deposition is the daughter of one of the
15 lawyers. She is not the witness, she is going to be
16 reading the written testimony of a witness named Dr.
17 Gurewitsch.

18 MR. GRAHAM: Your Honor, we would call Dr.
19 Gurewitsch.

20 THE COURT: Ma'am, if you would have a seat in the
21 witness box up here.

22 MR. GRAHAM: Also known by Grace Jordan. Just so the
23 record is clear, this deposition was taken by Mr. Davis
24 and I will be reading his part. So just so you understand
25 the context. That is where we are.

1 THE COURT: Just so the jury understands. So Mr.
2 Graham is going to read the questions that the attorneys
3 asked at the deposition. And then Ms. Jordan is going to
4 read the Doctor's answers.

5 MR. GRAHAM: First Dr. Gurewitsch was sworn and then
6 the questions start.

7 (Whereupon, the Deposition of Dr. Edith Gurewitsch is
8 read into the record. Mr. Graham is reading the
9 questions by Mr. Davis. Ms. Grace Jordan is reading
10 the answers by Dr. Gurewitsch. This reading of the
11 deposition starts at 10:07 a.m.)

12 THE COURT: A good time for a lunch break. Ladies
13 and gentlemen, let's a lunch break to 2:15. Have a great
14 lunch and see you back at 2:15.

15 (Whereupon, the jury is excused for a lunch break.)

16 THE COURT: After lunch what do we have.

17 MR. GRAHAM: We have the mother and just to make sure
18 all of our exhibits are in.

19 MR. DAVIS: I have got a witness under subpoena,
20 should be very short. Hope we can get her up today and I
21 will call Dr. Miller and that will be a very long direct.
22 I would appreciate the Court's consideration with where we
23 are today, just let me start tomorrow with Dr. Miller.
24 There is nothing else I can bring tomorrow other than his
25 testimony. I think in all fairness, would be more fair

1 for him, if we can go through with him. He is the only
2 witness I have tomorrow because my experts will be here
3 Wednesday.

4 THE COURT: Any objection, Mr. Graham, Mr. Jordan.

5 MR. GRAHAM: I don't know how long Dr. Miller will
6 take.

7 MR. DAVIS: A long time.

8 MR. GRAHAM: But if there is a time gap, it seems to
9 me he can go ahead and do the experts by the video link
10 just like we had to do.

11 MR. DAVIS: My experts are coming live and in person,
12 they will be here. They are coming tomorrow night.

13 THE COURT: Mr. Davis is asking to end today with his
14 short witness following the mother and that is, Dr. Miller
15 is tomorrow. Is that correct, Mr. Davis.

16 MR. DAVIS: And he is the only witness I have got all
17 day.

18 MR. GRAHAM: I have no objection.

19 THE COURT: All right, sounds good. See you back at
20 2:15.

21 (Whereupon, a lunch break was taken.)

22 THE COURT: Number six is into evidence without
23 objection.

24 (Whereupon, Plaintiff's Exhibit 6 was admitted into
25 evidence.)

1 THE COURT: Is the Plaintiff ready to proceed?

2 MR. GRAHAM: Yes, sir.

3 THE COURT: The Defense?

4 MR. DAVIS: Yes, sir.

5 THE COURT: Let's bring them in.

6 (Whereupon, the jury came into open court at
7 approximately 2:27 p.m.)

8 THE COURT: Mr. Graham, you can call your next
9 witness.

10 MR. GRAHAM: The Plaintiff would call Angela Patton.
11 Angela Patton, being
12 first duly sworn, testified as follows:

13 DIRECT EXAMINATION

14 By Mr. Graham:

15 Q Angela, state your full name for the record, please?

16 A Angela Louise Patton.

17 Q Where are you from originally?

18 A Edgemore, South Carolina.

19 Q And I don't like to ask a lady her age, so I will ask
20 you your date of birth?

21 A 3/6/72.

22 Q How far did you go in school?

23 A I graduated.

24 Q From what high school?

25 A Louisville High School.

1 Q Yesterday or not yesterday, last week we heard Antwan
2 brag a bit about his athletic accomplishments. Are you
3 and your family also into sports?

4 A Yes, sir.

5 Q You want to brag on you and your family in that
6 regard?

7 A Me, I played basketball, softball and I also ran
8 track. I have a son that was highly in football and
9 basketball and track. I also have two brothers that
10 played baseball and they went to school on baseball
11 scholarships.

12 Q Very good. Thank you. When did you move to Rock
13 Hill?

14 A Like 23 years ago.

15 Q Why did you move here?

16 A I am strictly from small town which we didn't have,
17 at the moment, no stores, no restaurants or no job or
18 housing, just pretty much country.

19 Q So you thought it was a good idea for your future?

20 A That is why I moved to Rock Hill.

21 Q When you got to Rock Hill, what was your first job?

22 A Ross Distribution.

23 Q What was that?

24 A Ross.

25 Q How long did you stay with Ross?

1 A For about five years.

2 Q What was your next job?

3 A West Marines.

4 Q West Marine?

5 A Yes, sir.

6 Q When you went to West, what was your first job there,
7 your first position?

8 A Order selector.

9 Q Order?

10 A Selector, I took orders from customers.

11 Q Get a little closer to the microphone, that would be
12 good. So you were an --

13 A Selector.

14 Q Are you still there?

15 A Yes.

16 Q What is your current job?

17 A I am a trainer. I train new hirees whenever they
18 come in.

19 Q So you moved up in the ranks, so to speak?

20 A Yes.

21 Q How did you and Antwan meet?

22 A Through my sister. It was like her baby's daddy and
23 Antwan was friends. So that is how we get to meet.

24 Q And obviously you hit it off. How long have y'all
25 been together?

1 A 21 years.

2 Q With him being a truck driver, is your job, is that a
3 full time job?

4 A Yes.

5 Q And Antwan works full time as well?

6 A Yes.

7 Q With two parents having full time jobs, how do you
8 take care of daycare?

9 A We had, his mom used to babysit for me and also my
10 sister.

11 Q And we have heard that Antwan's mother passed. How
12 long ago was that?

13 A Three years ago.

14 Q How would you describe her relationship with Alexia?

15 A Well, like a mom because everybody in the church
16 thought she was her mom because Antwan actually was the
17 only child.

18 Q So how many children have you and Antwan had
19 together?

20 A Two.

21 Q We know Alexia is 14. What is your other child's
22 name and age?

23 A Arie, she is nine years old.

24 Q You had some children before you met Antwan, right.

25 A Yes.

1 Q How many?

2 A Three.

3 Q Are they grown up and living on their own now?

4 A Yes. I have a 30 year old, a 28 year old and a, well
5 my son will be turning 23 next week.

6 Q Do they all work?

7 A Yes.

8 Q What kind of work?

9 A My oldest, she works with me at West Marines. And my
10 other two sons, they work with my brother. He owns his
11 own insulation company.

12 Q Let's move right along and talk about your pregnancy.
13 But before we get to this particular pregnancy with
14 Alexia, you already had three children?

15 A Yes.

16 Q Where were they delivered?

17 A In Chester, South Carolina.

18 Q Did you have an obstetrician over there you were
19 really fond of?

20 A Yes.

21 Q Who was that?

22 A Dr. PH Raut.

23 Q With Alexia's pregnancy, why didn't you go back to
24 that doctor?

25 A At the moment Chester Hospital cut out the pregnancy

1 ward so I couldn't go there and have kids anymore.

2 Q So did she keep delivering babies somewhere else?

3 A No, she just turned into a regular OBGY at the
4 moment.

5 Q And OBGYN?

6 A Yes.

7 Q So what made you pick the Rock Hill GYNOB practice as
8 opposed to the other one?

9 A At the moment it really wasn't no OBGY, so I didn't
10 want to deal with a mid-wife. I had heard at the time
11 that mid-wife's had to come and visit your home. So I
12 wanted to be in person, a doctor, so that is why I chose
13 Rock Hill OBGY.

14 Q So had you had any problems with the prior pregnancy?

15 A No.

16 Q (Inaudible, Attorney walking around.)

17 A Yes, due to a fall the night before.

18 Q So, if it was so important for you to have an OBGYN
19 deliver your fourth child instead of a mid-wife, were you
20 thinking just in case something goes wrong, who you would
21 rather have there?

22 A I would rather, prefer to OBGY because they give the
23 best care that a patient could have.

24 Q That's what you were expecting and that is why you
25 went there?

1 A Yes.

2 Q Is it fair to say you put your trust in the
3 obstetricians in that group?

4 A Yes.

5 Q Did you see Dr. Miller during that pregnancy, for any
6 prenatal?

7 A Yes, once.

8 Q How did he treat you?

9 A He was nice on the visit.

10 Q Nice?

11 A Yes.

12 Q You just saw him that one time?

13 A Yes.

14 Q We have heard before that you got induced. Tell me
15 how that came about?

16 A It was a routine checkup that I had. So they gave me
17 an ultrasound while I was in the visit. And during the
18 ultrasound they come to find out that I was delivering a
19 nine pound baby at the moment. So the nurse and the
20 doctor discussed, they was like your baby at nine pounds.
21 If you go a couple of weeks you are going to go at least
22 ten pounds. So do you think you want to be induced or you
23 are going to wait? I told them I wanted to be induced
24 because I didn't want to go like to a ten pound baby.

25 Q So they were talking about waiting two weeks so did

1 you go get induced two weeks before term?

2 A No. They made me an appointment with the hospital.

3 And I went to like the next day but the hospital ward was

4 full. I didn't have any bed at the moment so I had to

5 leave and come back later on.

6 Q They were too busy to take you?

7 A Yes.

8 Q So let me get this straight. The doctor recommended

9 inducement on one day and then you went to the hospital,

10 was that the same day or the next day?

11 A Next day.

12 Q That is when they had no room?

13 A Yes.

14 Q Then it was the next day when you actually went in

15 and they found a bed for you?

16 A Yes.

17 Q Two days after the conversation about being induced?

18 A It was that evening.

19 Q So they didn't have a bed for that morning?

20 A No, they had it like 6:00 o'clock that evening.

21 Q 6:00 p.m.

22 A Yes.

23 Q So when you did go in to be induced, did you ask for

24 an epidural?

25 A No.

1 Q With your three children before, had you had an
2 epidural?

3 A No.

4 Q Because you are a tough --

5 A I just didn't want to deal with the medicine. I
6 heard bad reviews on epidurals so I just dealt with the
7 pain.

8 Q So tell me when you, when you got to the hospital
9 that night and they put you in the labor and delivery
10 room, I guess?

11 A Yes.

12 Q Did they give you a nurse?

13 A Yes.

14 Q Do you remember her name?

15 A No, sir.

16 Q Was she nice to you?

17 A Yes.

18 Q Like, respectful?

19 A Yes.

20 Q What about people that were there with you. Do you
21 have any friends and family, loved ones with you?

22 A That night it was only me and Antwan. But the next
23 morning that is when all of my visitors start to come in
24 which it was my sister at first. She came to check on me.
25 Antwan's mom was there.

1 Q At some point did Dr. Miller come in?

2 A It was like later on that evening.

3 Q What happened then?

4 A He just checked my cervix to see how far along I
5 dilated.

6 Q Was it still pretty early in the process?

7 A Yes.

8 Q In terms of inducing you, the records refer to
9 something called agent Cytotec or cervical ripening. Is
10 that the way they started your induction, some kind of
11 medicine they gave you?

12 A All I know I was getting medicine in my IV, I don't
13 know what it was.

14 Q And then there is a drug called Pitocin that they
15 also use to speed up contractions to make them stronger
16 and more frequent. Do you remember getting Pitocin?

17 A All I know, I was getting medicine but they never
18 explained to me what medicine they was like giving me.

19 Q Did they tell you anything about what dosage they
20 were giving you?

21 A No.

22 Q You were totally in the dark about any medicine they
23 were giving you?

24 A Yes.

25 Q When Dr. Miller came in that first time, how would

1 you describe his tone of voice and demeanor, how he was
2 acting?

3 A My first impression was, when he came in he was like,
4 he was ready to get this delivery over. It wasn't like a
5 doctor, hey, how are you doing or nothing. He just came,
6 spoke with the nurse and went straight in to doing my
7 cervix check to see how far along I dilated.

8 Q Does he have anything to say to you, any kind of
9 pleasantries?

10 A No.

11 Q What is it that makes you say that he seemed like he
12 was in such a hurry. Was it something he said or the way
13 he was acting?

14 A It was just like his body language, the way he was
15 acting like he is just ready, it has been a long day and I
16 am ready to get this delivery over.

17 Q Could you tell anything about whether he was --

18 A Like he was tired.

19 Q When did Dr. Miller come back in next?

20 A Maybe a couple of hours later on.

21 Q What happened then?

22 A He was checking my cervix to see how far along I had
23 dilated.

24 Q What was his attitude and demeanor and tone of voice
25 that visit?

1 A At the moment it was like, this dilation ain't
2 moving. It is just like it is at a standstill.

3 Q But in terms of his tone of voice and the way he was
4 acting and talking. Had his demeanor changed from the
5 first time he came in?

6 A It was the same.

7 Q So how did his appearance and the way he was talking
8 to you and the way he was acting compare with how he was
9 at his office?

10 A It was totally different. At his office he spoke, he
11 was gentle, he was pretty much like the doctor. Hey, how
12 are you, I am Dr. Miller. I am your OBGY for today and he
13 checked me on his visit. And when he leaves out he would
14 say, have a nice day.

15 Q Did he come in some more, on the Alexia pregnancy,
16 did he come in some more after those first two?

17 A The last time he came in, that was the last time when
18 he decides to break my water.

19 Q What happened?

20 A After he checked my cervix he still say it is still
21 at a standstill, just only move a couple of inches. So he
22 checked my cervix, he told the nurse, I am going to break
23 her water. So he broke my water. So after he broke the
24 water it straight up shot to like nine something
25 centimeters right then.

1 Q So at that point you started progressing?

2 A Yes.

3 Q At least in terms of the cervix getting bigger?

4 A Yes.

5 Q Did anybody tell you where your baby's head was?

6 A No.

7 Q So did the time come when you were complete, ten
8 centimeters and the doctor was ready for you to start
9 pushing?

10 A Yes.

11 Q Did he stay in the room after that?

12 A The nurse prepared everything for the delivery and
13 that is when he came back in the room to present the
14 delivery.

15 Q All right. How was he acting then?

16 A Still the same, like he is ready to get this over.

17 Q Okay. Did people start yelling at you to push, push?

18 A On my first push everybody was like, the nurse, the
19 doctor, like, all right, Angela, it is time to start
20 pushing when a contraction comes. So when a contraction
21 come that is when I started pushing. So I started
22 pushing, wasn't nothing happening. That was on the first
23 push. On the second push, even start pushing again and
24 then that is when panic and all of it come of, from
25 everybody.

1 Q Panic, you said panic come from everybody. Where did
2 the panic start?

3 A With the Doctor.

4 Q And when you say everybody felt this panic. Explain
5 what you mean by that?

6 A Antwan was like, come on, Angela, push. My sister,
7 the mom, the nurse, everybody was like, come on, push. It
8 is time to push so that is when the panic started to come
9 in.

10 Q Did anybody make any threats to you?

11 A On my third push Alexia wasn't coming. And all of a
12 sudden, if you don't push this baby out I am going to cut
13 you. So I tried again, I tried my best to push again. It
14 was like, seems to me you ain't going to push this baby
15 out, I am going to cut you. Nurse, go get this paper
16 right now for her to sign so I can give her a C-section
17 and cut her to get this baby out. You are going to make
18 this baby heart rate drop if you don't, hurry up and get
19 her out of here.

20 Q So did the nurse bring back a form for you to sign?

21 A Yes. The nurse brought back the form for me to sign.
22 I was like, fine, I am going to sign and I sign the paper
23 for him to get my C-section.

24 Q What happened next. Did you stay in that room?

25 A The bed that I was in, they took me out of there and

1 carried me to the room to get my prep for the C-section.

2 Q Operating room?

3 A Yes.

4 Q So when you first went into the operating room, what
5 can you tell me about the size of it?

6 A It was a small room.

7 Q When you were there in the beginning, how many people
8 were there?

9 A It was like four.

10 Q Who besides you?

11 A It was a nurse beside me, on this side. A nurse for
12 her and Antwan was like almost at the foot of my bed onto,
13 to my left.

14 Q I am talking about in the very beginning when you
15 went into the operating room. Did they let Antwan in?

16 A No.

17 Q So at that point, before they let Antwan in, how many
18 people were there.

19 A It was four because they were prepping me to get the
20 C-section. I had got shaved. I pretty much went through
21 all the process of getting a C-section.

22 Q Was Dr. Miller there?

23 A No.

24 Q So were these, these three other people, were they
25 men, women?

1 A Women's.

2 Q Did you know what their role was, whether they were a
3 nurse, a doctor?

4 A No. I just knew that they was there.

5 Q Was one of those the nurse that had been in your
6 labor and delivery room?

7 A Yes.

8 Q As to the other two, had you ever seen them before?

9 A No.

10 Q So you getting prepped, they are shaving you. Were
11 you ready to go and get this surgery done?

12 A Yes.

13 Q What happened?

14 A Dr. Miller entered the room. He came to my side and
15 he had a conversation, he was like, a lot of women's don't
16 like to be cut. So whenever you feel like you have a
17 contraction you can start back pushing because women's
18 don't like to be cut.

19 Q Did he ask you if you --

20 A He didn't ask me did I still want to go through the
21 process or not.

22 Q When you signed the paper, were you signing the paper
23 because you wanted a C-section or because he wanted you to
24 have a C-section?

25 A He wanted me to have one.

1 Q All right. And then when you got to the operating
2 room, when he finally came in did he say anything about,
3 okay, well, let's go on with the operation?

4 A No.

5 Q What were the first words out of his mouth?

6 A A lot of women's don't like to be cut. So if you
7 feel like you want to push, when you have a contraction,
8 you can go back with the pushing.

9 Q Did you?

10 A Later on we prepared and my contractions started
11 back.

12 Q So once you agree to start pushing instead of having
13 the surgery, did they let Antwan back in?

14 A Yes.

15 Q So was the Doctor in by then?

16 A Yes.

17 Q So it was you, Antwan, the Doctor and how many other
18 folks?

19 A A nurse on each side of my bed.

20 Q Anyone else?

21 A That's it.

22 Q Was there plenty of room for all of you guys?

23 A Everybody pretty much was like close together.

24 Q Because of the size of the room?

25 A Yes.

1 Q How was Dr. Miller acting at that point?

2 A Just about the same.

3 Q What about the nurses?

4 A The same, they was calm.

5 Q Was Dr. Miller calm?

6 A No, he was, he been the same since he came in from
7 the first visit.

8 Q Did anyone ever tell you to stop pushing?

9 A No.

10 Q The nurses kept telling you to push?

11 A Yes.

12 Q What about Dr. Miller, did he keep telling you to
13 push?

14 A Yes.

15 Q They never stopped telling you to push?

16 A No.

17 Q At that point was the Doctor saying anything else to
18 you or, who was the next person you heard say something
19 other than push?

20 A Well, Antwan.

21 Q I want you, well, let me back up just a minute.

22 Let's position people in the room. Your head was at the
23 head of the bed?

24 A Yes.

25 Q And your, were your legs up in stirrups?

1 A Yes.

2 Q Was Dr. Miller in between your legs?

3 A Yes.

4 Q Did you have, well, was the nurse from the labor and
5 delivery room still there?

6 A Yes.

7 Q Where was she?

8 A On this side of me.

9 Q On the right side or you or the left?

10 A Right.

11 Q And was there another nurse on the other side?

12 A On the side Antwan was on.

13 Q Okay. Apart from the nurses, you and Antwan and Dr.
14 Miller, were there any other people in the room at that
15 time?

16 A No.

17 Q You don't remember anybody else?

18 A I don't remember by then.

19 Q Later on were there more people?

20 A Yes.

21 Q So once they started telling you to push again, you
22 said that you heard, well before you heard Antwan say
23 anything did one of the nurses do anything?

24 A When I started pushing one of the nurses crawled on
25 my bed and she was like, slumped over and she was like,

1 pushing like midway in my stomach down on my stomach.

2 Q You said she was on the bed, can you be more
3 specific?

4 A Her knees was like facing me but like her, the side
5 of her butt was mainly like closer to my face. When she
6 was bending down it is like the back part of her side,
7 butt was like facing my face when she was pushing.

8 Q And you got a big belly at that point. With her
9 rear-end in your face could you actually see where she was
10 putting her hands?

11 A No. All I know is that I can just feel she like
12 mashing on my stomach.

13 Q Even when she was doing that, did she get mean to you
14 or anything.

15 A No, she was still encouraging me to push.

16 Q Were both nurses always nice to you?

17 A Yes.

18 Q So then the lady has been pushing on you. At some
19 point you learn the head had come out?

20 A Yes.

21 Q How did you find out the head had come out?

22 A It was announced by the Doctor and the nurse that we
23 have a head, the baby's head is out.

24 Q Did they ever stop telling you to push or they still
25 wanted you to push?

1 A I still was like, they was like, keep pushing.

2 Q At some point you told us, was it around then when
3 you heard Antwan say something?

4 A Yes.

5 Q Tell me what he said and how he said it?

6 A When I made the last push, her head was out. I
7 heard, hey man, don't you think you are pulling on my
8 baby's head a little too hard.

9 Q And what did Dr. Miller say?

10 A Do you want this baby brain dead or retarded, I have
11 a certain amount of time to get this baby out and I have
12 got to do what I got to do to get this baby out.

13 Q Now, last week we heard Antwan basically give us that
14 same story. But his voice was a lot quieter than what I
15 just heard from you. I am not going to say it was a
16 gentle voice but it was, it wasn't that sharp edge to it.
17 Was it how you just described it?

18 A Yes.

19 Q How do you explain that you and Antwan said it
20 differently in court?

21 A He let his stage fright get the best of him of his
22 nerves. I guess he didn't want to portray, giving a bad
23 image of how he was.

24 Q Later on did you find out that he was really, really
25 angry at the Doctor?

1 A Yes.

2 Q So much he has to retrain himself of getting in his
3 face.

4 MR. DAVIS: Your Honor, I have let it go on for a
5 long time. I object to the leading.

6 THE COURT: I ask you to rephrase the question,
7 please. Sustained.

8 Q So tell me, after the delivery was over, whenever
9 y'all had a conversation, looking back. What did Antwan
10 tell you about how he was really feeling at that point in
11 time when he spoke to the Doctor?

12 A He came to, how that man was pulling on my baby's
13 head, I could have killed him in there.

14 Q So when did you first see that your Alexia had a
15 problem with her left arm?

16 A When the nurse cleaned her up and brought her to see
17 me.

18 Q After she cleaned up Alexia, where did she go from
19 the cleaning area, did she leave the room or did she take
20 her over to you?

21 A She was like actually cleaning her up in the room
22 where I was at.

23 Q So after she finished cleaning up Alexia did she let
24 you get a closer look or did she go straight out of the
25 room?

1 A She let us get a closer look.

2 Q And then left the room?

3 A Yes.

4 Q How long was it, as best you can remember, before the
5 nurse brought back Alexia to be with you in the bed?

6 A It was like a good ten minutes. After she cleaned
7 her she brought her and let me and Antwan look at her
8 before she carry her to the nurse's ward.

9 Q But so after she took Alexia away how long before she
10 brought her back?

11 A It was like an hour or so.

12 Q And where was Alexia for the rest of the
13 hospitalization?

14 A With us.

15 Q While you were in the hospital when is the time that
16 you saw Dr. Miller?

17 A Outside of the hospital.

18 Q Before you left the hospital?

19 A I didn't see him no more.

20 Q He never came back to the room to explain?

21 A No.

22 Q Did anybody else from the hospital come talk to you?

23 A The nurse. She explained it. I had a question
24 about, me and Antwan had a question about her eye, her
25 left eye had a slant to it like it was lazy and her arm.

1 And we were like, what is wrong with her arm and eye. And
2 that is when the nurse explained it to us. She was like,
3 her arm got pulled a little bit during delivery, should go
4 back in place in a couple of days.

5 Q Did a pediatrician come see you in the hospital?

6 A Before my discharge the pediatrician had to do like
7 an examine of her.

8 Q And you went ahead and got discharged after that?

9 A Yes.

10 Q Did you go back to see that doctor, pediatrician?

11 A Yes.

12 Q About how many times?

13 A I think at least two times.

14 Q Did you find a different pediatrician after that?

15 A Because my first visit, when she got discharged from
16 the hospital they told me she had a dislocated shoulder.
17 So when I did go back the second time, he checked her arm
18 again and he was like, it still seems like it is
19 dislocated shoulder. On my third visit he didn't even pay
20 her arm no attention. So that is what throws up a red
21 flag to me.

22 Q Where did you go?

23 A I went to Tri-County Pediatric.

24 Q Who is the first doctor you saw at Tri-County?

25 A Dr. Shaw.

1 Q How did Dr. Shaw treat you.

2 A On the first visit he examined her, he did a thorough
3 baby check, like a normal routine checkup.

4 Q And did you go back after that?

5 A Yes.

6 Q What happened then?

7 A On the second visit he was like, I don't like the way
8 her eye and her arm look. I am going to recommend you to
9 a specialist.

10 Q And with all of the various doctors and therapists
11 and surgeons that you have taken Alexia to see since 2007,
12 do you remember exactly who you saw when?

13 A Some doctors I can remember.

14 Q But in terms in the order of who you went to see
15 first and second?

16 A No.

17 Q At any rate, in those first few months, was there
18 some very significant medical treatment or surgical
19 treatment?

20 A She had surgery.

21 Q Where was that?

22 A MUSC.

23 Q Were you and Antwan there with her?

24 A Yes.

25 Q How many nights did you have to spend down there?

1 A Three.

2 Q How long did Alexia's surgery take?

3 A Fifteen hours.

4 Q When did you see her after the surgery?

5 A When the surgery was done, they put her in recovery,
6 it was like three hours after the surgery was done.

7 Q How did she look to you?

8 A She had a whole full body cast on.

9 Q A whole what?

10 A They had her with a full body cast, like in tubes all
11 in her nose and stuff like that.

12 Q A full body cast?

13 A Yes.

14 Q What were you saying about her nose?

15 A Tubes, they were feeding her through her tubes
16 because she had to be on a special medicine but it was
17 like, for your heart or something like that.

18 Q So she was getting, whatever food it was she was
19 getting through tubes in her nostril?

20 A Yes.

21 Q As far as you can remember, anything exciting at MUSC
22 other than the surgery itself?

23 A They were just a great hospital and doctor.

24 Q What about any, was there any treatment before the
25 surgery at MUSC to get her prepared for surgery?

1 A No.

2 Q Was there any treatment at MUSC after the surgery to
3 try to help her recover?

4 A Physical therapy.

5 Q Did you see her in between the body cast and physical
6 therapy?

7 A No.

8 Q When you first saw her, after the therapy started,
9 did you have to stay down there or did you have to go back
10 and forth or what?

11 A They did therapy down there but they also, for me to
12 find a therapist where I live to drive her to.

13 Q And you found a therapist?

14 A Yes.

15 Q Before we get there. Let me ask you, when you left
16 Charleston to head back to a local therapist up here, did
17 you, from your observations did it look to you as a mother
18 like she had improved some?

19 A We noticed that she did approve, because her eye
20 wasn't lazy no more. So we knew that it did do some
21 justice because her eye straightened up. And he
22 guaranteed that she might can improve and she might not
23 improve. So we were just happy seeing her eye just
24 straightened up.

25 Q What about her arm, did it look to you, as her mom,

1 like her arm had improved any?

2 A No, just hanging to her side.

3 Q After she started getting therapy up here in the Rock
4 Hill area, was it Rock Hill or Charlotte where you went to
5 therapy?

6 A It was in Rock Hill.

7 Q So in Rock Hill, when she started getting that
8 therapy did it seem like her arm was improving at that
9 point?

10 A No, it was the same.

11 Q But at some point, well, at that point could she move
12 her arm at all?

13 A No.

14 Q Move her elbow or fingers?

15 A No, she would try but no movement.

16 Q In court the other day, we saw her lift her left arm.
17 I didn't have a good angle but it was something like this,
18 from where I was sitting?

19 A That is the only part of her arm can like ever been
20 going.

21 Q But that is progress from where she was, right?

22 A Pretty much. I think, at first it was just hanging.
23 But it being like locked in that position, she can kind of
24 lift it because it is all, half way there. But as it was
25 hanging she couldn't lift it at all.

1 Q But the time came when she could lift it on her own
2 to about here?

3 A Yes.

4 Q And do you attribute that improvement to therapy or
5 being a good mom or what?

6 A Well, both therapy, her therapies helped her out a
7 lot.

8 Q And let's talk about that. Your first therapy was in
9 Charleston at MUSC?

10 A Yes.

11 Q The second therapy was, do you remember the name of
12 the second therapist?

13 A It was like a home group therapy that they like come
14 to your house to a certain age.

15 Q And do you remember what the age was?

16 A It was like up to age three, they offered therapy.

17 Q After age three did you find another therapist?

18 A She was going to a pre-K school which they had a
19 therapist inside of the school. So she was getting
20 therapy through the school district.

21 Q At first how frequently was she getting that?

22 A Once a week through school. The nurse would come and
23 get her out of class.

24 Q Were you happy with just one therapy a week or did
25 you do something to change the frequency?

1 A I changed the frequency.

2 Q Tell us about that?

3 A I went and got another therapist which is Carolina
4 Pediatric Therapy.

5 Q And where are they located?

6 A Rock Hill, South Carolina.

7 Q So how did they do, were you pleased with what they
8 were doing?

9 A Yes.

10 Q And you were still getting the treatment in the
11 school?

12 A Yes. And she also had a couple of treatments through
13 Piedmont Medical Center.

14 Q Tell me about that?

15 A She went through them a couple of visits and the
16 therapist that actually did a couple of visits said she
17 had, I guess a lot of people don't like to deal with the
18 injury of, they say you master some of your tasks. So I
19 didn't agree with that so that is when I went to Carolina
20 Pediatric Therapy. And that is where she has been in
21 therapy for a, almost ten years.

22 Q All right. Angela, we have got an exhibit already in
23 evidence. Plaintiff's exhibit 21. Is this the summary of
24 the medical bills?

25 A Yes.

1 (Whereupon, Plaintiff's Exhibit 21 was admitted into
2 evidence.)

3 Q I want to ask you a few questions about this. These
4 are past medical expenses that we were able to gather up,
5 right. You have got it here in three categories.
6 Evaluations and medical treatment of the brachial plexus
7 birth injuries; \$19,122 and change. You have got
8 occupational and physical therapy of \$72,217 and change.
9 And you have got charges for the nerve resection surgery
10 at MUSC for \$129,711.20. Making a total of, I am going to
11 round it down, \$221,000.00. Correct?

12 A Yes.

13 Q Those are the bills that you could find?

14 A Yes.

15 Q And we went looking?

16 A Yes.

17 Q And then on the next page you break these down into
18 three categories that I just mentioned. I just want to
19 ask you about a few of these. One of them on here is
20 Shriner's Hospital. There is one in South Carolina in
21 Greenville. What is your understanding about whether the
22 surgeons there that work on brachial plexus are in the
23 Greenville office or in another office like Philadelphia?

24 A Philadelphia.

25 Q But did you find a way to meet one of the

1 Philadelphia surgeons at Shriner's in Greenville?

2 A Yes.

3 Q Were they able to offer anything that they thought
4 would be a benefit?

5 A They would hold a brachial plexus clinic there I
6 would carry Alexia to.

7 Q At that clinic was she getting any kind of meaningful
8 treatment or improvement?

9 A They brought other kids from like around the world
10 that had other brachial plexus injuries and like introduce
11 her to them just to get a feel, show her that other kids
12 do have this injury.

13 Q I see. So it was really more socialization and
14 self-esteem?

15 A Yes.

16 Q The first date of therapy that we have a bill for is
17 in May of 2007 and it runs through August of 2007 at
18 Amasub, (phonetic), Outpatient Therapy. How does that fit
19 into the therapy you were telling us about?

20 A That was through Piedmont Medical Center.

21 Q Is that where you got therapy the first time when you
22 came back from --

23 A Yes.

24 Q And then we have some more Amasub Outpatient Therapy,
25 Carolina Pediatric Therapy and then two individual names,

1 Diane, I don't want to try to pronounce her last name.

2 And then another individual, Jyothera or something, I
3 can't pronounce her name either. But then finally, some
4 prosthetics from Agile Prosthetic Orthopedic. Is that
5 something that you got through the therapy office, the
6 braces and so forth?

7 A Yes.

8 Q Do you have those here with you? Tell me about this,
9 what does Alexia do with this?

10 A This is for when she go to sleep at night that she
11 puts her elbow in this one to prevent, when she got to
12 sleep that its like tucking up under so. Just to keep her
13 elbow straight.

14 Q So the natural tendency to go in like this?

15 A When she puts it in is to keep it straight, so when
16 she go to sleep at night they are trying to keep it for,
17 where it don't, because she has a tendency of like
18 sleeping and her arm is like all the way like this. So
19 they put this on her to keep straight, to keep her from
20 bending it a lot.

21 Q Is this for her hand?

22 A Yes. It is to keep her hand, her hand bends a lot so
23 that is a thing to keep her hand just straight out.

24 Q Is there other braces and splints and orthopedic
25 devices across the years?

1 A Yes.

2 Q As she grows up.

3 A I recommend this one a couple of months ago because I
4 was like, can you make it, it is just like her wrist is
5 sprung or something so she won't have attention on her at
6 school. So they made this one for her to put her hand in
7 at school, where it won't bend so it just like her wrist
8 or something just, something is wrong with her wrist. It
9 will position her hand better.

10 Q I understand that is good physically. But you are
11 saying something else too that it helps her hide her
12 problem from other kids?

13 A Yes.

14 Q Tell me about that.

15 A They will think that, oh Alexia, you hurt your wrist
16 instead not saying, her hand is bent. So they will just
17 think that she has got like a wrist injury or something.

18 Q Have you taken pictures, of course you have taken
19 pictures of Alexia across the years, right?

20 A Yes.

21 Q We just pulled out a few. Can you just, when we pull
22 them up, could you pull up the baby picture. Are you able
23 to see that far?

24 A Yes.

25 Q Your eyes are much better than mine. What do you see

1 in this picture that you have already talked about?

2 A Her eye is lazy.

3 Q How old was she when this picture was taken?

4 A I think around three months.

5 Q That is shortly before surgery?

6 A Yes.

7 Q Did the surgery improve that right away?

8 A She came out and, her eye was straighted when they
9 brought her out. It approved like right then.

10 Q Tell me about this picture?

11 A That is after surgery.

12 Q She seems to be taking it pretty well, seems to be
13 kind of happy there. Could you tell us what her mood was
14 in those days as a youngster?

15 A Happy baby.

16 Q Did that happy baby, did the happy baby ever change
17 to a not so happy?

18 A Yes.

19 Q Tell us about the change?

20 A From maybe kindergarten through the sixth grade she
21 was happy. But then started getting like seventh through
22 ninth her attitude in everything just completely changed.

23 Q Had she been sociable and active with her peers of
24 her age group before then?

25 A Yes.

1 Q After you saw the change has she been sociable and
2 active with others?

3 A The one person that she is sociable active with his
4 with my niece.

5 Q We have got this last picture. Approximately how old
6 was she in that one?

7 A Last week.

8 Q So I want to ask you about a couple of things. I see
9 a hoodie, I see a baggie, sweatshirt part of a hoodie.
10 And I see that her left hand is not visible, left arm is
11 not visible. Can you tell me what is going on there?

12 A Her left arm is like actually tucked in her pocket.

13 Q What is that all about?

14 A She tends to hide her arm a lot when she goes in
15 public.

16 Q Has she told you why that is?

17 A At first I used to fuss at her during the summertime.
18 It will be 100 degrees outside, we are getting ready to do
19 to a cookout. Alexia used to put on a hoodie. And I used
20 to be like, girl, where you going with that hoodie. It is
21 100 degrees outside. But not knowing when she do put it
22 on she sticks her arm in there. So I finally realized
23 that she was actually hiding her arm.

24 Q Do you know whether other children at school in the
25 seventh grade and after that, do you know whether children

1 at school were teasing her, making fun of her, bullying
2 her --

3 MR. DAVIS: Your Honor, that is calling for indirect
4 hearsay and I object to that.

5 THE COURT: I am going to allow the question as
6 phrased.

7 A I wouldn't know because my child is so bottled up.
8 But I done heard my nine-year-old done bully her before.
9 So I can image somebody at school because she come to me
10 and say, mom, if every time she want her hair in a
11 ponytail, that is why, I have got one arm.

12 Q Let me make sure I understand. You are saying that
13 Alexia's younger sister puts her own hair in a ponytail.
14 She knows that Alexia can't so she is making fun of
15 Alexia?

16 A She asked Alexia to try to put, the sister go to
17 Alexia and say, can you help me put my hair in a ponytail.
18 And Alexia will say, I cannot put your hair in a ponytail.
19 And she was like, that is why you got one arm and she will
20 leave out of the room. And Alexia will come and say, mom,
21 Arie saying that is why I have got one arm.

22 MR. DAVIS: Your Honor, this is hearsay. I object
23 again.

24 THE COURT: Counsel, can you approach.
25

1 (Whereupon, a bench conference was held in the
2 presence of the jury but out of the hearing of the
3 jury.)

4 Q Angela, I don't want you to say what somebody told
5 somebody that told you. Have you seen, tell us whether or
6 not you have seen Alexia crying?

7 A Yes.

8 Q Do you know what had happened before she started
9 crying?

10 A The other day when I asked her to take a picture for
11 me she started crying because she do not want to, want me
12 or nobody taking pictures of her. So I said, Alexia, can
13 you let me take a picture of your arm. And she busted
14 out, I am tired of this, I don't want to take pictures any
15 more. This is very aggravating me. So if, I can't even
16 take a picture of her without her having an outburst of me
17 taking a picture of her.

18 Q Obviously we have seen that Alexia has issues with
19 her left arm in terms of how it looks and how it moves.
20 Can you give us an idea of how that affects her in her
21 regular activities in terms of what she just can't do or
22 she can't do it in a normal way; or maybe it takes her a
23 very, very long time to do it. Can you give us some
24 examples of that?

25 A Once she can, like try to tie her shoe. But she will

1 place her hand down and use her thumb as a hold so she can
2 wrap the thing around her thumb and then she will just
3 pull it. She tries to tie her shoe but it takes her a
4 while to tie her shoe.

5 Q Are you proud of her for doing it the way she does?

6 A Yes. Even her therapy was proud of, she learned how
7 to tie her shoe.

8 Q What are some of the other things she can't do or
9 can't do the normal way?

10 A She can't cut an apple, she can't ride a bike, she
11 can't pretty much do nothing.

12 Q Has she ever ridden a bike?

13 A One time.

14 Q Tell us about that?

15 A It was like they had to do a project in the fourth
16 grade, Rock Hill has a bike facility. So the class went
17 there for a field trip but they had to ride a bike.

18 Q So what arrangements, if any, were made to
19 accommodate Alexia?

20 A I had to sign a paper, that the school teacher had to
21 have it where she had a person to put special training
22 wheels on the bike for Alexia to, for the bike to stand up
23 and keep her balance.

24 Q And what is your understanding of why she did that?

25 A I guess she didn't want Alexia to feel left out

1 because everybody in her class was, had to ride the bike
2 and she didn't want Alexia to feel left out, she couldn't
3 ride a bike.

4 Q If Alexia fell off of a bike to the left, would she
5 have any way to protect herself?

6 A No because she had a incident one day at school that,
7 she was running and playing. And she did actually fall
8 and skint her whole side of her face up.

9 Q On the left side?

10 A Yes.

11 Q She fell and just couldn't --

12 A To brace herself for falling.

13 Q Could you give us some other examples of things she
14 cannot do?

15 A She cannot play a video game, she pretty much can't
16 do nothing. She cannot wash her back, so I have to try to
17 help her wash her back.

18 Q That is a good point. Let's talk about dressing and
19 personal hygiene kind of things. What do you have to do
20 for her in terms of dressing and staying clean and doing
21 hygiene type things?

22 A Well, she pretty much, I buy her that, she can put on
23 easy like a hoodie or a pair of jogging pants. That was
24 on her Xmas list, jogging pants and hoodies and crocks.
25 So that is what everybody got her.

1 Q So she can handle that kind of clothes?

2 A Yes.

3 Q What about keeping her clean like washing her hair?

4 A I have to wash her hair or whoever does her hair has
5 to wash her hair.

6 Q Any other things like that she can't do?

7 A She can't put her hair in a ponytail.

8 Q What about in the kitchen, is she able to like twist
9 open a gallon of milk?

10 A No.

11 Q Or a bottle of water, soft drink, soda?

12 A No.

13 Q Is she able, we saw that rocker cutter thing the
14 other day, is she able to cut meat now that she has that?

15 A Yes.

16 Q Did she before?

17 A No.

18 Q How did you wind up getting that, was that through
19 the therapist?

20 A Yes.

21 Q Have some of the therapists provided assistance, the
22 aids and devices to help her do things, has that benefited
23 her?

24 A Yes.

25 Q Let's talk about sports. With you and Antwan and

1 your family being seriously into athletics. Is that a
2 value that is expressed throughout the home?

3 A Yes.

4 Q With trophies and photos and such?

5 A Yes.

6 Q Has Alexia tried to follow in your footsteps?

7 A Yes.

8 Q Tell us about that?

9 A She was like, mama, I want to try out for basketball.
10 So we prepped her, even her therapist worked with her to
11 pretty much like use one hand. If something comes she
12 will catch the ball and just brace it in. So pretty much,
13 she was, her therapist and me and a family member was
14 preparing for her to try out.

15 Q What happened?

16 A She came home and said, mom, I didn't make the
17 basketball team.

18 Q Any other sports?

19 A Volleyball.

20 Q Tell us about that?

21 A She was like, I am going to try out for volleyball.
22 So I let her therapist know. So her therapist, every time
23 she go to therapy, it is on Wednesday, her therapist would
24 prepare her to like, we had Alexia, even though she
25 couldn't use this hand, she was like prop her right hand

1 up under your left hand. If the ball was coming toward
2 you just use your right hand to knock the ball up like
3 that. So when she went to try out, she was like I didn't
4 make it. So when I told her therapist she was even upset
5 because she was like, I prepared you good, you was pretty
6 good to me. So I took upon myself, I was going to call
7 the coach and say, why didn't my child make it. But I
8 just went on, I had to let it went.

9 Q Were there other activities at school that she tried
10 out for?

11 A After that she just pretty much, her confidence just
12 shot down.

13 Q We have heard about the piano playing. Is that,
14 based on your observations, is that something that has
15 been good for her?

16 A Yes.

17 Q Has she applied herself to do the very best she
18 could?

19 A Yes.

20 Q When she is doing that, she just plays, as we heard,
21 plays half a piece of music. Is she able to turn the
22 sheet music, pages?

23 A No, her piano teacher actually sits beside her and
24 whatever notes that she need to hit, she will hit one note
25 and the piano teacher will flip the music for her.

1 Q Let's talk about some of the things you are really
2 proud of about Alexia. What are your, what is your
3 reaction to the progress she has made playing piano?

4 A I am proud of her very much because she progress
5 because Ms. Kim, before the virus hit she was going up on
6 her stage, of the piano. She was liking her level, four
7 or five before the corona hit.

8 Q How is she doing in school?

9 A She is doing good in school. She is actually in
10 Spanish V.

11 Q That is an advanced --

12 A Advanced Spanish class because she has been taking
13 Spanish ever since kindergarten.

14 Q What are some of the other things you are proud about
15 of Alexia for?

16 A I am proud about her is that, at least she tried to
17 do things.

18 Q What are your hopes and dreams for Alexia?

19 A My hopes and dreams that she can, all she can be to
20 fight her injury, don't let nothing get you down. Keep
21 pushing and trying and don't never give up.

22 Q Thank you. Please answer any questions Counsel may
23 have.

24 THE COURT: Mr. Davis.

25 CROSS-EXAMINATION

1 By Mr. Davis:

2 Q The last child you had born prior to Alexia, I may
3 get the name wrong but I will give it a try, Aquavian?

4 A Yes.

5 Q Did I get it right?

6 A Yes.

7 Q Thank you. And he was born January 18, 1999?

8 A Yes.

9 Q And he weighted 9 pounds, 11 ounces?

10 A Yes.

11 Q Did you have any problems with his birth?

12 A No.

13 Q And Alexia was born April 5 of 2007 and she weighed
14 nine pounds, six ounces?

15 A Yes.

16 Q And that was your fourth child?

17 A Yes.

18 Q And you had another child after that?

19 A Yes.

20 Q Any problems of the birth of the fifth child?

21 A No.

22 Q You agree that Dr. Miller, as things were going along
23 closer to the end of labor, told you that he had some
24 concern about your baby's heart rate and that if the baby
25 could not be delivered pretty soon, he would have to

1 consider doing a cesarean section, correct?

2 A His exact words were, you gone make the baby heart
3 rate go down. He did not presume that to me, that her
4 heart rate was down. Because usually the nurse will be
5 the one that monitors the heart rate the whole entire
6 time.

7 Q Well, to refresh your memory, Ms. Patton, I will ask
8 you to look with me and I am going to hand you the
9 original deposition that I took of you under oath on
10 February 22, 2011. Do you remember me taking your
11 deposition?

12 A Yes.

13 Q Do you remember being under oath to tell the truth,
14 the whole truth and nothing but the truth?

15 A Yes.

16 Q Just like you are sworn to tell the truth today?

17 A Yes.

18 Q Let me ask you, let me hand you this.

19 MR. DAVIS: Your Honor, can I open the deposition?

20 THE COURT: Yes.

21 Q Have you had a chance to review your deposition prior
22 to today?

23 A No.

24 Q Let me hand you the original. And if you would,
25 please Ma'am, turn to page 40 of your deposition. Let me

1 know when you are at page 40. Okay.

2 A Yes.

3 Q If you will look on the left hand-side of the page
4 there are numbers, 1 through 25, those are called line
5 numbers. If you will go with me to line 17. I am going
6 to read the question and answer and then I am going to ask
7 you a question about it. So read with me.

8 My question. So, he, and that would be Dr. Miller.
9 He said something to you that if you don't push harder or
10 don't push better he is going to have to do a cesarean
11 section because the baby's heart rate is going down. Is
12 that right.

13 Answer. He said I would make it go down if I didn't
14 push her out.

15 Did I read that correctly?

16 A Yes.

17 Q Let's go back to my question just above that at line
18 nine. My question to you. When you described for me a
19 moment ago that the Doctor said he would have to cut you,
20 does that mean that he said that he would have to do a
21 cesarean section. Is that what you meant.

22 Answer. Yes, that is how he presented it to me

23 Question. But you understood that to be a cesarean
24 section.

25 Answer. Yes.

1 Did I read that part of your deposition correctly, Ms.
2 Patton?

3 A Yes.

4 Q Okay. Thank you. Do you recall whether or not
5 Alexia's heart rate went down at some point?

6 A No.

7 Q You don't recall that?

8 A No.

9 Q Your understanding is to why Dr. Miller offered the
10 cesarean section, which you consented to, was because of
11 your baby's heart rate. And that if you didn't get her
12 delivered then her heart rate was going to go down. Is
13 that your understanding?

14 A Yes.

15 Q And you were concerned about your baby's heart rate
16 so that you were ready to get the cesarean section. Is
17 that fair?

18 A Yes.

19 Q Beside Dr. Miller and you and Antwan, do you recall
20 that there were like four or five nurses in the operating
21 room. Is that right?

22 A Yes.

23 Q And you recall that one of the nurses, I think her
24 name was Julie Bibb, did some suprapubic pressure, is what
25 medical people call it, as she was pushing down near the

1 pubic bone to try to help the baby get delivered. Is that
2 right?

3 A Yes.

4 Q And I think you said just a moment, questioning by
5 Mr. Graham, that Julie Bibb was actually, she had climbed
6 up on that operating room table and her rear-end was in
7 your face as she was pushing down?

8 A Yes.

9 Q Is that what you said, does that seem a little
10 unusual to you having had three babies before?

11 A Yes. I think was, they going to kill me in here.
12 That is what I am thinking. I haven't experienced that
13 like in delivery before. I just thought it was going to
14 be a normal delivery.

15 Q Yes, ma'am. And you recall that Ms. Bibb, the nurse,
16 was pushing down on the baby for about a minute. Is that
17 right?

18 A Well, it could have been a minute or so. But like I
19 say, I knew she was pushing on my stomach. But I can't
20 recall for how long that she was actually up there
21 pushing.

22 Q Well, if you would turn with me, it was a long time
23 ago and we talked earlier. If you will look at page 62
24 with me, please, at line one. Let me know when you there,
25 please. Are you with me on page 62, Ma'am.

1 A Yes.

2 Q Thank you. We are talking, I was asking you
3 questions and you and I were talking back and forth about
4 Julie Bibb. And line one, it is an answer. Yeah, it was
5 like she was just pushing down on the baby.

6 Question. How long approximately was she pushing
7 down on the baby. Do you know?

8 Answer. About like a minute.

9 Did I read that correctly?

10 A Yes.

11 Q About like a minute?

12 A Yes.

13 Q Thank you. And then line 11, well, after she
14 finished pushing she got up, she got down off the table
15 after that. Is that right?

16 A Yes.

17 Q Okay. You really couldn't tell if Ms. Bibb, the
18 nurse, was real hard, if it was real hard pushing or not.
19 You really couldn't tell. Is that fair?

20 A Yes.

21 Q And as you recall it was like a motion and she was
22 like pushing and she did it just one time for about a
23 minute and that was it. Is that right?

24 A Well, I mean I am in the process, she is on my
25 stomach and I am just in panic and so I ain't going to be

1 actually timing how long a person is up on you. All I
2 know she was on my stomach pushing down and I felt her on
3 my stomach pushing down.

4 Q For about a minute?

5 A It could be longer than that. But like I say, I
6 wasn't really timing her, anything at the time.

7 Q Let's look at line 19, page 62.

8 Question. So she pushed for about a minute and got
9 off the table and then what happened after that.

10 Answer. I can't remember what happened after that.
11 Did I read that correctly?

12 A Yes.

13 Q But Alexia wasn't born yet when she got off the
14 table, right?

15 A It was shortly, she came down, is when her head came
16 out.

17 Q Well look at line 24.

18 Question. But Alexia wasn't born yet.

19 Your answer. No.

20 Did I read that correctly?

21 A Yes.

22 Q Thank you. Do you remember that there were two other
23 nurses there. And one was holding one leg and one was
24 holding the other leg. One nurse on each side of you
25 holding one leg and pushing your legs back towards your

1 head. Is that right?

2 A Yes.

3 Q And you can't remember how long those nurses were
4 holding your legs back. Is that fair?

5 A Yes.

6 Q You do remember that Antwan, do you remember being on
7 your left side of your bed, had been behind one of those
8 nurses on your left side, he was like behind one of them,
9 wasn't he?

10 A She was right here and he was like on the bottom
11 side, I am going to just say my feet.

12 Q Let's look at page 63, line 22, please Ma'am.

13 Line 19, Question. Okay, how long did the nurse on
14 one side and the nurse on the other hold your legs.

15 Answer.

16 THE COURT: Hold one second, Mr. Davis.

17 A What page did you say.

18 Q Page 63, Ma'am. Thank you, Judge. Tell me when you
19 are there.

20 A What line.

21 Q Let's pick up on line 19. My question there.

22 Question. How long did the nurse on one side and the
23 nurse on the other side hold your legs.

24 Answer. I can't remember.

25 Question. Would Antwan have been behind one of those

1 nurses on your left side.

2 Answer. Yes, he was like behind one of them.

3 Did I read that correctly?

4 A Yes.

5 Q Do you remember whether or not, there was a drape
6 that covered your bottom? Do you remember that, was there
7 a drape?

8 A No.

9 Q There was not a drape?

10 A No. It was like the sheet that they had, that was
11 over me, it wasn't like a drape.

12 Q You know what a drape is, a surgical drape?

13 A Yes.

14 Q And you didn't have a surgical drape?

15 A No.

16 Q Okay. During the two or three minutes, just before
17 Alexia was born, was delivered, you do not remember
18 anything that Dr. Miller did or anything that Dr. Miller
19 said, correct?

20 A Aside to what he said to Antwan.

21 Q Let's look at page 44 of your deposition taken in
22 2011, please Ma'am. Let me know when you are there.

23 A I am here.

24 Q Question, line one. And the two or three minutes
25 just before Alexia was born, do you remember anything that

1 Dr. Miller did or said that sticks out in your mind.

2 Answer. No.

3 Did I read that correctly?

4 A Yes.

5 Q Nothing further.

6 THE COURT: Redirect?

7 MR. GRAHAM: Yes, sir.

8 REDIRECT EXAMINATION

9 By MR. Graham:

10 Q Let's just, do you remember the story about blind men
11 trying to feel the parts of an elephant.

12 MR. DAVIS: Objection, Your Honor. This is not a
13 question and I didn't talk about elephants on my cross.

14 THE COURT: Let him finish the question and I will
15 make a ruling. Go ahead, Mr. Graham.

16 Q In the same way by analogy as a blind man might feel
17 a elephant, (inaudible). Let and, perception matters.
18 What I want to ask you, when you were talking about him
19 being behind the nurse that was on your left, let's think
20 about what your, (inaudible).

21 COURT REPORTER: Can't hear you.

22 Q When you were talking about, in the deposition,
23 talking about Antwan being behind the nurse on the left,
24 okay. You are lying down in bed, the nurse is on your
25 left, Antwan is here.

1 MR. DAVIS: Your Honor, first of all it is leading.
2 It is not even a question. He is just demonstrating
3 things and I object.

4 THE COURT: You need to rephrase the question, Mr.
5 Graham.

6 Q You testified, didn't you, where was Antwan standing
7 with regard to the Doctor at the time of delivery?

8 A Beside the Doctor.

9 Q So if you are lying down in bed, and a nurse is here
10 and Antwan is standing beside the Doctor down there, from
11 your perception is he behind the nurse?

12 A Yes.

13 Q Now there was a question, obviously there is a
14 disconnect between the deposition testimony that you
15 didn't, nothing stood out in your memory in the last two
16 or three minutes. And you gave some pretty vivid
17 testimony about what stands out in your mind now. Can you
18 explain why you would be able to remember and tell us
19 about that today and not have it stand out in your mind at
20 the time of the deposition?

21 A As time progresses, during delivery, what I was going
22 through, I was experiencing a lot. So some things I did
23 remember and some things I did forget. But as things
24 progressed later on, things was coming back to me.

25 Q When you gave the deposition, back in, I think it was

1 2011?

2 A Yes.

3 Q Had you been living with the case like you have been
4 getting ready for this trial and having lawyers asking you
5 questions and such?

6 A Yes.

7 Q So as you have listened to others to what they have
8 to say, has that brought back memories?

9 A Yes.

10 Q You didn't have back in 2011?

11 A Yes.

12 Q Is the way that Antwan talked to Dr. Miller and the
13 way Dr. Miller responded, something that --

14 MR. DAVIS: Your Honor, I never asked him, her
15 anything on cross about what Antwan said to Dr. Miller.

16 MR. GRAHAM: You asked if she remembered --

17 THE COURT: Hold on, let me make my ruling first. I
18 will overrule the objection. Go ahead.

19 Q Having listened to the various testimony and
20 listening to your husband talk the other day about those
21 last few minutes, now that you have had that memory come
22 back, at this point, tell us whether or not it is a vivid
23 memory and whether or not it is seared into memory?

24 A It was like, when he was explaining it, I can picture
25 it as he said it in the delivery room. It brought back a

1 lot of memories when he was speaking.

2 Q Did you have a watch on?

3 A No.

4 Q Was there a clock on the all?

5 A No.

6 Q Were you counting seconds or minutes?

7 A No.

8 Q Did you have any conception of time?

9 A No.

10 Q What were you doing those last two or three minutes?

11 A Wondering, I am ready to get this delivery over
12 before they kill me. That is what my perspective was.

13 Q Okay. So looking back on it now compared with when
14 you were at the deposition, back then did you, did you
15 have any conception of how many minutes it was before
16 delivery that the conversation took place?

17 A No.

18 Q Even now, even now do you know exactly what the time
19 was when that conversation took place?

20 A No.

21 Q Thank you.

22 THE COURT: Mr. Davis.

23 RECROSS-EXAMINATION

24 By Mr. Davis:

25 Q Do you still have your deposition.

1 A Yes.

2 Q Would you look on page 59, please Ma'am, tell me when
3 you are at page 59 and I will direct you to the line?

4 A I am ready.

5 Q Line five. Questions. If after today something
6 comes to mind that you remember about this case, that is
7 any conversations with Doctors, particularly Dr. Miller,
8 nurse or events surrounding Alexia's birth, either just
9 before her birth or just after her birth that I have asked
10 you about which you have honestly told me that you don't
11 recall, and I will respect that. If after today something
12 comes to mind, oh I remember this, or oh I remember that,
13 would you agree to tell your attorney of those facts. And
14 you said, yes. Right?

15 A Yes.

16 Q When did you first tell your attorney about the
17 things you have testified today, that you didn't testify
18 to in your deposition.

19 MR. GRAHAM: Objection, Your Honor.

20 THE COURT: I am going to sustain the objection.

21 Q Nothing further.

22 THE COURT: Mr. Graham, any redirect?

23 REDIRECT EXAMINATION

24 By Mr. Graham:

25 Q Ma'am, as I saw, as I was reading along with Mr.

1 Davis I saw that the lawyer representing you at that
2 deposition was Ms. Waters. I wasn't there, was I?

3 A I didn't hear your question.

4 Q I am sorry. As I read along with the deposition that
5 Mr. Davis was asking you about, I saw that the lawyer
6 representing you at the deposition was Ms. Mary Waters.

7 A Yes.

8 Q I wasn't at the deposition, was I?

9 A No.

10 Q That is all.

11 THE COURT: Mr. Davis.

12 RECROSS-EXAMINATION

13 By Mr. Davis:

14 Q Mr. Waters was working for Mr. Graham that day. Do
15 you understand that, didn't you?

16 A Yes, but he wasn't in the presence.

17 Q Thank you very much.

18 THE COURT: Mr. Graham?

19 MR. GRAHAM: Nothing further.

20 THE COURT: Ma'am, you can step down. Counsel, can I
21 see y'all briefly?

22 (Whereupon, a bench conference was held in the
23 presence of the jury but out of the hearing of the
24 jury.)

25 MR. DAVIS: We call Dr. Susan Lupo to the stand.

1 Susan Lupo, being
2 first duly sworn, testified as follows:

3 DIRECT EXAMINATION

4 By Mr. Davis:

5 Q Doctor, would you please introduce yourself to the
6 jury.

7 A My name is Susan Lupo. Last name is spelled L-U-P-O,
8 middle name, Elizabeth.

9 MR. DAVIS: Your Honor, it would be okay if she were
10 comfortable removing her mask.

11 THE COURT: Please, Doctor, if you don't mind on the
12 witness stand.

13 MR. DAVIS: Do you feel comfortable doing that,
14 Doctor?

15 MS. LUPO: I was told that I could keep it on.

16 MR. DAVIS: You may but I want to be sure that we
17 hear you clearly.

18 THE COURT: Ladies and gentlemen, if any of you are
19 having trouble understanding the Doctor when she speaks
20 just raise your hand, please. Okay.

21 Q Dr. Lupo, are you a Medical Doctor?

22 A Yes, sir.

23 Q Give the jury just a thumbnail overview of your
24 training, education and background as a physician.

25 A I have a BA Degree from Wake Forest University,

1 followed four years later by my MD Degree also at Wake
2 Forest University School of Medicine. I did an internal
3 medicine residency at North Carolina Baptist Hospital also
4 in Winston Salem. And then I went to University of
5 Pennsylvania where I did my anesthesiology training. I
6 did a residency in anesthesiology.

7 Q How long was your residency in anesthesiology?

8 A I did a combined, I combined the two residencies and
9 was Board eligible after five years. And then I did
10 another six months of cardiac training. So I was in
11 post-graduate training for five and a half years.

12 Q Okay. And tell the jury where you began to work as
13 an anesthesiologist?

14 A I moved to Charlotte in 1984, maybe, I think.

15 Q And where did you work?

16 A I was working what used to be Presbyterian Hospital.

17 Q At some point did you work in Piedmont Hospital?

18 A I did. I began to work there in 1990.

19 Q Have you ever been the MD anesthesiologist in the
20 operating room at Piedmont when a cesarean section was
21 being done?

22 A Yes.

23 Q Do you have any idea how many times?

24 A No, I couldn't begin --

25 Q More than once?

1 A Yes.

2 Q And during that career at Piedmont as an
3 anesthesiologist, in the cesarean sections that you were
4 the anesthesiologist for in the operating room, Dr. Miller
5 ever one of the physician's?

6 A Yes. Of course, he was a member of one of the GYN
7 groups that we worked with.

8 Q Have you ever spoken to Dr. Miller about this case?

9 A No.

10 Q Have you ever spoken to me about this case?

11 A No, sir.

12 Q I want to show you and we will mark these as
13 exhibits, copies of records, it is called a pre-anesthesia
14 questionnaire. And then, so one page, anesthesia record.
15 Let me get these marked.

16 MR. DAVIS: Your Honor, exhibit number 27 is
17 questionnaire; and exhibit 28 is the anesthesiologist,
18 (inaudible.)

19 THE COURT: Any objection?

20 MR. JORDAN: Your Honor, can I look at these briefly.

21 THE COURT: Certainly.

22 MR. JORDAN: No objection, Your Honor.

23 (Whereupon, Defense Exhibits 27 and 28 were admitted
24 into evidence.)

25 Q Doctor, if you can look at 27 and 28, and ask you to

1 look at those a moment. And have you seen those before
2 today?

3 A I have, yes sir.

4 Q Is that a result of my office sending those to you
5 for your review?

6 A Yes.

7 Q And your deposition was taken in this case a long
8 time ago, like everybody else's?

9 A Yes.

10 Q Describe the pre-anesthesia checklist. Tell the jury
11 what that is about?

12 A Essentially this is an evaluation of the patient's
13 health status and readiness for an anesthetic. A lot of
14 questions about health related questions on the left side
15 of the page which, of course, with obstetrics with young,
16 healthy patients is usually negative.

17 Q If you can speak up just a little bit, please. Pull
18 yourself up to the microphone.

19 A The right side of this form has a place for lab work,
20 it has an area for a cursory physical examination for out
21 purposes. As you probably know the airway management is a
22 big deal for us so we do an airway management, evaluate
23 the patient, the intention to be sure that we won't do
24 harm to the teeth if we have instrument the airway. So
25 that is a big, the biggest part of this in obstetrics

1 basically. There is an ASA classification to 2E on here
2 and that stands for American Society of Anesthesiology
3 Class 2 and E stands for emergency.

4 Q Did you fill out that form?

5 A I did.

6 Q And who do you typically talk to to get that
7 information for your preanesthesia checklist record?

8 A It looks like the, there is a signature at the bottom
9 of the left half, the health questionnaire that I cannot
10 read. Many times the RN in the labor room who is taking
11 care of a laboring patient would complete that for us.
12 And there are markings on there that are not my writing.
13 So I think that is what happened.

14 Q And the other record is called the anesthesia record?

15 A That's right.

16 Q And did you sign and authenticate at the time?

17 A I did.

18 Q I want to get to your record in just a moment, just
19 hold that aside. I want to ask you about a cesarean
20 section, first, let's be sure we understand. You have no
21 independent recollection of this particular cesarean,
22 proposed cesarean section.

23 A That's correct.

24 Q All right. So generally then, in your experience in
25 having done that before at Piedmont Hospital and with Dr.

1 Miller and others. Describe for the jury the best you can
2 how that room is set up from your perspective as the
3 Doctor Anesthesia person?

4 A How the operating room?

5 Q What it looks like, how it is set up, just kind of
6 describe that for us?

7 A Well, an operating room where C-section's place is
8 set up like any other operating room, quite frankly. The
9 patient is rolled, usually on a gurney, foot first through
10 the door and the operating room table lies length wise in
11 the room. The surgical personnel, the obstetrician, the
12 scrub tech's, whoever, is helping the operating surgeon
13 are at the other end of the room, the extreme end of the
14 room. And that is where all of their equipment is set up
15 and opened and sterile. And on the wall where the door is
16 is the, where, is where our equipment is which includes an
17 anesthesia machine which you probably have seen photos
18 before that deliver anesthetic gases as well as provide
19 ventilation. It is a ventilator as well, provides
20 ventilation for a patient who requires that. We have a
21 big cart there that has all of our drugs and our equipment
22 and airway and emergency equipment that backs up against
23 the wall. And the patient is situated on the operating
24 room table with her head in front of me, directly in front
25 of me and her feet away from me. Does that make sense.

1 Q Are there other personnel besides you and the
2 delivering physician in a cesarean section?

3 A Most of the time there would be several other people.

4 Q Nurse, scrub tech, nurse from labor and delivery, at
5 least?

6 A And there might be two anesthesia personnel as well.
7 I might have had an anesthetist helping me.

8 Q And if the Doctor had summoned neonatology to put
9 them on alert because this is an emergency C-section,
10 would somebody from neonatology at least a tech or nurse
11 be in the operating room to take the baby and give the
12 baby to the neonatologist in an adjoining room?

13 A That's correct. There is a little adjoining room and
14 they usually, where the bassinet is, they usually kind of
15 wait in there to stay out of the way and get their
16 equipment ready for the baby. But they are present, that
17 is correct, as part of the team.

18 Q Are drapes used for cesarean section in the operating
19 room?

20 A Yes.

21 Q Describe those, please, as best as you can. From
22 your perspective, from the delivering physician
23 perspective, anything that you can help us to understand.

24 A The drapes are a plasticized paper drape that stretch
25 from, there are two IV poles, two metal IV poles that

1 stand on either side of the head or the patient's bed.

2 And those drapes are attached by some clips so I have to
3 and look over, you know, I have to peer over the drape and
4 then the drape covers the patient completely.

5 Q All the way down to her feet?

6 A That's right. And there are several drapes, there
7 are a couple of layers of drapes for sterility. They are
8 all sterile.

9 Q Can you see through those drapes?

10 A No.

11 Q What is a sterile field in an operating room, what is
12 that?

13 A The sterile field is the area that is, that has been
14 prepped sterilely. Before the drapes are placed the
15 abdomen in a case of a serrat section is prepped and then
16 the drapes is placed in an area that takes into account
17 the surgical field. And that is the, that is the sterile
18 field, that is the sterile area. Where the operation
19 itself is going to take place.

20 Q As a person who is in a cesarean section, one is
21 being planned or performed in the operating room, do you
22 have any opinion or knowledge as to whether anybody other
23 than the physician and his scrub tech are allowed or
24 permitted in the sterile field?

25 A Most of the time there would be, most of the time

1 there would be two people at the bedside, on either side
2 of the sterile field. One would be the operating surgeon
3 and the other would be, the surgeon's tech, the OR tech
4 who is the technician who passes instruments, provides
5 the, what the surgeon needs, suction, you know, is the
6 main assistance to the surgeon.

7 Q Is that main assistant sterile?

8 A Yes.

9 Q And the surgeon is as well?

10 A Correct.

11 Q And that is for patient's safety?

12 A Of course, yes, sterility, yes.

13 Q Looking at your records again, both preanesthesia
14 checklist and your anesthesia record which I want to ask
15 you about in some detail, it is not very long. I think
16 everybody knows why. When you were reading earlier you
17 said something about an emergency. Did I hear that
18 correctly, explain that?

19 A Yes. That is right. The ASA Classification was a
20 2E, and a 2 means a patient who is in general and in quite
21 good health but not a perfect specimen of health like a
22 healthy 20-year-old. And we consider a pregnancy a Class
23 2 for purposes of grading. And then E means emergency.

24 Q Who makes that determination?

25 A I would have done that.

1 Q Dr. Lupo, looking at your anesthesia record and the
2 jury will have that document into evidence to look at
3 together. Tell them what all of your markings and
4 abbreviations, writing, because maybe we can't read all of
5 it. If you will do that for us I would appreciate it.
6 Just take us through that note.

7 A The date, as you see, is 4/5/07. The proposed
8 surgery is to be a vaginal delivery. The operating
9 surgeon is Dr. Miller. And then I have a time stamped, of
10 a handwritten 20:30 just to start the timeframe. And this
11 graph on this anesthesia record is divided into 15 minute
12 increments. I have an initial blood pressure of 107/80.
13 And then I have a time that I must have come into the room
14 at 20:28. And then a stop time, a time at which my
15 services were no longer required and I left the operating
16 room. There are three or four blood pressures that are
17 listed here that are graphed on a graph. And the EKG is
18 reported as being sinistocardia. And this is the
19 patient's, the laboring mother's EKG, not the baby's.

20 Q Tell the jury, what is tachycardia?

21 A Tachycardia is a fast heart rate, faster than 100.

22 Q Okay. Thank you.

23 A There is a notation for LR which stands for lactated
24 ringers and that is the IV solution that was being infused
25 through an angio cath in the arm. On the right side of

1 the form is a box that is denoted, airway management. And
2 I have written SV which stands for spontaneous
3 ventilation. It means that there was no artificial
4 management of the airway and the patient was breathing on
5 her own. And then I have notes that are in the section to
6 the right.

7 Q That is what I want you to read and explain for us,
8 please, and those are on the right-hand side of your
9 chart?

10 A That's right. And I will say, not having independent
11 recall of this, I am reading my notes and I am surmising
12 what must have been going on at that time. Does that make
13 sense?

14 Q Yes, ma'am.

15 A So my writing, in my writing it says, called to OR
16 emergency for C-section, CS cesarean section, secondary to
17 fetal decreased heart rate. So that would be the reason I
18 was called to participate in a vaginal delivery at some
19 point they, because of fetal bradycardia, slow heart rate
20 in the baby they moved to the operating room for a
21 C-section.

22 Q What is bradycardia?

23 A Bradycardia is slow heart rate.

24 Q Okay. Thank you.

25 A The opposite of tachycardia.

1 Q All right.

2 A My notes says that the patient was in the OR upon my
3 arrival. And then it says, Dr. Miller says that the heart
4 rate is back up and I have an arrow that says opt to
5 continue pushing. And next it reads, patient pushing in
6 OR, monitor's on, big baby/difficult delivery due to
7 uncoordinated pushing. Patient with three prior vaginal
8 deliveries and a history of big babies. And then I have
9 written vaginal delivery, baby to neonatologist. And then
10 the last notation is, services no longer needed.

11 Q Do you have any recollection of whether or not this
12 case involves shoulder dystocia from 60 to 90 seconds
13 prior to the baby's delivery. Do you have any
14 recollection?

15 A I do not.

16 Q Okay. Do you recall seeing Alexia, the baby, after
17 she was delivered, do you have any recollection of that?

18 A No.

19 Q In any cesarean section that you have been involved
20 in or any delivery that you have been involved with in the
21 operating room, such as this case; have you ever seen a
22 nurse climb up on the operating table with her rear-end to
23 the face of mom pushing down on the abdomen or suprapubic
24 area. Have you ever seen that?

25 A No.

1 Q In your opinion, is there room enough for a nurse to
2 do that on an operating room table, to straddle the mom
3 and apply suprapubic pressure?

4 A It would be a very difficult position. I have never
5 seen anything like that.

6 Q Never seen that, have you?

7 A No.

8 Q One moment, please. Dr. Lupo, answer any questions
9 they have for you.

10 THE COURT: Mr. Jordan.

11 CROSS-EXAMINATION

12 By Mr. Jordan:

13 Q Good afternoon, Dr. Lupo.

14 A Good afternoon.

15 Q I just want to make sure I understand. You have no
16 recollection of Alexia Lumpkin being born, Angela Patton's
17 delivery of Alexia. Is that correct?

18 A Yes sir, that is correct.

19 Q No recollection whatsoever?

20 A It was 14 years ago.

21 Q And you recalled, let me ask you, you don't recall
22 any conversations that occurred in that room, do you?

23 A No, sir.

24 Q And in fairness, if Ms. Patton was not sitting here,
25 you wouldn't recognize her, would you?

1 A I don't think there is any way I could, no sir.

2 Q And it is rare that you are in a vaginal delivery,
3 isn't it?

4 A That's true.

5 Q And so when Mr. Davis asked you about the vaginal
6 deliveries and what occurs there, you really are not in
7 those, are you? You are called for an emergency
8 C-section?

9 A I was called for an emergency C-section, that is
10 correct.

11 Q And you were called for an emergency C-section that
12 never happened?

13 A That's correct.

14 Q In fact, the last line of your notes, what does it
15 say, do you have a copy there in front of you?

16 A It says vaginal delivery, baby to neonatologist. Is
17 that what you, the part you mean.

18 Q And the last line?

19 A Services no longer needed.

20 Q Services no longer needed because that C-section that
21 was an emergency never occurred, did it?

22 A There was a vaginal deliver.

23 Q It was a vaginal delivery. You don't do any type of
24 follow-up with the baby, do you?

25 A No.

1 Q And your testimony was that, in a C-section there is
2 a sterile optical field and there is a drape, right?

3 A That's right.

4 Q And, again, tell the jury, there was no C-section,
5 was there?

6 A There was a vaginal delivery, that means there was no
7 C-section.

8 Q And you don't have any specific recollection of what
9 Alexia's fetal heart rate was, do you?

10 A Alexia is the baby.

11 Q The baby.

12 A No.

13 Q No specific recollection of mother pushing?

14 A I have no recollection of that, no sir.

15 Q Don't know if this case involves shoulder dystocia?

16 A No.

17 Q Don't remember seeing Alexia after the delivery, do
18 you?

19 A No, I do not.

20 Q You don't know who the nurses were that were taking
21 care of Angela, do you?

22 A No.

23 Q You don't know the OB nurse or the labor and delivery
24 nurses?

25 A You mean from recall?

1 Q Recall.

2 A No, sir.

3 Q And in your practice you don't manage vaginal
4 deliveries, you don't deliver babies, do you?

5 A No, sir.

6 Q And you know what a McRoberts or a suprapubic
7 pressure is, do you deal with that?

8 A No, sir.

9 Q And Angela was in the operating room when you got
10 there, isn't that true?

11 A That's right.

12 Q That is pretty rare, isn't it?

13 A No, it's not rare. When a decision is made for a
14 C-section and that's what, when, I would have been paged
15 for a stat C-section, for fetal bradycardia. And when a
16 decision is made to go ahead with a C-section because of
17 fetal bradycardia, everything flies and they role the
18 patient back while I am getting there or while the
19 anesthesia team is getting there, all happens very
20 quickly.

21 Q And you don't remember how you got this page or call,
22 do you?

23 A I don't remember how. But I am pretty certain it
24 would have been over a page or a hospital pager system.
25 That is how we communicated all the time.

1 Q And is it fair to say that you don't know what the
2 nurses protocol is, do you?

3 A Protocol for what?

4 Q For the nurses handling a vaginal delivery?

5 A I am not exactly sure what you are asking.

6 Q You supervise nurses in vaginal deliveries?

7 A No.

8 Q It is not something you do?

9 A That's correct.

10 Q And you don't understand or operate within, or
11 perform the maneuvers that an obstetrician would do in
12 dealing with shoulder dystocia, that is not something you
13 would deal with, is it?

14 A No, sir.

15 Q And you didn't have any responsibility in trying to
16 relieve the shoulder dystocia that was present in this
17 case, did you. You had no responsibility for that?

18 A That is correct.

19 Q How long have you known Dr. Miller?

20 A 20 years, 22 or 3 years.

21 Q He is a colleague or was a colleague?

22 A Yes.

23 Q And when you are on call together you would work with
24 him on a routine basis, wouldn't you?

25 A That's right.

1 Q Thank you, Dr. Lupo.

2 THE COURT: Mr. Davis.

3 MR. DAVIS: Briefly, Your Honor.

4 REDIRECT EXAMINATION

5 By Mr. Davis:

6 Q Dr. Lupo, are you currently inactive to practice
7 medicine?

8 A I am retired.

9 Q And when did you retire, Ma'am?

10 A My first year of retirement was 2017.

11 Q And Dr. Miller practices in Beaufort, you know that?

12 A I do.

13 Q Been there for eight years. Nothing further, thank
14 you.

15 THE COURT: Any recross, Mr. Jordan?

16 MR. JORDAN: No, Your Honor.

17 THE COURT: Any objection to excusing this witness?

18 MR. JORDAN: No, Your Honor.

19 THE COURT: Thank you, Doctor, you can step down.

20 Ladies and gentlemen, that brings us to the end of our
21 testimony for today. Please remember the rules I have
22 given you, please don't discuss the case with anyone,
23 don't do any kind of outside research. Other than that I
24 hope you have a great evening, see you back at 9:30
25 tomorrow morning.

1 (Whereupon, the jury was excused for the day.)

2 THE COURT: We have got a couple of things for the
3 record. Counsel agreed that Plaintiff, it is time to
4 clean up some exhibits, hard copies were left at the hotel
5 room?

6 MR. GRAHAM: No sir, photographs.

7 THE COURT: Okay. And then, Mr. Davis, I think you
8 probably have some motions that we delayed.

9 MR. DAVIS: May it please the Court?

10 THE COURT: Yes, sir.

11 MR. DAVIS: Thank you, very much.

12 MR. GRAHAM: And we need to redact some of the
13 exhibits.

14 THE COURT: Before they go back to the jury, yes.

15 MR. DAVIS: We have agreed to that. Your Honor, on
16 behalf of the Defendants, as to the allegations of
17 negligence, we would ask the Court to grant a directed
18 verdict. The fact that they have failed to sustain the
19 burden of proof absent of res ipsa loquitur which is the
20 basis for their experts opinions that there was some
21 negligence. Based it almost exclusively on the injury,
22 the injury, the injury, not of anything else of any
23 substance. So that the basis, primarily our motion for a
24 directed verdict as to the allegation of negligence.

25 THE COURT: Mr. Graham.

1 MR. GRAHAM: Your Honor, my understanding is
2 reasonable ipsa means the injury proves negligence. This
3 case, the injury is certainly highly significant of the
4 mechanism of injury. Whether the mechanism of the injury
5 is negligent or not depends on the circumstances of the
6 labor and delivery, as Dr. Duboe and Dr. Gurewitsch
7 covered in some detail. There is alternative causes that
8 have to be ruled out first. In terms of causation, the,
9 when you have an injury like this, it may not
10 automatically mean that the sole cause is excessive force
11 but that mechanical activity is what causes the injury if
12 there is no cancer on the face or infection in the uterus
13 or a long standing in-utero position where the arm comes
14 out withered. But once you get past those issues, then
15 the question is, what is going on in the operating room.
16 Has it been six minutes since the head came out, if so
17 this is not negligence to pull that hard. If it is, we
18 have heard 45 seconds, 90 seconds and two minutes. Any of
19 those put it in a situation where there is no immediate
20 danger and there is no extenuating circumstances that
21 would justify that kind of excessive forceful manipulation
22 of the head and bending of the neck.

23 THE COURT: Mr. Davis, would you like to reply?

24 MR. DAVIS: Very briefly, Your Honor. Thank you very
25 much. With all due respect to my friend and his

1 statements, Dr. Gurewitsch, whose deposition was read
2 almost in its entirety. I am not objecting to that, but
3 over and over and over again when asked what is the basis
4 of your opinion that my client used excessive traction or
5 inappropriate lateral traction, she ran to the results of
6 the injury, the injury, the severity of the injury which
7 is a basis of her opinion that excessive force was applied
8 to, inappropriate lateral traction was applied which gives
9 her then the opinion that that was malpractice. She sets
10 up a strong argument. Well, I think, I am looking at the
11 injury, the only way this can happen is excessive force,
12 inappropriate lateral traction based on the injury.
13 Therefore malpractice is below the standard of care,
14 therefore my opinion is Dr. Miller deviated from the
15 standard of care. It is all based on the injury. And
16 that was essentially what Dr. Duboe testified to, as a
17 basis of his opinion. They are all looking at this from
18 the injury and going backwards and then basing their
19 opinion on the standard of care based on the injury. That
20 is why I make the motion, Your Honor, thank you.

21 THE COURT: I have given this some thought especially
22 as the testimony has been proceeding. I think there is
23 enough to send it to the jury, I mean, Dr. Gurewitsch's
24 testimony from today was, there are other causes of
25 permanent brachial plexus injury, severe infection,

1 mal-positioning, et cetera; but in her testimony she
2 believed she had eliminated those causes. And then her
3 testimony was that given the lack of extenuating
4 circumstances or emergent nature beyond four to six
5 minutes, that the amount of traction necessary to cause
6 those injuries was below the standard of care. So I think
7 it is enough to go to the jury.

8 MR. DAVIS: Thank you, Your Honor. My second motion,
9 if it please the Court, is as to the allegation of gross
10 negligence. There is no testimony presented by Plaintiffs
11 experts that would rise to the level of any implication or
12 inference of willful, wanton, reckless, conscious
13 disregard of the safety and welfare of either Angela
14 Patton or the baby in this case. And for that reason I
15 would ask the Court to grant a directed verdict on the
16 issue of gross negligence and also as to punitive damages.

17 THE COURT: Mr. Graham or Mr. Jordan.

18 MR. GRAHAM: Several cases in our case have different
19 definitions of gross negligence. But, in cases there has
20 been a more, a more encompassing definition. As an
21 example, the Taylor versus Medenica case, gross negligence
22 is, "is a relative term, it means the absent of care that
23 is necessary under the circumstances."

24 THE COURT: How would that be different than ordinary
25 negligence. Isn't that, by definition, the absence of

1 care necessary under the circumstances?

2 MR. GRAHAM: Well, if Your Honor, please. It is in
3 the case law, over and over and over. I understand Your
4 Honor's comment. But the, some people think that the only
5 definition of gross negligence in this State is the
6 absence of slight care. But that's not how it is defined
7 in more, in other cases. And we have got, this case
8 doesn't give the full definition that I am looking for. I
9 am looking at a case now which is typical of the line of
10 cases. So the case I am citing is Bass versus South
11 Carolina Department of Social Services, 414 SC 558, 571;
12 780 SE 2nd.

13 THE COURT: Okay, I am there.

14 MR. GRAHAM: Gross negligence is the intentional
15 conscious failure to do something which it is incumbent
16 upon one to do; or the doing of a thing intentionally that
17 one ought not to do. And then I will skip the internal
18 cite. In other words, "it is the failure to exercise
19 slight care." Gross negligence has also been defined as a
20 relative term and means the absent of care that is
21 necessary under the circumstance. Normally the question
22 of what activity constitutes gross negligence is a mixed
23 question of law and fact. However when the evidence
24 supports but one reasonable inference the question becomes
25 a matter of law --

1 THE COURT: The last bit, citing the Hollands case
2 from 1993. What does that mean, a relative term. That is
3 the exact same as the definition for ordinary negligence.

4 MR. GRAHAM: Well, it is slightly different. If Your
5 Honor, please. It is not really focused on reasonable
6 care so much as it is necessary care. And, I mean it is
7 not that, that act or omission which a reasonable man or
8 woman would adhere to. But by talking about necessary
9 rather than reasonable conduct, it is somewhat different.
10 I understand Your Honor is saying, that it is
11 substantially similar but it is the law of South Carolina.
12 And that is a --

13 THE COURT: I mean, that language may appear in the
14 cases. But I just pulled the Hollands case that it cites
15 from, and in that case the holding of the Court says, we
16 hold, under these factual circumstances that whether, the
17 school district exercise slight care. That is the
18 standard they are using in that case. It is a slight care
19 standard. Can you find any case where that other standard
20 has been used as the actual operative standard in the
21 case. They keep saying, we have also defined it this way
22 but it doesn't appear to have been used.

23 MR. GRAHAM: I am happy to take the time now. I
24 can't, as I stand on my feet right this moment. But since
25 we are done for the day in terms of witnesses, is it

1 possible that we could have overnight to do that.

2 THE COURT: Sure. Based on what I heard so far and
3 my understanding of the law, I am going to grant the
4 motion as to punitive damages and gross negligence. But I
5 will be happy to reconsider that tomorrow morning if you
6 have case law that I am not aware of or anything. The
7 basis for that, I have not heard any testimony from an
8 expert for the Plaintiffs saying that there was an
9 intentional act or a failure to exercise slight care.

10 MR. DAVIS: I have got another motion, this may not
11 be the appropriate time, under Rule 15, to amend my answer
12 to assert the affirmative defense of the emergency
13 statute. And in all fairness, I can't remember in the
14 tortured long history of this case, whether we ever did
15 that. But if not I want to be able to do that and I am
16 happy to wait until after my case is presented. But I
17 believe even Dr. Duboe and Dr. Gurewitsch both -- this was
18 an emergency and I think alone and --

19 THE COURT: 32-230.

20 MR. DAVIS: I hope I got that right.

21 THE COURT: Emergency medical and obstetrical care
22 exceptions.

23 MR. DAVIS: Yes, sir. And we would specifically want
24 to assert that as an affirmative defense to conform our
25 pleadings to the evidence that has been presented, even by

1 the experts for the Plaintiff and also Dr. Lupo who also
2 called this an emergency in an obstetrical suite. So I
3 think in all fairness that the Court should consider,
4 liberally consider allowing us to amend our pleadings to
5 assert that affirmative defense to conform to that
6 evidence, again, presented by the experts for the
7 Plaintiff. It will probably become no surprise to the
8 Court or to my friend, that our two experts and Dr. Miller
9 will also hammer that point home. And I am happy to wait
10 and renew my motion at a later time.

11 THE COURT: That is something that I will think
12 about. I don't need to make a ruling on that issue until
13 it becomes time for the jury charge, correct.

14 MR. DAVIS: Yes, sir. And that is fine with me and I
15 am happy to wait at any time, I just want to get it before
16 the Court for your consideration. And I am happy to renew
17 the motion at any time the Court deems.

18 THE COURT: I don't know what my ruling will be. I
19 will have to think about that. It does appear to be a
20 case on point.

21 MR. DAVIS: Yes, sir.

22 THE COURT: Byrd v. McLeod Physician Associates.
23 Counsel, I don't want to go any further. I will need to
24 read this case. This is not something I am prepared to
25 rule on now.

1 MR. DAVIS: Your Honor, and also the Flowers versus
2 Giep case in Spartanburg County before Judge Cole. I
3 think that case has already been decided by the Court of
4 Appeals.

5 THE COURT: All right.

6 MR. DAVIS: I am happy to give you the cite for
7 Flowers case.

8 THE COURT: Let me look one second. Is Flowers cited
9 in the Byrd case. Give me one second. Yes, I do need it,
10 please.

11 MR. DAVIS: This is the best cite I have. 5864, 2021
12 SC Appellate Court, Lexus 121; Court of Appeals, October
13 6th, 2021.

14 THE COURT: Did you happen to know who the Defendant
15 was, Mr. Davis, in the Flowers case?

16 MR. DAVIS: I do, it was Dr. Bang, B-A-N-G; last
17 name, Giep G-I-E-P, MD. Was defended by Gary Lovell.

18 THE COURT: Flowers v. Bang, B-A-N-G.

19 MR. DAVIS: G-I-E-P is his last name. And
20 Spartanburg and Pelham, OBGYN, PA.

21 THE COURT: I have got it.

22 MR. DAVIS: Thank you.

23 THE COURT: I thought I had it. It popped up and now
24 I have got, it must have included. Yes, the West Law cite
25 is 2021, WL 4570930. All right. I have got some reading

1 to do on that issue. Anything else we need to take up
2 today, Counsel?

3 MR. GRAHAM: May we submit a brief?

4 THE COURT: Certainly, I will read anything you
5 submit.

6 MR. GRAHAM: Thank you. What deadline?

7 THE COURT: We think Dr. Miller will take all day
8 tomorrow, is that reasonable?

9 MR. DAVIS: I am sure we will get through with him
10 tomorrow. I don't think that is any question.

11 THE COURT: And you have a couple of additional
12 experts, Mr. Davis?

13 MR. DAVIS: Yes, I will call two experts, Dr. Chauhan
14 and Dr. Mack Ernest on Wednesday, one after the other and
15 I will be done.

16 THE COURT: My hope then is we will charge and close
17 Wednesday afternoon and that may be overly optimistic. So
18 let's say, any brief on this issue by first thing in the
19 morning on Wednesday. Counsel, I have fairly standard
20 charges on medical malpractice cases and so if there is
21 anything particularly you want charged in this case please
22 send it to my Law Clerk. And his email is,
23 wmckinnonlc@sccourts. And especially if you have a draft
24 charge on this emergency statute please send that over.

25 MR. GRAHAM: May we get your standard charge?

1 THE COURT: Sure, I basically I work off, I can send
2 you the charge, the last medical malpractice case I tried
3 was one with John Cassell and Matthew Cole from North
4 Carolina was the primary counsel for the Defense. I will
5 send you that one, it will have all the normal stuff that
6 I charge on med-mal.

7 MR. GRAHAM: Keep us from reinventing the wheel.

8 THE COURT: Right. Anything else?

9 MR. DAVIS: No sir, thank you very much.

10 THE COURT: From the Plaintiff?

11 MR. GRAHAM: No, sir.

12 THE COURT: Gentlemen, I will see you at 9:30
13 tomorrow.

14 (Whereupon, the trial will resume the next day at
15 9:30 a.m.)

16 January 11, 2022

17 THE COURT: All right. The last thing we were
18 talking about -- or one of the last things we were talking
19 about was punitive damages and gross negligence and I
20 think y'all wanted to submit some further authority on
21 that issue?

22 MR. GRAHAM: Yes, sir, you said we could have until
23 tomorrow morning?

24 THE COURT: Yes, sir. Okay. I thought that was on
25 the other issue with the emergency statute, but that's

1 fine.

2 MR. GRAHAM: Your Honor, it was my understanding it
3 was both.

4 THE COURT: It's okay. It'll be fine. Anything else
5 from the Plaintiff before we get going?

6 MR. GRAHAM: Your Honor, one thing, you gave us
7 permission to submit photographs.

8 THE COURT: Yes, sir, the hard copy, yes, sir.

9 MR. GRAHAM: We were unable to get a hard copy of all
10 of those three, so we are just letting Your Honor know
11 that we will get those as soon as we can get access.

12 THE COURT: Okay.

13 MR. GRAHAM: The problem is with the hours of their
14 business and the hours of court.

15 THE COURT: Okay. Who has the photos?

16 MR. GRAHAM: We have it, it's just a matter of
17 printing them.

18 MR. JORDAN: They'll be printed --

19 THE COURT: Do we just need a color printer? Is that
20 the issue? The clerk's office has a very fancy color
21 laser printer. Just a few things, right?

22 MR. GRAHAM: Three.

23 THE COURT: Three, yeah. Ms. Foster, what should
24 they do?

25 THE CLERK: They can e-mail it to me.

1 THE COURT: Okay. If you could just e-mail Ms.
2 Foster, she can print them out.

3 MR. GRAHAM: Thank you, Your Honor.

4 THE COURT: Anything from the Defense before we get
5 started?

6 MR. DAVIS: No, sir, Your Honor.

7 THE COURT: All right. Let's bring them in.

8 MR. GRAHAM: I'm sorry, Your Honor, there is one
9 thing.

10 THE COURT: Hold the jury. Hold them one second.
11 Yes, sir.

12 MR. GRAHAM: I got a photo last night e-mailed to me
13 that Defense proposed to put into evidence. I don't know
14 if it was today or when. We do have an objection to it.

15 MR. DAVIS: We're not going to put it in evidence.
16 We're just going to use it as a demonstrative.

17 MR. GRAHAM: We have an objection to that.

18 THE COURT: What is it?

19 MR. GRAHAM: It's a photo of a C-section of another
20 lady with a giant drape.

21 MR. DAVIS: It's not a giant drape, it's a drape.

22 THE COURT: I mean, I understand that the Plaintiff
23 contest there was a drape there, but the Defense says
24 there was and I am confident that Dr. Miller is about to
25 testify that there was a drape present. So what is the

1 objection to the demonstrative?

2 MR. GRAHAM: The objection is it has nothing to do
3 with the facts of this case. May I show it to you?

4 THE COURT: Sure.

5 MR. GRAHAM: It's a different lady. It's a
6 C-section. There's no shoulder dystocia and -- I mean,
7 it's just a totally different situation. The testimony is
8 that when Dr. Miller came into the room, he switched from
9 plans for a C-section to plans to push as soon as he got
10 there. So -- I mean, this just has no bearing on any
11 facts in the case.

12 THE COURT: I'll withhold the ruling right now. I
13 will say -- I mean, if Dr. Miller does testify there was a
14 drape present and he wants to use the demonstrative to
15 show the jury what he means by that, I don't think that's
16 objectionable for that purpose.

17 MR. GRAHAM: May we have an agreement that they won't
18 use it until you give the ruling?

19 THE COURT: Mr. Davis, before you pull out the
20 demonstrative, if you don't mind, just give us a chance to
21 make a formal ruling on that.

22 MR. DAVIS: Be glad to, Your Honor.

23 THE COURT: Yes, sir. Anything else, Mr. Graham?

24 MR. GRAHAM: No, Your Honor.

25 THE COURT: Let's bring them in.

1 (WHEREUPON, the jury enters the courtroom at
2 approximately 9:43 a.m.)

3 THE COURT: Good morning, ladies and gentlemen.
4 Again, thank you again for being so punctual. Has
5 everyone been able to follow the rules I've been giving
6 you?

7 (No audible response.)

8 THE COURT: Wonderful. I appreciate that. Mr.
9 Davis, call your first witness.

10 MR. DAVIS: Thank you, Your Honor. I'd like to call
11 Dr. Miller.

12 THE CLERK: Place your left hand on the Bible and
13 raise your right hand.

14 Gregory Miller, being
15 first duly sworn, testified as follows:

16 THE WITNESS: Yes, I do.

17 THE CLERK: Thank you. Please be seated.

18 DIRECT EXAMINATION

19 BY MR. DAVIS:

20 Q Dr. Miller, would you please introduce yourself to
21 this jury?

22 A My name is Greg Miller. My middle initial is A for
23 Atwood.

24 Q Dr. Miller, are you a medical doctor?

25 A Yes, I am.

1 Q Before I get into some of that, let me just ask you
2 some other questions about you. Where did you grow up?

3 A I was born in a little town in New Jersey, Summa, New
4 Jersey. Fairly quickly, my parents moved to Atlanta. I
5 was in Atlanta, in Sandy Springs until I was about eight.
6 From there, we moved on to Midlothian, Virginia, which is
7 a small town or was a small town outside of Richmond, sort
8 of like Rock Hill is to Charlotte. Ended up going to
9 Midlothian High School. I grew up playing a lot of
10 tennis. Went to college, College of William Mary in
11 Williamsburg, Virginia on a tennis scholarship. Graduated
12 there. In fact, that's where I met my wife and we've been
13 married for 36 years.

14 Q Is she here in the courtroom?

15 A Yes, she is.

16 Q Okay. Thank you. And your daughter?

17 A My second daughter is here as well, Jessica. At
18 William Mary, I played tennis. When I graduated, I got
19 into medical school immediately. Asked for a deferment
20 because I wanted to play one year of professional tennis
21 in Europe, so between '84 and '85, I played one year
22 professional tennis in Europe. Came back from Europe and
23 entered into medical school at the Medical College of
24 Virginia in Richmond, Virginia. I went to the Medical
25 College of Virginia on an academic scholarship. My second

1 year, I decided I wanted to join the military, so I signed
2 up with the Navy through Health Professions Scholarship
3 program. So the last three years, I was inactive duty,
4 but in the Navy at that time. I then requested a
5 deferment. I really wanted to go to the University of
6 Florida to do my residency. And I did my residency at the
7 University of Florida, spent four years there. At the
8 University of Florida, I was awarded the Hugh C. Hill
9 award, which was for the outstanding resident teacher. I
10 was pretty proud of that award because that was given not
11 just to an OBGYN resident, that was given -- that was for
12 every resident in the entire program. And it was -- you
13 were awarded that by the medical students. So it wasn't
14 attendings that you were giving you that award, it was the
15 medical students.

16 Q What is an attending?

17 A An attending is somebody that tends to do more
18 research and they do a lot more education of the students
19 and the residents, but, typically, don't have nearly as
20 much hands-on experience in delivering healthcare. So I
21 finished up at the University of Florida. From there, I
22 went on to Camp Lejeune Naval Hospital with the Marine
23 Corp. I was there from 1993 to '96. Within two months,
24 the chairman of the department, Dr. Ed Boston elected me
25 to be chairmen of gynecologic surgery even though I was

1 the youngest member of the staff. When -- for obstetrics,
2 you have to get board certified. And what happens is for
3 two years, you collect every case you do, whether it
4 obstetrical or gynecologic, and then you have to present
5 that to the American College of Obstetrics and Gynecology.
6 And then you get to sit for your boards. During your
7 boards, you -- it's an entire morning and part of an
8 afternoon. But you sit and there's three different
9 examiners that look over your case list and then ask you a
10 bunch of questions and then they determine whether you
11 pass your boards. And I passed my boards the first year
12 that I could take them in 1995. In 1996, I got out of
13 Camp Lejeune and at that point, moved to Rock Hill, South
14 Carolina. During my stay in the military, I was awarded
15 the Navy and Marine Corp commendation medal for
16 meritorious service. I rose from rank of lieutenant JG to
17 lieutenant to lieutenant commander in three years.

18 Q I'm an Army guy, so lieutenant commander, there's 01,
19 02 --

20 A I was an 04.

21 Q 04?

22 A Yes.

23 Q Okay. That's like a major in the Army?

24 A I think so, yeah. Then I got to Rock Hill and joined
25 Rock Hill GYN/OB, became a partner after two years. I had

1 a great experience there. In 2014, I left Rock Hill
2 GYN/OB. There was -- an opportunity opened up down in
3 Beaufort, South Carolina, which if anybody has ever been
4 there, it's a really idyllic and beautiful seaside town.
5 But they had had a catastrophe where the hospital there at
6 one point had 11 OBGYN'S practicing and within around a
7 year, they lost all 11. They actually had one woman still
8 there, but she had lost two of her partners and she was
9 thinking about quitting and, subsequently, did. So they
10 were in dire straits. I had never started a practice on
11 my own. It sounded like a really interesting thing to do
12 at that time in my career, so myself and one of my good
13 friends, Dr. Chris Benson, we went down there and started
14 a practice in 2014. There were a few other differences
15 that made it attractive. Probably the most important,
16 Chris was in the Army. I don't hold that against him.
17 Sometimes I do, but the Air Force is worse, so. But we
18 both felt a calling to get back to taking care of our
19 service members and this gave us the opportunity. Parris
20 Island is there. The Marine Corp Air Station is there.
21 So we've had a great time getting back to taking care of
22 our service members. The other thing that's really nice
23 about our little hospital there. Whereas Piedmont, I want
24 to say is 300 -- maybe even larger now, but, at least, 300
25 beds, we're around 200 beds, so we're a little bit smaller

1 hospital. But the distinction is we're a community
2 hospital that is a nonprofit hospital. And that's a big
3 difference. A nonprofit hospital, their focus is not
4 necessarily to push profits to stockholders, their focus
5 is to take care of their community. So down there, it was
6 a lot easier, not so much the obstetrics, but the
7 gynecologic stuff to take care of people that needed to
8 have surgery and not have to worry about if they could
9 afford to pay for it. And that's been very rewarding as
10 well. So I've been there since 2014.

11 Q Let me ask you this, Dr. Miller, you and Dr. Benson
12 leaving for that opportunity in Beaufort from the practice
13 here in Rock Hill, did that have anything to do with this
14 case?

15 A Oh, no. No, absolutely not.

16 Q Do you still have a home in Rock Hill?

17 A Yes. And those are probably two of the people that
18 would probably attest to it. I always thought that
19 Beaufort might be a place to retire to. It's a really
20 neat little seaside town and I moved down with the
21 expectation that everybody would follow me. Eight years
22 of renting later, nobody has followed me. And I think
23 it's mainly because my kids feel like they grew up in Rock
24 Hill. You know, I have a daughter who's -- my oldest
25 daughter is in LA and when she comes back, the only place

1 she wants to come is to Rock Hill.

2 Q You have four children?

3 A Four children. So the long and short of it is, I
4 think our plans have changed. I have kept my house in
5 Rock Hill and I think when it's time for me to retire, I
6 think -- we all call Rock Hill home, so I'll be back.

7 Q You mentioned board certification. Are those written
8 and oral boards?

9 A No, the first time you take them, they're oral
10 boards. Then every year or so after that, you have to be
11 recertified. And I've been recertified now maybe 30
12 times. So each time the American Board of Obstetrics and
13 Gynecology sends out a list of articles and you need to
14 review anywhere from 30 to 40 articles and turn in your
15 answers. It's all online and if you get enough right,
16 then you pass. You know, I think the last five or six
17 years, I haven't missed an answer. So every year, we are
18 recertified. They pick out articles they think are
19 pertinent to the practice and, you know, in the different
20 specialities, whether it's infertility, whether it's GYN,
21 whether it's obstetrics. And you get to sort of pick and
22 choose what might interest you.

23 Q Did you pass your boards on the first attempt?

24 A Yes, sir.

25 Q And when were you first certified as a board

1 certificate OBGYN, what year?

2 A It was in 1995.

3 Q Then recertified?

4 A Every year, you have to be certified again.

5 Q How long have you been delivering babies, sir?

6 A I guess 33 years now. I did my first babies when I
7 was a medical student. I did about 20 deliveries when I
8 was a medical student at Medical College of Virginia. It
9 was a busy, busy place. The residents were getting tired
10 of doing deliveries, so any medical student that showed
11 any interest, they would kindly let us do them. So I
12 think I did about 20 as a medical student.

13 Q Do you have an estimate of how many deliveries you've
14 done in your career?

15 A It's -- I think I'm over 9,000 now. And that's 9,000
16 -- you'll hear people talk about the number of the
17 deliveries they do. You'll hear people in academics talk
18 about the number of deliveries. Mine are 9,000 where my
19 hands were on. You know, an attending will say they did
20 9,000 deliveries, but they oversaw probably 7,000, meaning
21 they -- like, possibly, in their research lab when they
22 did it. But somebody under their guidance was over in the
23 labor and delivery unit doing it. I have done over 9,000.

24 Q Have you ever encountered other than this case a
25 shoulder dystocia in any of those deliveries?

1 A Yes.

2 Q Do you have any estimate about how many times you've
3 encountered that in your career?

4 A Probably somewhere in the order of 150 to 250.

5 Q And has any of those babies other than Alexia
6 suffered a permanent brachial plexus injury?

7 A No.

8 MR. DAVIS: I would offer Dr. Miller as an expert in
9 OBGYN.

10 THE COURT: Any objection from the Plaintiff?

11 MR. GRAHAM: Yes, sir, Your Honor. May we?

12 THE COURT: Ladies and gentlemen, I need to take up a
13 legal matter with the attorneys. I'm going to ask you to
14 go back to the jury room for a moment.

15 (WHEREUPON, the jury exits the courtroom at
16 approximately 9:57 a.m.)

17 THE COURT: Yes, sir, Mr. Graham.

18 MR. GRAHAM: Your Honor, to the best of our
19 knowledge, Dr. Miller has never been identified as an
20 expert. Mr. Davis and I had a discussion about it the
21 other day and the response was something to the effect of
22 well, he's an obstetrician, of course, he's an expert.
23 He's the Defendant in the case. Just being a party
24 Defendant in a medical malpractice case doesn't make you
25 an expert.

1 THE COURT: But he has to be able to give his
2 opinions, doesn't he? I mean, how can he not -- you know,
3 because if I say he's not an expert, then he's limited to
4 only the facts, correct? How can he describe why he -- it
5 seems a difficult proposition when you have a professional
6 defending professional decisions.

7 MR. GRAHAM: Well, it's easy enough to identify him
8 as an expert. I've had plenty of medical defendants who
9 either chose not to be experts or chose to be experts.
10 And just because he's a doctor in a medical malpractice
11 case does not ipso facto mean that we're supposed to know
12 that he will be treated as an expert at trial. We don't
13 see anything -- just to try to confirm my recollection, we
14 don't see anything in his deposition that talks about him
15 being an expert. He said he had no -- he was not a
16 causation expert. That's the only thing he said. I don't
17 think he said he was a standard of care expert.

18 MR. DAVIS: He was never asked, in all fairness, in
19 his six-hour plus deposition, but he considered himself an
20 expert in OBGYN, but, obviously, Graham did a very good
21 job, a very thorough job of asking him lots and lots of
22 opinions for which Dr. Miller was under oath and gave.
23 And, also, Your Honor, if it please the Court, I would ask
24 you in the alternative to consider the Court taking
25 judicial notice that Dr. Miller, based on his brief voir

1 dire just now is qualified to be an expert in this case.

2 MR. GRAHAM: That sounds like a concession that he
3 was not identified. Oh, yes, sir. Here's what I was
4 looking for. On Page 131 of his deposition -- well, this
5 is with respect to the babies. Question: Okay. So you
6 don't do an exam of the baby, true? Answer: Not a formal
7 exam, no, I do not. Question: And you don't even do a
8 cursory exam or evaluation that would permit you to have
9 personal knowledge whether your babies have a brachial
10 plexus birth injury or not; is that fair? Answer: I
11 depend on the expert in this case, Pediatric Services, to
12 do that examining for me if there is a -- if there is any
13 issue. So I believe there's another section, too. That's
14 what he said about the -- certainly, the neonatal aspect
15 of it and the examination. He doesn't know of personal
16 knowledge of whether his children that he's delivered have
17 brachial plexus birth injury or not. He's -- well, that
18 evidence just came in without objection, so I'll drop
19 that. Okay. On Page 138, Line 5: Do you consider
20 yourself qualified to render opinions as an expert witness
21 about causation of nerve injuries in newborn children?
22 Answer: An expert witness, no.

23 THE COURT: Mr. Graham, I'm going to allow it. I'm
24 going to qualify him as an expert. And the basis for my
25 decision is -- I mean, you had a very late disclosed

1 expert and I gave you the benefit of the doubt on that
2 one. And this is the same test here. I mean, he's an
3 expert. It's not a late disclosed fact witness. I mean,
4 he is the party Defendant in the case, so as counsel,
5 y'all knew he was going to give his explanation of why he
6 did what he did, so I don't see there's any prejudice. So
7 for the same reasons I permitted a late disclosed expert
8 from the Plaintiff, I'm going to qualify him as an expert.

9 MR. GRAHAM: I understand that. May we inquire -- is
10 he planning to use any literature?

11 MR. DAVIS: I don't have to disclose all my
12 examination at this time. I mean --

13 MR. GRAHAM: If he plans to use literature, Your
14 Honor, that catches us blind-sided. We were provided some
15 literature that the other experts were going to use and
16 that's a different element. So we would -- I understand
17 Your Honor's ruling and, certainly, accept that.

18 THE COURT: Did you send an interrogatory response
19 where you -- interrogatory request where you asked Defense
20 to identify treatises they were going to rely on at trial?

21 MR. GRAHAM: I'm sure we did, Your Honor. I don't
22 have it in front of me.

23 MR. DAVIS: I honestly don't recall. It's been a
24 long time.

25 MR. GRAHAM: It's a standard thing we ask for.

1 MR. DAVIS: Your Honor, we identified several weeks
2 ago 14 or 15 articles that we would be using in defense of
3 our case.

4 MR. GRAHAM: We were informed that Dr. Ernest would
5 be using those in defense of their case. We never got any
6 type of disclosure that Dr. Miller would be using any sort
7 of literature. And we did ask a standard lengthy question
8 with numerous subparts about what does he rely on, what
9 literature.

10 THE COURT: I think we need to pull the
11 interrogatory. I need to see exactly what the question
12 was and what the response was if it's going to come down
13 to that. Mr. Davis, if you can pull the e-mail you said
14 you sent recently where you identified that article, that
15 would be handy as well.

16 MR. DAVIS: Yes, sir.

17 THE COURT: Is this something we need to decide right
18 now or will this come up in a later portion of the exam?
19 Like, we can pick this up at the lunch break or something
20 or do we need --

21 MR. DAVIS: Your Honor, I'm happy to -- if the Court
22 would permit me to just instruct Dr. Miller now not to
23 refer to any medical articles in his -- we've got a lot of
24 other things to talk about.

25 THE COURT: That sounds good.

1 MR. DAVIS: At this point, just to refrain from that
2 until the Court has a chance to rule.

3 THE COURT: I appreciate that. Is that satisfactory
4 to the Plaintiffs?

5 MR. GRAHAM: It is, Your Honor. I would just point
6 out one thing. We have answer to interrogatory number 23
7 -- I'm sorry, this is request for production, written
8 material published in medical journals or tests by any
9 individuals you may use or expect to use as a trial
10 expert. Response, none at the present time.

11 THE COURT: We'll pick it up -- please keep that
12 handy and we'll take it up later in the proceeding. So I
13 think what I'll do now is I'm going to bring the jury back
14 in and tell them a little more than I normally say about
15 expert qualifications. I am qualifying him as an expert
16 based on his training and experience, but like any other
17 expert, that does not mean they have to believe what he
18 says and that's especially true because he's a defendant.
19 It's their job as jurors to determine whether or not his
20 actions met the standard of care and they should not draw
21 any conclusion from the fact that I have qualified him as
22 an expert.

23 MR. GRAHAM: I have one request. Could you start off
24 by asking me if I have any objection? I said yes and I'd
25 like to be able to answer that question in front of the

1 jury.

2 THE COURT: You want to give the jury the basis for
3 your objection?

4 MR. GRAHAM: No, sir. I just want to answer the
5 question. It will not include --

6 THE COURT: Tell me what you would say. If I --
7 because you objected and I'm going to rule on it. So what
8 do you want to say?

9 MR. GRAHAM: You have ruled against me on that point,
10 but are you planning to tell the jury about that?

11 THE COURT: Yes, sir, I've got to say he's qualified
12 as an expert, like with any other expert.

13 MR. GRAHAM: Okay.

14 THE COURT: I mean, don't I?

15 MR. GRAHAM: Well, as to obstetrics only, not as to
16 these other matters. Not as to anything related to the
17 child --

18 THE COURT: Obstetrics and gynecology was what I was
19 going to say.

20 MR. GRAHAM: Nothing related to whether the child has
21 a brachial plexus injury. Nothing related to -- oh, and
22 nothing as to causation.

23 MR. DAVIS: We're not contesting the fact that this
24 child has a permanent brachial plexus injury. That's
25 never been a part of our defense.

1 THE COURT: Is Dr. Miller intending to offer an
2 opinion on causation?

3 MR. DAVIS: Not that I'm aware of. I think he's
4 already said he's not an expert on causation.

5 THE COURT: All right.

6 MR. GRAHAM: I had two objections, but the primary --
7 I mean, I had one global objection, but I also had an
8 objection to him as an expert on causation and him as an
9 expert on examining -- or neonatal matters, including but
10 not limited to examining babies to see if they have a
11 brachial plexus.

12 THE COURT: I'm going to qualify Dr. Miller as an
13 expert in obstetrics and gynecology, which is what he's
14 board certified in. Any objection to that?

15 MR. GRAHAM: I think the jury could be confused about
16 the limits to that in terms of examining babies and what
17 causes, so I would just request that he be qualified in
18 that restrict way, but --

19 MR. DAVIS: Your Honor, may it please the Court?

20 THE COURT: Yes, sir.

21 MR. DAVIS: With all due respect to my friend,
22 there's no intent, there's no plan to ask Dr. Miller about
23 examining babies post-delivery. He's not going to do
24 that.

25 THE COURT: Just one second. Dr. Miller, if you

1 decide at some point that you're going to give testimony
2 as to causation or any kind of examination of the child or
3 anything like that, please tell your attorney so we can
4 stop and discuss that. Is that fair?

5 THE WITNESS: I guess what I'm wondering -- I mean, I
6 can talk about obstetrical issues?

7 THE COURT: Yes, sir. You just --

8 THE WITNESS: I won't talk about the baby whatsoever.

9 THE COURT: Right. And especially -- I mean,
10 obviously, you can talk about what you did and why you
11 believe it met the standard of care, but as to what -- are
12 you going to offer a theory as to what caused the injury
13 in the child?

14 THE WITNESS: I was going to offer my opinion on
15 where the injury occurred in the obstetrical process.

16 THE COURT: All right.

17 MR. GRAHAM: Causation. But, Your Honor, he's
18 already testified -- right before the objection, he
19 testified that he had never had a baby -- he had never
20 delivered a baby with a brachial plexus injury and the
21 truth of the matter is, he doesn't examine the babies to
22 see if he has.

23 THE COURT: I mean, that's a fair question for
24 cross-examination. But the causation issue troubles me,
25 so let's get back again. What was the deposition

1 testimony on causation? He said he was not going to give
2 causation testimony?

3 MR. GRAHAM: Yes, sir, that was clear.

4 THE COURT: Can you give me the exact quote?

5 THE WITNESS: May I?

6 THE COURT: Yes, sir, you've not been sworn and
7 you're not -- Has he been sworn in, Ms. Foster?

8 THE CLERK: Yes, sir.

9 THE COURT: You can't discuss your testimony, but
10 you're welcome to step down.

11 MR. DAVIS: I think he had a question.

12 THE COURT: What was your question, Dr. Miller?

13 THE WITNESS: When I said I wasn't going to be
14 talking about causation, I meant I do believe an
15 obstetrician having contact with the baby. I know about
16 what are the events that can lead to a brachial plexus
17 injury. You know, causation, I was talking about sort of
18 post-delivery baby, looking at the brachial plexus after
19 the incident itself. I could determine some cause of when
20 and where and how that happened. In terms of the
21 obstetrical process, I do believe that I am a witness to
22 causation and understand the causation. It's just I was
23 not going to look at her neurosurgical results and injury
24 and say based on that, then I think this is the reason
25 why. I would just say these are these typical events or

1 times when people -- women can have brachial plexus
2 injuries during obstetrics. Beyond that, I agree with Mr.
3 Graham, I was not going to look at the baby or make any
4 reference to causation based on the baby or the degree of
5 injury. I was not going do that, but from a clinical
6 standpoint, I think I am a legitimate causation expert
7 witness.

8 THE COURT: All right. Thank you. Mr. Graham.

9 MR. GRAHAM: At Page 138 of his deposition taken on
10 February 22nd, 2011, my question at Line 5: Do you
11 consider yourself qualified to render opinions as an
12 expert witness about the causation of nerve injuries in
13 newborn children? Answer at Line 8: An expert witness,
14 no.

15 MR. DAVIS: In all fairness to Mr. Graham, just prior
16 to that, and I'm reading Page 137, his question beginning
17 on Line 18, his context, I'm not disputing it. Question:
18 All right. Do you have any evidence to suggest that
19 Alexia's brachial plexus injury occurred prior to delivery
20 of her head? Answer: I have no evidence to suggest when
21 her brachial plexus injury occurred. Question: All
22 right. Is it a fair statement that as you sit here today,
23 you have absolutely no evidence tending to show that her
24 injury occurred before delivery of her head? Answer: I
25 have no evidence suggesting that it occurred before the

1 delivery or after the delivery of her head. I think
2 that's an area of contention. And then the question: Do
3 you consider yourself qualified to render opinions as an
4 expert witness about causation of nerve injuries in
5 newborn children? Answer: As an expert witness, no.
6 That's the whole context. I'm not disputing that's what
7 he said.

8 THE COURT: I'm going to sustain the objection to
9 causation testimony then given what he testified to in his
10 deposition. Dr. Miller, you can testify to the standard
11 of care and why you believe your actions met the standard
12 of care, but given what you testified to, I am going to
13 prevent you from giving causation testimony.

14 THE WITNESS: So I can't -- you want me to not talk
15 about where the injury might have occurred; is that --

16 THE COURT: That's correct. Yes, sir.

17 THE WITNESS: If I forget, please correct me. I
18 might.

19 THE COURT: Yes, sir. Anything else?

20 MR. GRAHAM: No, Your Honor.

21 THE COURT: Okay. Let's bring them back in.

22 (WHEREUPON, the jury enters the courtroom at
23 approximately 10:17 a.m.)

24 THE COURT: Ladies and gentlemen, I thank you for
25 your patience. I have qualified Dr. Miller as an expert

1 in the fields of obstetrics and gynecology, which is the
2 care of women and delivery of babies and pregnancy. But,
3 ladies and gentlemen, as I said with other expert
4 witnesses, that does not mean you have to believe his
5 testimony. You should evaluate his testimony just like
6 every other expert and every other witness and it does
7 mean he's allowed to give his opinions. And because Dr.
8 Miller is a Defendant, I just want to make sure to clarify
9 as a Judge, I do not have an opinion as to whether or not
10 Dr. Miller's care met the standard of care. That is your
11 decision as jurors you will have to render at the end of
12 the case. So the fact that I have qualified him as an
13 expert, because he is an expert, that does not mean that I
14 believe or disbelieve anything about his care. I am not
15 allowed as a Judge to have any kind of opinion as to
16 whether or not his care met the standard in this case.
17 Mr. Davis.

18 BY MR. DAVIS:

19 Q Dr. Miller, will you agree that whenever you give an
20 opinion in this case that your opinions are within a
21 reasonable degree of medical certainty unless you tell us
22 otherwise?

23 A Yes, sir.

24 Q You've reviewed some of the office records, I think,
25 in this case?

1 A Yes, I have.

2 Q And in reviewing those records -- and I'll be glad to
3 put them in your hand if you need me to --

4 A Probably will.

5 Q That will help, okay.

6 MR. DAVIS: Your Honor, we have medical records --

7 THE COURT: All right. I think the last two you put
8 in, Mr. Davis, were 27 and 28. You want this marked as
9 29?

10 MR. DAVIS: Yes, sir. For the record, I've pulled
11 these out of our notebook. I'm going to clip them
12 together and have them marked as one exhibit number.

13 THE COURT: All right. Any objection, Mr. Graham?

14 MR. GRAHAM: Subject to our agreement on the other
15 records.

16 THE COURT: Yes, sir. Ladies and gentlemen, Defense
17 Exhibit 29, which is the prenatal office visit records in
18 evidence without objection.

19 MR. DAVIS: Thank you, Your Honor.

20 (WHEREUPON, Defendant's Exhibit No. 29 was admitted
21 into evidence.)

22 BY MR. DAVIS:

23 Q Dr. Miller, I've handed you a set of medical records
24 from Rock Hill GYN/OB of Angela Patton and her pregnancy
25 with Alexia. I apologize for the way that we have

1 organized them with different tabs as you see, that's
2 probably not the way -- I'm sure it's not the way y'all
3 organize them in your office, so if you need to look
4 through there -- Do we have that index? Let me get an
5 index so you'll know how we broke them down.

6 BY MR. DAVIS::

7 Q Dr. Miller, that's 34 in the index there?

8 A Okay.

9 Q Can you tell us, Dr. Miller, when did Ms. Patton
10 become a patient of your practice with this pregnancy?

11 A Her first visit was on September 19th, 2006.

12 Q Okay. Would you reference the page?

13 A This is 001.

14 Q Thank you. Dr. Miller, do you see -- did you see her
15 on any of the prenatal visits?

16 A Yes, I saw her on one prenatal visit.

17 Q Do you recall the date or can you find that in the
18 chart?

19 A This is numbered 007, and I saw her on March 14th.

20 Q Do the records reflect, if you can tell, whether you
21 saw her at any other prenatal visits?

22 A It doesn't look like I saw her at any other time.

23 Q All right, sir. And according to the office records,
24 Dr. Miller, what sort of history did she have with regards
25 to prior pregnancies?

1 A She had had three prior pregnancies.

2 Q And the last one, I think, was in 1999?

3 A The last one was in 1999 in Chester, 40 weeks
4 gestation, vaginal delivery of a little boy who weighed
5 nine pounds 11 ounces.

6 Q All right. Is that more or less than Alexia's birth
7 weight?

8 A That was more than Alexia's birth weight.

9 Q Was there any shoulder dystocia noted in the records
10 with that bigger baby?

11 A No. They did notate that there was a two-hour labor.

12 Q Two-hour labor?

13 A Yes.

14 Q What is a problem list? If we see in the records a
15 problem list, what does that represent?

16 A A problem list tends to represent any obstetrical,
17 medical or surgical factors or issues that we need to keep
18 an eye on.

19 Q Is there a problem list in that chart?

20 A Again, the problem list is back on 007. The first
21 problem listed is advanced maternal age, that she would be
22 35 years old at the time of delivery. There's, typically,
23 a couple issues related to that. The first is people tend
24 to have an increased risk for miscarriage. They also have
25 increased risk for chromosomal anomalies. And they have

1 an increased risk for still birth. The second is history
2 of preterm labor and delivery at 30 --

3 THE COURT: Just hold on one second, Doctor. Yes,
4 sir.

5 MR. GRAHAM: The numbers you're using are not the
6 numbers that we have been provided here. We would just
7 ask that -- may we examine each page --

8 MR. DAVIS: Your Honor, we e-mailed Mr. Graham's
9 office every one of these records some time ago. I don't
10 know what they did with them, but here we are.

11 THE COURT: Counsel, can y'all approach the bench,
12 please?

13 (WHEREUPON, a bench conference was held in the
14 presence of the jury, but outside the hearing of the
15 jury.)

16 THE COURT: Ladies and gentlemen, we're going to take
17 a short break and let the clerk's office make a copy of
18 the documents so each side will have a copy.

19 (WHEREUPON, the jury exits the courtroom at
20 approximately 10:41 a.m.)

21 THE COURT: All right. Let's bring them back in.

22 (WHEREUPON, the jury enters the courtroom at
23 approximately 10:44 a.m.)

24 THE COURT: Mr. Davis.

25 MR. DAVIS: Thank you very much.

1 THE COURT: Yes, sir.

2 BY MR. DAVIS:

3 Q Dr. Miller, if I could have you turn back to Page 10
4 of your office chart. I think this is the note that has
5 your signature, March 14th, 2007?

6 A Yes, sir.

7 Q And, Dr. Miller, I'm going to ask you if you could
8 take your mask off while you testify.

9 A (Witness complies.)

10 Q Thank you, sir. What's an ultrasound?

11 A An ultrasound is what we call a sonogram. It's the
12 ability for us to look inside the pregnancy and gather
13 details about the baby, the placenta, the amniotic fluid
14 and the cervix.

15 Q What is a normal period of gestation, how many weeks?

16 A Typically, 40 weeks.

17 Q And on March 14, 2007, when you saw Ms. Patton, how
18 many weeks gestation was she?

19 A She was 36 weeks.

20 Q Was an ultrasound done that day?

21 A Yes. Actually, when I did my exam -- we do something
22 called Leopold and we measure fundal height. And that's
23 from the pubic up to the top of the uterus and she was
24 measuring large. She was measuring 40 centimeters. We
25 would expect her to be plus or minus two of 36

1 centimeters. Because of that, I said well, I wanted to go
2 ahead and order an ultrasound to try and get an idea of
3 the size of the baby and the quantity of amniotic fluid.

4 Q What is amniotic fluid?

5 A That's, basically, the fluid that circulates around
6 the baby, sort of provides protection to the baby,
7 provides protection to the umbilical cord.

8 Q And why is it important as an OBGYN with a prenatal
9 patient to know what the level of the amniotic fluid is?

10 A There can be -- an elevated or a decreased amniotic
11 fluid can have certain risk associated with it.

12 Q And you did an ultrasound that day?

13 A Yes, sir.

14 Q And when we see polyhydramnios, am I pronouncing that
15 right?

16 A Yes, you are.

17 Q Okay. And an AFI, what's AFI when the jury sees
18 this?

19 A AFI is what's called the amniotic fluid index. What
20 you do is you take the mother's -- the sonographer takes
21 the mother's belly button and they bisect it so there's
22 four quadrants. Then you take the maximum vertical pocket
23 in each one of those quadrants and you add that up and you
24 get what's called the AFI, the amniotic fluid index.

25 Q And your note documents that she had an AFI of 27.

1 Is that good, bad, indifferent, normal?

2 A That's elevated. Depending on which textbook you
3 use, some will say greater than 20, some will say greater
4 than 25. So regardless of that definition, 27 is
5 considered elevated.

6 Q As an obstetrician, what does that mean to you in
7 taking care of a lady at 36 weeks?

8 A The most common cause for that is idiopathic, which
9 means we don't really have a good explanation for it.
10 There are some congenital anomalies, particular some
11 called tracheoesophageal fistula where the baby has
12 problems swallowing properly, that can lead to that.
13 We'll often see that in somebody who is diabetic. But in
14 this situation, this seemed to be sort of an idiopathic --
15 we weren't sure why that was occurring. We do get
16 concerned if that AFI gets too large because if there's
17 too much fluid in there, we're concerned about the
18 possibility of causing compression, internal compression
19 of the umbilical cord. So in her case on that day, I went
20 ahead and ordered something called a non-stress test where
21 we put the baby on a monitor to monitor the fetal heart
22 rate. And we look to see that there's a certain number of
23 accelerations within a certain period of time--

24 Q What's an acceleration?

25 A That's when the -- you determine what the fetal heart

1 rate baseline is and then you want to see accelerations,
2 meaning the heart rate goes up. Typically, it goes up
3 related to fetal movement. It's just like if any of us
4 moved, our heart rate is going to respond. If you go out
5 and -- if you go walk down a flight of stairs or go out
6 for a run, your heart rate responds in a positive way. So
7 not only is it sort of you're measuring the heart, but
8 indirectly, you're assessing whether neurologically the
9 baby is intact. So we did an NST that day. And my
10 concern for Angela was that her AFI was 27. We had a
11 reassuring NST. We would now start ordering NSTs on a
12 weekly basis and I wanted to look at her AFI again in two
13 weeks.

14 Q This was on March 14, 2007, and Alexia was born April
15 5 at 39 weeks; is that right?

16 A That's correct.

17 Q When you note in your record here, sir, on Page 10,
18 ultrasound today showed a seven pound and seven ounce baby
19 at 93rd percentile with obvious polyhydramnios and an AFI
20 of 27. NST today is reactive. How do you get the seven
21 pounds, seven ounces thing?

22 A There's multiple measurements that are put together
23 into an algorithm that ultimately spits out a weight of
24 the baby. At full term or close to full term, they're not
25 very reliable. They can be off a pound or so in either

1 direction, but they are the best that we have.

2 Q The record documents that the patient also complains
3 of some asymmetric swelling in her left ankle. Tell the
4 jury what that was all about.

5 A Angela complained that her -- you know, anybody
6 that's been pregnant knows that swelling is inevitable,
7 but it should be sort of uniform, both legs should be
8 similar. And she was complaining of more swelling in her
9 left leg as opposed to her right leg.

10 Q What concerns, if any, does that raise for you as her
11 physician?

12 A Well, the main issue is a deep venous thrombosis,
13 that somebody gets a blood clot. Pregnant women are at
14 increased risk for developing blood clots and that could
15 be, you know, potentially, a life threatening issue or
16 illness. And so in the note -- you know, there's
17 something called a Homan's sign. And that's if you take
18 the calf -- if you straighten the leg and take the calf
19 and you hit their heel, if they have a developing blood
20 clot in their calf, they'll experience pain. So she had a
21 negative Homan's sign. But then the other way is you want
22 to measure the diameter of the calf. So you can see what
23 I did was measure the right versus the left. It was nine
24 and a quarter inches on the left and eight and
25 three-quarters on the right. In the mid-calf, I measured

1 from -- it was about -- it was approximately 14 inches, so
2 both measurements looked okay, but regardless, went ahead
3 and ordered what's called Doppler studies, which are an
4 ultrasound study of the venous anatomy in those legs to
5 make sure that she didn't have a deep venous thrombosis.

6 Q Read the -- what is your assessment on this note?
7 You have typed in assessment number one and number two.
8 What are you doing there?

9 A So assessment number one is term IEP with --

10 Q What's IEP?

11 A Intrauterine pregnancy. With impending microsomia,
12 we're worried about -- this baby looks big at this point
13 and we're worried that it's going to get bigger -- with
14 polyhydramnios. And then asymmetric lower extremity
15 swelling. So I went ahead and initiated NSTs, went ahead
16 and did the Doppler studies on her. And, you know, it
17 doesn't say here, but the other note, I ordered an
18 ultrasound for two weeks to take a look at the AFI in two
19 weeks.

20 Q So your plan is written here, number one and number
21 two, number one NSTs weekly, what's that?

22 A That's the non-stress test that we talked about that
23 you put a monitor on the mom, particularly on the baby.
24 It's, typically, a belt and that's to monitor the baby's
25 heartbeat. You look a period of time to establish what

1 the baseline is of that heartbeat. And then you're going
2 to look for accelerations and you like to see, at least,
3 two accelerations. And there's a 15 by 15, which means
4 you want the heart rate to rise 15 units above the
5 baseline for 15 seconds, at least, twice over a 20-minute
6 time period.

7 Q Does the chart reflect whether she was ever tested
8 for diabetes?

9 A Yes, she was.

10 Q What were the results of that?

11 A The typical test for diabetes is checking a one-hour
12 GCT, which is a glucose tolerance test, where they're
13 given 50 milligrams of glucose and an hour later, you
14 check their blood sugar. And she tested at 128. Anything
15 less than 140 is considered to be normal.

16 Q What about maternal weight gain during her pregnancy,
17 do y'all track that, record that somewhere?

18 A Yes, we do.

19 Q What does the record indicate as a clinician what
20 that was about? And is that in that flow chart, flow
21 sheet?

22 A She gained approximately 54 pounds.

23 Q Is that a lot of weight gain for a mom?

24 A That's a little bit above average, yes.

25 Q In your opinion, does that in any way predict

1 shoulder dystocia?

2 A No.

3 Q Does that predict a big baby?

4 A It puts her at risk for a big baby, yes.

5 Q Let's turn to April 5 of 2007. Tell the jury, that
6 day, what you were on duty for, where you were, how long a
7 period of time you were on duty, that sort of thing?

8 A Do you know which tab that is on here?

9 Q Let me just ask it this way. That day, were you at
10 the hospital?

11 A Yes.

12 Q Were you, like, on call for that whole day?

13 A Yes, sir. Call, typically, started at eight o'clock
14 in the morning.

15 Q Eight o'clock on what day?

16 A On the 5th.

17 Q And it goes for how long?

18 A 24 hours.

19 Q Eight o'clock on the 6th?

20 A Yes, sir.

21 Q Alexia was born about what time?

22 A She was born at almost nine o'clock in the evening on
23 the 5th.

24 Q Halfway through your shift?

25 A Yes.

1 Q Dr. Miller, do you have any recollection of this
2 delivery?

3 A Yes, I do.

4 Q How is it you can remember this delivery with 9,000
5 or 5,000?

6 A Certain deliveries stand out.

7 Q Does this one stand out?

8 A Yes, it does.

9 Q When your deposition was taken in this case on
10 February 22, 2011, was that about six hours in length?

11 A Yes, sir.

12 Q Did you learn shortly after Alexia's delivery that
13 there was some problem with one of her arms?

14 A Yes, I did.

15 Q What did you learn?

16 A Well, during the delivery -- and this delivery
17 started way back in her labor and delivery suite and we
18 had to move her emergently to the OR, she experienced a
19 shoulder dystocia, right shoulder dystocia.

20 Q We're going to drill down in those details, yes, sir.

21 A The shoulder dystocia was reduced effectively, baby
22 delivered, handed the baby off to the pediatric team. At
23 the time in the OR -- and an OR setting is extremely -- is
24 completely different than delivery in the labor and
25 delivery suite. Handed off to a neonatal nurse. There's

1 sort of an annex room next to the OR directly adjacent and
2 that's where the neonatologist, a pediatrician who
3 specializes in small, early, early babies was there, Dr.
4 Mercado. Whenever you have a shoulder dystocia, you want
5 to make sure that the shoulder that was stuck is okay.
6 And so, you know, Angela had what's called a third degree
7 repair. Before starting that, because that takes
8 approximately a half an hour to fix, I just stepped up and
9 went over and poked my head in the room and I asked Sonia
10 and she said, Yeah, there's an arm weak, it's the left
11 arm.

12 Q Which shoulder got stuck?

13 A It was the right shoulder that was stuck.

14 Q Okay. Go ahead.

15 A And I asked her a couple of times, Are you sure it's
16 the left arm because it was the right arm that was stuck?
17 She said, No, the left arm was stuck. And I was, you
18 know, I was shocked.

19 Q Dr. Miller, when did you first learn about Alexia's
20 brachial plexus injury being permanent?

21 A I think it was after I was served with the lawsuit.

22 Q Sometime in 2009?

23 A Yes, sir.

24 Q Do you have an opinion whether or not you met the
25 standard of care when you delivered Alexia Lumpkin?

1 A Yes, I did.

2 Q We're going to talk about that. The jury has already
3 heard from other experts. I'm sure they may hear from
4 other experts. I want you to tell the jury what is --
5 what you understand -- what is shoulder dystocia, what is
6 that?

7 A Shoulder -- so, first of all, honestly, most moms
8 don't necessarily need us. We're sort of an insurance
9 policy. Most moms are capable of pushing a baby out and,
10 unfortunately, sometimes they do before we can ever get
11 there. But a shoulder dystocia, typically, an anterior
12 shoulder dystocia is --

13 Q Help us, anterior, posterior?

14 A So shoulder dystocia, typically, the anterior
15 shoulder dystocia is when the baby comes down and the head
16 delivers outside the vagina. There's resistance to the
17 rest of the baby coming out. Okay, so you have the pubic
18 bone and the anterior shoulder gets stuck behind that
19 pubic bone. So that's the top -- there's a bottom
20 shoulder, I said top shoulder. You apply a little gentle
21 downward traction and you meet resistance, then you have
22 to move on to various maneuvers to reduce that shoulder
23 dystocia.

24 Q Doctor, do you have an opinion whether or not
25 shoulder dystocia is predictable or foreseeable?

1 A Shoulder dystocia is neither predictable nor
2 foreseeable.

3 Q That day while Ms. Patton was in labor with Alexia,
4 had you been in and out of the labor and delivery room
5 several times during the day?

6 A Yes, sir.

7 Q At some point, did the fetal monitor strips give you
8 some sort of increased concern for Alexia, for the baby?

9 A Yes.

10 Q It's in evidence, there's another form that I want to
11 hand to you, the fetal monitor strips.

12 MR. GRAHAM: Your Honor, once again, we're provided
13 Bates stamp numbers that don't match up with what the
14 witness has. I hate to ask the Court's indulgence, but --

15 MR. DAVIS: May it please the Court, Your Honor. We
16 got these by subpoena from the hospital. They got a copy.
17 We got them from the hospital earlier --

18 THE COURT: Counsel, let me see you at the bench,
19 please.

20 (WHEREUPON, a bench conference was held in the
21 presence of the jury, but outside the hearing of the
22 jury.)

23 MR. DAVIS: Your Honor, can we proceed with my
24 examination?

25 THE COURT: Yes, sir.

1 BY MR. DAVIS:

2 Q Dr. Miller, I've given you what's been marked as an
3 exhibit by the Plaintiffs of the fetal monitor strips.
4 Would you look at those and as we go through, I want you
5 to explain to the jury as you review those strips -- did
6 you review the strips, by the way, that night?

7 A Yes, sir.

8 Q And as you look at those fetal monitor strips, what,
9 if any, concerns did you have in reviewing the fetal
10 monitor strips that measured the contractions of the mom
11 on the bottom of the strips and the baby's heart rate on
12 the top of the strip, sir?

13 A I'm sorry, they're just a little disorganized.

14 Q Yes, sir.

15 A So at approximately six o'clock in the evening on 4/5
16 -- excuse me, April 5th, 2007, the patient -- excuse me,
17 Alexia began to experience or show what we call variable
18 decelerations.

19 Q What is a variable deceleration, sir?

20 MR. GRAHAM: Can we get those page numbers, please?

21 BY MR. DAVIS:

22 Q Is there a page number somewhere on the --

23 THE COURT: The witness can refer to the time if
24 that's easier. Because the time stamp --

25 THE WITNESS: The time stamp is not -- you only get a

1 time stamp -- they're not on every page.

2 THE COURT: They're not, okay.

3 THE WITNESS: The PMC number is 0301 or the page
4 number is 280.

5 BY MR. DAVIS::

6 Q Okay, that's fine. Let's refer to the PMC, I think
7 we call that Bates stamp?

8 A Yes, sir.

9 Q We get the things from the hospital, so we'll use
10 those. Thank you. At six o'clock, what was going on?

11 A So at six o'clock, she was having contractions every
12 two to four minutes, which is an appropriate interval for
13 labor. At that time, ruptured membranes had occurred and
14 she was having variable decelerations with virtually every
15 contraction.

16 Q Explain to the jury when you say variable
17 decelerations on the fetal monitor strips, what does that
18 mean to you as the delivering physician?

19 A So there's several things to think about when
20 somebody starts having variable decelerations. The
21 underlying cause of a variable deceleration of the fetal
22 heart tracing is that the umbilical is being compressed.
23 So the umbilical cord is in some situation or position
24 where with each contraction, it gets compressed, so
25 there's a decreased amount of blood supply delivered to

1 the baby at that time. Variable decelerations -- at this
2 time, we used to -- back in 2007, we described strips as
3 either reactive or nonreactive. Since then, the
4 nomenclature, the way we name things are a little bit
5 different. We call them category 1, category 2 and
6 category 3. They're trying to get everybody on the same
7 page. Category 1 is considered to be a very reassuring
8 tracing, one that you really have little to no concern of.
9 Category 3 is an extremely ominous tracing, meaning that
10 you need to do something almost immediately about that. A
11 category 2 tracing, which that's what this represents, is
12 a tracing which you need to continue to monitor carefully
13 and make sure there's no significant change in the
14 tracing.

15 Q What is an extended bradycardia, what is that?

16 A An extended bradycardia is one that last for several
17 minutes.

18 Q Was there on these fetal monitor strips, in your
19 opinion, an extended bradycardia?

20 A So from six o'clock on, she had well over 50 of these
21 variable decelerations. And then there was an episode of
22 bradycardia. And, again, that's something that you are
23 concerned when a baby is experiencing multiple variable
24 decelerations. The possibility is the baby could become
25 compromised. And then it looks like somewhere around

1 2012, which would be a little bit after eight o'clock, she
2 was dilated to ten centimeters. The station of the baby
3 is still pretty high at zero station, but she was dilated
4 ten centimeters. And we know that the heart rate
5 precipitously dropped, something we call bradycardia, into
6 the 60s. The baby had been running a baseline of closer
7 to 140 and it dropped down in the 60s to 90s at that
8 point.

9 Q What concern, if any, did that give you for this
10 baby?

11 A It gives us a lot of concern. That's a
12 life-threatening situation.

13 Q Why is that a life-threatening situation?

14 A Because when you see bradycardia, that means the baby
15 is no longer being oxygenated well and the babies have
16 limited time before they'll suffer some damage or even
17 die. And that was our concern in this case.

18 Q What, if anything, did you do in response to your
19 observing the extended bradycardia at about -- did you say
20 8:00 p.m., is that when it happened?

21 A A little after 8:00 p.m., yes.

22 Q After 8:00, okay. What, if anything, did you do?

23 A So the cervix is now completely dilated, so the
24 patient is in a situation where they can push the baby
25 out. Prior to that when the cervix is not fully dilated,

1 the baby is not going to fit, so you can't even -- the
2 only option would be a C-section if the cervix is not
3 completely dilated. I knew that Angela had a nine pound,
4 11 ounce baby before in a labor that took two hours, which
5 is very short, so I thought we had a very real chance of
6 being able to successfully deliver this baby vaginally.
7 You know, I tried to encourage her to push harder and push
8 harder. The baby wasn't descending. It was stuck at that
9 zero station. It wasn't descending down and that gave me
10 even greater concern that we were going to have to do
11 something more emergent. I tried to put a vacuum on. A
12 vacuum is a device that helps us provide some extra effort
13 in the labor process. But, unfortunately, it wouldn't
14 attach. And in this case, putting a vacuum on at zero
15 station, typically, you don't do that and that would
16 probably not be the standard of care unless you have a
17 life-threatening situation. And knowing Angela's history,
18 I believed that she was going to be able to push this baby
19 out. I thought her history was in our favor. We just had
20 to get the coordinated pushing effort to occur. So I was
21 hoping to put the vacuum on, maybe bring the baby down
22 just one or two centimeters. A lot of times when the baby
23 is that high and they are not pushing, you know, it does
24 not appear they're pushing well, the problem is that the
25 baby is just not low enough. Anyone that's ever had a

1 baby, you will reach a certain stage where the urge is
2 almost overwhelming to push a baby out. That pressure
3 down there is truly, you know, amazing in the sense that
4 it motivates everybody to push. And Angela hadn't reached
5 that. So I was hoping that we'd get the baby down just a
6 little bit, she would be able to effectively push. The
7 vacuum wouldn't apply. We were still not making any
8 descent at all, so at that time, the decision was made to
9 take her to the operating room for possible C-section.

10 Q Describe to the jury as you recall how you
11 communication to Ms. Patton about urging her or
12 encouraging her to push.

13 A At this point, this is an emergency and the baby's
14 life is on the line. So you're somewhat succinct in the
15 way you describe it. We need to take you to the back --

16 Q Excuse me, how did you encourage her to push? What
17 kind of words would you have used?

18 A The main thing is you just say you've got to push
19 harder. You've got to push harder. Can you feel where
20 the pressure is? Push where that pressure is. Push
21 harder. Push harder. And as you've heard in earlier
22 testimony, it's not just me encouraging her. It's family.
23 It's the nurses. We're all -- this is a team effort and
24 we're all trying to get this baby out, you know, as
25 quickly and as safely as possible.

1 Q Did you yell at her, Doctor?

2 A No, no.

3 Q Were you mean to her in tone?

4 A No, sir.

5 Q Or words? Did you threaten her in any way, sir?

6 A No, no way.

7 Q What led you as things were unfolding before you with
8 this low heart rate -- and how long a period of time did
9 that low heart rate go on the fetal monitor strips as you
10 reviewed them?

11 A It's somewhere between eight and ten minutes.

12 Q At what point did you decide it would be safest to do
13 a cesarean section?

14 A When the heart rate stayed down and we weren't making
15 progress and it didn't look like we were going to deliver
16 the baby as quickly as the baby needed to be delivered.

17 Q Dr. Miller, does the standard of care require that
18 the reasonably prudent OBGYN in a situation that you were
19 in, does the standard of care require that OBGYN to
20 explain the risks and benefits and alternatives to a
21 cesarean section in order to try to obtain informed
22 consent? Are you required to do that?

23 A Yes, sir.

24 Q Did you do that, sir?

25 A Yes, sir.

1 Q Tell the jury as best you can how you described and
2 informed your recommendation for a C-section to Ms.
3 Patton.

4 A The first thing is you just have to tell them why. I
5 think at that point any mother knows that it's an
6 emergency and that something is happening, something very
7 dangerous is happening. But you just tell them, say,
8 listen, the baby's heart rate is down, it's not coming up.
9 We need to get this baby out. I'm going to make an
10 incision in your lower abdomen and do a C-section. You
11 know, the risks of C-section include pain, infection,
12 bleeding, damage to internal organs and even death. Do
13 you have any questions? And it has to be that quick
14 because you don't want to spend ten minutes trying to
15 explain something. I wish you could, but you don't have
16 that time because you have to start moving her back.

17 Q Did you ever say I'm going to cut you?

18 A No.

19 Q Sir?

20 A No, sir.

21 Q Did she sign the consent to the cesarean section?

22 A Yes, sir.

23 Q Was there anything that she expressed to you about
24 any hesitation or reservation about proceeding with the
25 C-section?

1 A No, sir.

2 Q Did you explain to her, Dr. Miller, the reasons why
3 you were recommending a C-section relating to the low
4 heart rate of her baby?

5 A Yes, sir.

6 Q Dr. Miller, were you in sort of a hurry at that point
7 in your interaction with Angela or any time during the
8 delivery from that point on?

9 A You are in a little bit of a hurry.

10 Q Why?

11 A Because you know you just can't blink and the baby is
12 going to pop out. We're in one room in a part of the
13 hospital and we need to transport her to another room.
14 And not only do we need to transport her in that bed, she
15 has to be transferred from one bed to another. Not only
16 does she have to be one bed to another, the whole
17 operative team has to be ready to go. The neonatal team
18 has to be ready to go. Anesthesia has to be ready to go.
19 Those things, unfortunately, take time. So you know that
20 there's going to be a window where you really don't know.
21 When you start moving her, she's not attached to a
22 monitor, you don't know. So when you get back to the OR,
23 depending on how long it takes and that can take sometimes
24 as little as five to six minutes, but usually somewhere
25 around eight to ten minutes it takes to get a mother from

1 one room to another on the table and you can check that
2 heartbeat.

3 Q Are you able to monitor the heart rate of the baby in
4 that transition period?

5 A No, sir.

6 Q Doctor, were you tired at eight o'clock that night?

7 A No.

8 Q How did she go from the labor and delivery room to
9 the operating room?

10 A In this situation, when it's an emergency, what
11 happens is we have to -- the first thing we do is we make
12 sure, you know, her arms and legs are inside the railing
13 and we put the railing up on the bed --

14 Q Is this a bed she's been in for hours?

15 A Yes, sir.

16 Q Okay.

17 A And then what happens is, she has an IV pole in the
18 room, we have to extend the -- there is an IV pole
19 attached to the bed, but the IV pole in the room is
20 separate. You move her IV fluid over to that. That IV
21 fluid is also the medication and the medication pump.
22 Once you have those things onto the bed, then you start
23 moving. In Angela's case, this was an emergency, so I'm
24 moving her. I'm at the front of the bed and the nurse is
25 at the back of the bed.

1 Q You're moving her, what are you doing?

2 A I'm pulling the bed.

3 Q To the operating room?

4 A Yes.

5 Q All right, sir. How far away is that operating room
6 from the labor and delivery room where she was located?

7 A You know, it's all in the same floor. It's not --
8 you know, the ward is designed for it to be relatively
9 close. We were in labor and delivery room 3, which is
10 almost -- at Piedmont, there's a nurse's station there and
11 this was just down the hallway, just a little bit from the
12 nurse's station. And then we came back to the OR and we
13 were in operating room 2. There's three operating rooms
14 there, but we're in operating room 2. It's not very far.

15 Q As she's getting prepared for the cesarean section,
16 are you there in the room with her?

17 A So in Angela's case -- you know what happens is we
18 pull her back and she's on a big bed. This is the bed
19 that's in her room. And she's got to go on an OR bed so
20 we can manipulate the bed and get her in various positions
21 that we need to get her in to do the surgery or the
22 delivery. Angela at the time did not -- you know, a lot
23 of women will have an epidural. And if they have an
24 epidural, they, typically, have some numbness and that,
25 typically, is somewhere below the belly button. Angela --

1 you know, she's pretty tough. She didn't want or need an
2 epidural, so she didn't have an epidural. So in that
3 situation it's her responsibility to move from the bed in
4 the room, which we wheeled it back into the OR. We put it
5 right next to the OR bed. So she has to shimmy over to
6 the OR bed. As soon as she shimmies over, you know, the
7 first thing that I do -- because we have an ultrasound
8 machine in there and that's the quickest way to determine
9 a fetal heart rate. And I just stuck the ultrasound probe
10 on and we could hear Alexia's heart rate was up in the
11 120s. You know, I alerted the team to go ahead and prep
12 her for surgery, but we're going to check her as soon as I
13 finish scrubbing, and that's what happened. So she was
14 draped for a C-section.

15 Q Describe the drapes.

16 A So the draping for a C-section, the bed is very
17 narrow. As a matter of fact, it's so narrow that you
18 can't even put your arms next to your side for most
19 people, so they put arm boards out. So patient's arms are
20 out. And right around the level of her heart, there's a
21 vertical sterile drape there because when you prep for a
22 C-section, that it a sterile field. Matter of fact, the
23 whole OR for the most part is considered to be sterile.
24 So there's a vertical drape that's probably as high as
25 this Plexiglass. And that's to make sure anything the

1 anesthesiologist has, their equipment, the respirator --
2 well, that's not technically sterile. They don't come in
3 an sterilize that. So this drape is to keep anything from
4 an anesthesia side of things up there and keep our field
5 sterile.

6 Q Let me get the picture --

7 THE COURT: Is this the picture of the drape?

8 MR. DAVIS: Yes, sir.

9 THE COURT: Ladies and gentlemen, Mr. Davis is about
10 to put up an example picture of a surgical drape. Before
11 he does that, let me make sure, this is not evidence.
12 There is a factual dispute in the case as to whether or
13 not there was a surgical drape used. So this is not a
14 photograph of this patient. This is an example picture of
15 what a surgical drape looks like so that Dr. Miller can
16 explain that to y'all, but it is not evidence in the case.
17 It's just an example.

18 MR. DAVIS: Thank you.

19 MR. GRAHAM: May we approach?

20 THE COURT: You may.

21 (WHEREUPON, a bench conference was held in the
22 presence of the jury, but outside the hearing of the
23 jury.)

24 BY MR. DAVIS:

25 Q Doctor, this isn't a picture of Angela or the

1 operating room?

2 A No, sir, it's not.

3 Q Describe what we're seeing here just generically.

4 Does this look like a cesarean section?

5 A Yes. That's a typical C-section and that's the way
6 that somebody is draped. The anesthesiologist, for
7 example, Dr. Lupo, would be behind that drape so you
8 couldn't see. If you see in that picture, you can see
9 where the father is positioned. He has to be above that
10 drape because he is not sterile. Typically, the fathers
11 are seated because -- in my career, I've had two fathers
12 pass out. That complicates a situation, so they're asked
13 to be seated. So that's the position where the father
14 typically is. At this stage, it looks like the scrub tech
15 is on the patient's right-hand side and the surgeon is
16 technically on the left-hand side. That's actually how I
17 operate. And that's their first table or tray where
18 they'll move instruments. The more immediate instruments
19 will go on that table and then she has a back table with
20 other instruments. The Bovie-cardio (ph) electrical
21 machine is in the background on the left-hand side.

22 Q Where is mom's head?

23 A Mom's head is behind that curtain.

24 Q Where are her legs?

25 A You cannot see her legs, but if you see the table

1 with the instruments on top of it below her abdomen, her
2 feet are at the very end. You can almost see at the very
3 end of the bed something pointed up and that's the
4 mother's feet.

5 Q Can you come down and just sort of use this paper and
6 draw for the jury what the OR layout was as you remember
7 it so they can get an overview, bird's eye view of what
8 that operating room layout was that day. And you're not
9 an artist.

10 A (Witness complies.)

11 Q How wide is that operating room table? Can you find
12 something here in the courtroom? That's an exercise mat,
13 can you measure that?

14 A This is the width of an operating table.

15 Q What did you just draw?

16 A These are the arm boards.

17 Q Okay.

18 A The drapes and blanket.

19 Q Just label that.

20 A This is approximately where Dr. Lupo would be.

21 Q She's an anesthesiologist?

22 A Anesthesiologist that you met yesterday.

23 Q Now, you've been in this operating room several
24 times?

25 A Many times.

1 Q Many times, all right, sir.

2 A For OB and GYN surgery.

3 Q All right.

4 A This is the entranceway into the operating room. Dr.
5 Lupo will have the back table here. She had a smaller
6 table here. And the respirator is over here (inaudible).

7 Q Okay.

8 A Angela is here. I dotted this line because at some
9 point, we decided to abandon (inaudible) and drop the
10 bottom of the bed.

11 Q Is it like on hinges?

12 A Yeah.

13 Q Okay. All right.

14 A Typically, when you're operating, I'm going to be
15 here and my scrub tech is going to be here. Now, this is
16 -- right here is the door (inaudible), right over there is
17 a door where Dr. Mercado is.

18 Q And she's a neonatologist that you had summoned to
19 the delivery?

20 A Yes.

21 Q Okay. And why did you ask neonatology to come to
22 this cesarean section?

23 A Because of the bradycardia.

24 Q The low heart rate?

25 A Bradycardia, we, you know, honestly don't know what

1 that might involve. Sometimes it might be a cord that was
2 trapped. (Inaudible.) Sometimes you don't, sometimes you
3 find out there was a placental abruption, the placenta is
4 separated from the uterine wall, again, another emergent
5 situation. So then what happens when you're operating,
6 she has her sterile table here --

7 Q Whose table is that?

8 A That's the scrub tech.

9 Q Okay.

10 A So this is -- so in that picture there, you saw a
11 little table here.

12 Q Is that a Mayo table?

13 A That's a Mayo table right there.

14 Q Right.

15 A That's where we put all the instruments that we're
16 going to use back and forth. This is where she puts the
17 other instruments to transfer back and forth. They're not
18 used as much, but if we need them, they're back there.

19 Q Okay.

20 A Then, typically, in our OR, the electrical machine is
21 here --

22 Q What's an electrical machine for?

23 A So (inaudible) electricity (inaudible.) In this
24 case, we used a Bovie --

25 Q What does it do? What does a Bovie as you make an

1 incision?

2 A So you typically won't use a Bovie on the skin
3 because you're always worried about burning the skin. You
4 use a Bovie once you get beneath the skin. You always use
5 the scalpel on the skin, you use a Bovie beneath the skin
6 because what it does, it cauterizes the smaller vessels
7 because you --

8 Q What does cauterize mean?

9 A It means you burn them until the stop the bleeding.
10 (Inaudible.)

11 Q Okay.

12 A Now, back here, there's another table back here.
13 This has instruments that we use less often. For example,
14 when I come in the room, my drape, my dressing is down
15 there, my gloves are there. It's a sterile back table,
16 but a lot of this (inaudible.) And then that's sort of
17 the way it's built in a C-section.

18 Q Okay. Now, at what point -- if you could explain,
19 please, sir, at what point did you decide to go from the
20 cesarean section which you lined up to continued attempts
21 for vaginal delivery. Tell us about that.

22 A So when we brought Angela in here, we would have
23 lined up these two beds and she would have transferred
24 over to this bed. As soon as she transferred over -- we
25 also have an ultrasound machine, it's either in OR 2 or OR

1 1, if it was in OR2, scrub tech knows to move that. And I
2 just put the ultrasound machine on her belly because her
3 belly has not been (inaudible), and that's when we noticed
4 the heart rate went up. And I think -- I want to say Dr.
5 Lupo came in before we did (inaudible) draping, but we had
6 had the patient and transferred her over before Dr. Lupo
7 got there.

8 Q Okay.

9 A We know we had bradycardia and (inaudible) on my
10 part. I said, Well, let's go ahead and prep her for
11 C-section. I'm going to go scrub. So then I had to go
12 out here, the scrub sink is out in this area. And it's a
13 three-minute scrub that you do. You do two 90-second
14 scrubs and then you come back in, come back to here where
15 the scrub tech will hand you a towel, you dry off your
16 hands. So I said, Okay, let's check the heart rate again.
17 (Inaudible.) So we checked again and the heart rate is
18 up. And that's great news.

19 Q Why is that great news?

20 A C-sections are not without risks. They're not
21 without (inaudible) sepsis.

22 Q What is sepsis?

23 A It's an infection. (Inaudible.) C-sections are not
24 without risks and if you can, you'd like to avoid them.

25 Q Okay.

1 A Angela had three babies, hadn't had a C-section.

2 Now, we have a baby who's bradycardia (inaudible) she can
3 push a little bit better. She does start pushing better.

4 So we postponed the C-section at that point.

5 Q Let me ask you this, you say that she did not have an
6 epidural and she had to move herself from the delivery
7 table onto this table, she had to get up and move herself.
8 Do you have an opinion whether or not that would cause any
9 shift in the baby's position?

10 A I suppose it can, yeah.

11 Q So we're back here, everything is set up for
12 C-section. You check the heart rate again and the heart
13 rate is back up. Is it at a normal and acceptable level?

14 A Yes.

15 Q And your decision is then to do what?

16 A So at that point, we decide okay -- you know, again,
17 (inaudible.) Just by the fact that she didn't get an
18 epidural, I know she's tough. I know she can do this. So
19 we start encouraging her to start pushing again. So what
20 we do -- and I'm going to -- it's going to be a mess when
21 I'm done with it, you know, (inaudible).

22 Q You want to do something in red?

23 A Okay, we'll do red. So the scene changes, the drapes
24 do not change. The reason why the drapes don't change is
25 because at any moment if the heart rate goes down again,

1 you know, fool me once, shame on you. Fool me twice,
2 shame on me. If this heart rate goes down again, we're
3 going (inaudible).

4 Q So that option is still on the table?

5 A It absolutely is on the table. That's why we're in
6 the operating room.

7 Q Okay.

8 A She's not going to go back. We're not going
9 (inaudible).

10 Q Yes, sir.

11 A So what happens now is we do drop (inaudible) right
12 here. We drop (inaudible). Matter of fact (inaudible).

13 Q Oh, sorry. Go ahead.

14 A (Inaudible.)

15 Q That's good. Sorry about that.

16 A Initially, you can attach -- there's rails on the bed
17 you can attach stirrups to. So attaching stirrups
18 anywhere from being (inaudible) at this level and we
19 actually use these stirrups even in (inaudible), but
20 (inaudible). So the stirrups are up about here.

21 (Inaudible) 45-degree angle. So the stirrups are here at
22 this point. So at this point, the case changes from a
23 C-section to a vaginal delivery. Now, you put another
24 drape up. Now, we drape across here. So now, there's a
25 drape that hangs across here and hangs over those

1 stirrups.

2 Q Over the legs?

3 A Over the legs right there.

4 Q Okay.

5 A You know, at this point, Antwan is not there. We
6 want to make sure (inaudible). So at that point, I don't
7 want the father there. (Inaudible.) I don't need him
8 back here. He has nothing to do with this. He needs to
9 be right there. Just like that (inaudible) we always
10 position the father right there and they're seated right
11 there.

12 Q On the left side of the patient, okay.

13 A (Inaudible) we've got a drape here. Angela is doing
14 a nice job.

15 Q Take us through from there. She's pushing, what
16 happens?

17 A So Angela does a nice job pushing. She's able to
18 push the head out. So now, Alexia's head is -- you know,
19 if you consider this is Angela right here, Alexia's head
20 was right here.

21 Q It delivered?

22 A (Inaudible.)

23 Q Are you seated on a stool, are you standing or --

24 A (Inaudible.)

25 Q Okay. What happens? Head delivers, now what?

1 A Head delivers. And so at that point (inaudible).

2 Q And what happened?

3 A (Inaudible.)

4 Q What does that tell you?

5 A (Inaudible.)

6 Q What do you do?

7 A So the first thing you do (inaudible). So you
8 communicate to your nurses, you know -- and at this point,
9 okay, Angela had already had her legs into a
10 semi-McRoberts position. She's holding them up really,
11 but we're going to get much more -- we're going to press
12 them back even more. McRoberts, what it does, it takes
13 (inaudible) and sort of flattens it out. I believe you
14 heard some of the Plaintiff's experts say (inaudible). So
15 she does the McRoberts. Nurse Julie is right here.

16 Q Is that Julie Bibb?

17 A Julie Bibb. She's putting suprapubic pressure right
18 here.

19 Q What is suprapubic pressure? Can you demonstrate
20 that?

21 A (Inaudible.)

22 Q Okay.

23 A Then I cut what's called a third degree episiotomy.

24 Q What's that?

25 A Episiotomy is where you cut the bridge of the

1 perineal body. The perineal body -- this is your vagina
2 and this is your rectum. The perineal body is this
3 picture right here.

4 Q In between?

5 A In between. Years before, we were trained
6 (inaudible).

7 Q That was part of your training?

8 A Yes, my training. (Inaudible.) There's controversy.
9 You know, some (inaudible). One is you need all the room
10 you can get. If you're going to start sticking your hand
11 (inaudible). Two, (inaudible). And people don't realize
12 (inaudible). But the perineal body is not just tissue.
13 And this is a tough, tough (inaudible) here. (Inaudible)
14 muscles come in and insert here as well right on this
15 bridge. You have your transverse (inaudible) muscles and
16 insert here as well. You've got a lot going on there.
17 There's also what we call the (inaudible) muscle
18 (inaudible). This is soft tissue. This is tough, tough
19 tissue. And I think any time (inaudible) you might --
20 again, (inaudible).

21 Q Is it part of your training?

22 A Yes.

23 Q In your opinion, did that comply with the standard of
24 care?

25 A Yes.

1 Q All right, sir. So when you ordered McRoberts, were
2 there nurses there to assist to hold her legs, her thighs
3 back up further?

4 A There was one right here (inaudible).

5 Q All right. After you did the McRoberts and the
6 nurses are holding the legs back, did you then -- I don't
7 know if you ordered it or the nurse knew to do suprapubic
8 pressure at some point. I don't know how that works. How
9 does that work?

10 A She knows (inaudible).

11 Q Okay.

12 A But I also instruct her. She's not going to do
13 anything without me saying something.

14 Q Okay.

15 A But she knows what she needs to do.

16 Q Okay.

17 A Typically, they get a small step-up stool about this
18 high and they step up (inaudible).

19 Q Do you recall whether or not Julie Bibb got up and
20 climbed on that 20-inch wide table straddling --

21 MR. GRAHAM: He's leading, Your Honor.

22 THE COURT: I'm going to sustain the objection.

23 BY MR. DAVIS:

24 Q Do you recall whether or not anyone ever got up on
25 that table and straddled the patient, sir?

1 A (Inaudible).

2 Q Okay. Do you recall at any point in time during this
3 delivery, and we're going to get to the maneuvers in a
4 second, Mr. Lumpkin ever saying to you hey, aren't you
5 pulling too hard on her head or anything like that?

6 A (Inaudible).

7 Q Did you ever say anything to Mr. Lumpkin, Mr. Antwan
8 Lumpkin, or anybody else in the operating room during your
9 delivery as you were trying to resolve the shoulder
10 dystocia, which we'll get into in a second, I only have a
11 certain amount of time before she's brain damaged or
12 retarded? Did you ever say anything like that?

13 A (Inaudible.)

14 Q Have you ever said anything like that at any point in
15 time?

16 A No.

17 Q Were you ever rough with Alexia's head in any way
18 during the delivery?

19 A This (inaudible). So your hand slides -- pardon the
20 graphic, but your hand slides so much you can't see your
21 hand. You can't above your wrist (inaudible). There's no
22 way you (inaudible) to the head. The head is out. The
23 head's down here. Your hand is up here on that shoulder.
24 So no, there was no rough (inaudible).

25 Q Okay. I want to show you some diagrams.

1 MR. GRAHAM: Your Honor, may we approach?

2 THE COURT: You may.

3 (WHEREUPON, a bench conference was held in the
4 presence of the jury, but outside the hearing of the
5 jury.)

6 THE WITNESS: Thank you very much.

7 MR. DAVIS: Should have reminded about that sooner.

8 THE WITNESS: Testing. Testing.

9 BY MR. DAVIS:

10 Q This is just an illustration to hopefully help the
11 jury understand as you are describing what was going on.
12 It's got four frames. Number one, view from the
13 obstetrician's perspective. Is that representative and
14 help you to explain what was going on?

15 A It is, but this is a wrong orientation.

16 Q Okay. The orientation in this case was what?

17 A Left occiput posterior.

18 Q Which would have had the baby facing which way?

19 A So if you guys can see, the nose is -- I'm not
20 screaming at you, but the nose is here and the back of the
21 head is here. So the orientation is always done based on
22 mom, not on -- you're the delivery physician, the
23 orientation is based on mom. So this is mom's left side,
24 but the occiput is pointing up here. So this would be
25 consider LOA, left occiput anterior. Alexia was left

1 occiput posterior. So if you turn the baby about 90
2 degrees, Alexia was down in this -- pointing in that
3 direction so that the nose was pointing up here to what we
4 call ROA.

5 Q Thank you. You can sit down. We'll get you back up
6 in a minute. Thank you. Dr. Miller, do you have an
7 opinion whether or not a shoulder dystocia is an
8 obstetrical emergency?

9 MR. GRAHAM: Your Honor, may we approach again?

10 (WHEREUPON, a bench conference was held in the
11 presence of the jury, but outside the hearing of the
12 jury.)

13 BY MR. DAVIS:

14 Q Let me ask the question again, Dr. Miller. As a
15 board certified obstetrician gynecologist delivered over
16 9,000 babies, do you have an opinion within a reasonable
17 degree of medical certainty whether or not a shoulder
18 dystocia constitutes an immediate obstetrical emergency?

19 A Yes, I do.

20 MR. GRAHAM: Objection.

21 Q Why? Or what's the basis of your --

22 THE COURT: Hold on one second. For the reasons you
23 just stated at the bench?

24 MR. GRAHAM: Yes, sir.

25 THE COURT: Okay. Your objection is preserved for

1 the record. Go ahead.

2 BY MR. DAVIS:

3 Q Explain in your opinion why that's considered by you
4 to be an immediate and genuine obstetrical emergency?

5 A It's considered to be immediate and genuine
6 obstetrical emergency by everyone.

7 Q Why?

8 A Because a baby's life's on the line.

9 Q Why?

10 A You have just a few minutes to resolve this issue. I
11 know we've heard a six-to-eight-minute interval in
12 previous testimony, but it's four to five minutes. And
13 it's four to five minutes before -- we're trained and
14 taught that it's four to five minutes before that baby can
15 quite possibly experience -- it's a fancy term for hypoxic
16 ischemic encephalopathy, but it means brain damage. Plain
17 and simple, it's brain damage. If that doesn't meet the
18 standard of an emergency, I don't know what does. There
19 are reports of babies even dying in less than five
20 minutes. So I think that once you determine that there's
21 a shoulder dystocia, you have to call it what it is. And
22 it is truly one of the main or major emergencies that we
23 deal with and part of that is because it is so
24 unpredictable. Part of that is because it is
25 unpreventable. And, unfortunately, sometimes, injuries to

1 the baby and the mom are unavoidable. But once you make
2 that determination, then it's game on and you have to in a
3 methodical way go through a series of maneuvers that
4 you've determined over your time and experience what works
5 for you. And I've done that. And I have a very effective
6 routine or series of maneuvers that I do.

7 Q Explain to the jury, Dr. Miller, what you did in this
8 case when you encountered the shoulder dystocia. Walk us
9 through that.

10 A We've gone through a little bit in the diagram, but
11 the first thing you do is you communicate to everybody in
12 the operating room that there's an emergency, especially
13 to the nurses because the nurses are going to help you
14 out. In this case, we immediately went to McRoberts,
15 which is sort of hyper-flexing the hips. And at the same
16 time, almost simultaneously, you're trying to do all these
17 things. You're trying not to waste any time. Julie got
18 the step-up and started doing the suprapubic. And at that
19 time, I cut the episiotomy and start doing what's called a
20 posterior shoulder delivery.

21 Q Describe that.

22 A So the posterior shoulder in this case was the left
23 shoulder and that's the shoulder down closest to the
24 ground. And there's -- everybody has their sequences of
25 how to deliver posterior shoulder. Typically, what I like

1 to do or try first is to slide -- depending on the
2 orientation of the baby, but in this case, it was my right
3 hand behind the baby, behind the baby's back and you try
4 to slide your hand down to behind the arm. And what you
5 want to do is you want to push that arm toward the front,
6 toward the baby's chest. What you're trying to do is get
7 that arm on the baby's chest so you can grab that hand and
8 pull that hand up and over. Once you get -- that's a
9 posterior shoulder delivery. The problem is -- again,
10 every single thing we're doing, we're trying to get the
11 baby down, but we're also trying to decrease the amount of
12 space. So, typically - and I think you've heard this,
13 something called the bisacromial diameter and that's going
14 from, basically, shoulder to shoulder. And that's sort of
15 -- particularly in bigger babies, that's usually the
16 biggest diameter, bigger than the head. Shoulder
17 dystocia, what that does is takes it now instead of here
18 to here, you're diameter is here to here. And so it's an
19 axillary acromial diameter, which is known to be smaller
20 than bisacromial. So in this case, I tried to push that
21 shoulder anteriorly and the arm anteriorly and it wouldn't
22 budge. It was stuck. At that point then, because of the
23 way that this baby is oriented, I reached down with my
24 left hand. And with my left hand, you try to go down so
25 -- the arm in this case, the arm was pinched behind the

1 baby's left hip. And if you know anatomy and I'll show
2 you because I have a skeleton of a pelvis, it's up above
3 the pelvic inlet. And it's stuck there. So I tried to
4 push this way and it didn't work. So the next thing you
5 do is you try to reach down and grab the forearm. I
6 couldn't even get to the forearm. It was rotated so much.
7 The last thing you can sometimes do if you put enough
8 pressure on the biceps tendon, it will cause it -- sitting
9 here, you put pressure here, you're hopefully trying to
10 get it to reflex forward. That didn't work either. That
11 arm was stuck in that position. So at that point, we go
12 to something called a rotational maneuver. You try to
13 rotate the baby. It's what's called a woodscrew maneuver.
14 And that works. The woodscrew maneuver, although it's
15 been described as a steering wheel, that's not true.
16 There's no textbook or no article that ever has described
17 it, it's never been published anywhere, I've never seen
18 anything like that. It is just what it sounds like, it's
19 a woodscrew maneuver. It's across the threads of a bolt
20 going through a nut. So as you turn the baby, the baby is
21 coming down towards you, towards you. So what happens in
22 this case -- and I'm left-handed, so I might favor my left
23 hand, but I put my left hand back behind Alexia's left
24 shoulder, on the shoulder in the back and we started
25 turning the baby. And Alexia actually turned really well.

1 It was pretty easy to get her moving. And it only took
2 five to ten seconds in its entirety to turn that baby. So
3 a woodscrew by definition -- and you can look in any
4 textbook. Even Dr. Gurewitsch has her own educational
5 video from John Hopkins where she shows it. And she
6 details it as being an 180-degree turn, and the fact that
7 the shoulder is now released. The shoulder is now not
8 stuck behind the pubic bone. It's below the pubic bone.
9 And every time I've ever done a woodscrew maneuver, that's
10 what's happened.

11 Q Is that what --

12 A And that's what happened in this case.

13 Q Okay. That was my question.

14 A So now the left shoulder is now anterior. The one
15 that was posterior, you've moved it 180 degrees, is now
16 anterior. At that point, there's no dystocia. That's
17 resolved. As a matter of fact, Angela was such a good
18 pusher, she could have pushed the baby out without me.
19 All I do at that time is I'm just a guide. I'm just
20 providing slight, gentle downward traction to finish the
21 delivery. There's no way you could put anything more than
22 slight, gentle downward -- and it was actually less than
23 the typical traction -- gentle downward traction I might
24 use because the head was now moved. It was below the
25 pubic bone.

1 Q Doctor, as you've described it, let me ask you this
2 question, when you did the rotational maneuver, the
3 woodscrew maneuver and turned the baby about 180 degrees,
4 did you then cause her left shoulder to become impacted
5 behind her pubic bone, sir?

6 A No, that's what I was just saying. That shoulder
7 moved, it's a screw maneuver. So not only did the baby
8 turn, but the baby distends to a lower position below the
9 pubic bone. There is no left shoulder dystocia.

10 Q How do you know it didn't cause that left shoulder to
11 become impacted when you did the rotational maneuver? How
12 do you know that?

13 A Because I was there.

14 Q You remember that?

15 A Absolutely. I was there.

16 Q You mentioned -- come down here and show the jury
17 what this is and explain this to them, please. Tell them
18 what this is.

19 A So this is not just a replication of female pelvis,
20 this is a female pelvis. I bought this on the internet to
21 hopefully try to help you guys understand what we're
22 talking about. We're throwing around a lot of crazy
23 terms, a lot of this, a lot of that. So here's the spine,
24 okay.

25 Q Where's the baby in the labor and delivery process?

1 A Well, the baby -- so when you hear us describe
2 numbers, stations for baby, from here to the sacral
3 promontory, if you had a plane here, if the baby's above
4 that, the baby is considered to be floating, okay. Once
5 the baby breaks that plane, it's called engagement. It's
6 part of what we call a cardinal movement. The baby
7 engages. Now, it's hard to see, but these two prominences
8 are called the ischial spine. And if you drew a line
9 there between those spines, as soon as the baby hits that
10 -- okay, so it's gone from here to here, that's a zero
11 station. And that's what you hear us mostly talk about is
12 zero station. One centimeter below that is one station.
13 Two centimeters, two, three centimeters, three, four
14 centimeters, four. Somewhere between four and five, so
15 four to five centimeters below that, you're going to start
16 seeing the baby's head protruding through the vagina. And
17 so when you look at this, okay, this is the crest of the
18 ilium here, another crest of the ilium.

19 Q What's the ilium?

20 A Just your pelvic bone.

21 Q Okay.

22 A So this is where your hip sockets are here. The two
23 areas important in shoulder dystocia are -- this is the
24 sacral promontory. And I know it was described as
25 something (inaudible), but promontory means an area that

1 protrudes. That's a sacral promontory. And this is a
2 pubic symphysis here. So those are the areas in question.
3 Now, the sacral promontory, also, just so -- and I think
4 it was Dr. Gurewitsch talk about it's more or less
5 prominent depending upon the bend in your spine. There's
6 something called lordosis. So if somebody has -- if their
7 lower back is really sort of bent -- if you see people
8 walk around like that, in pregnant women, as you can
9 imagine, there's a lot of low back pain and a lot of
10 lordosis. And what that does is that takes the spine and
11 moves it down to here and makes that sacral promontory
12 even more prominent.

13 Q So what? What's that got to do with the birth
14 process?

15 A Well, you know, for shoulder dystocia, in this case,
16 the right shoulder was the one that was stuck here, the
17 anterior shoulder. And when we reduced that -- so coming
18 down the birth canal, the left shoulder was here --

19 MR. GRAHAM: Objection. I object. May we?

20 THE COURT: Yes, sir, you may approach.

21 (WHEREUPON, a bench conference was held in the
22 presence of the jury, but outside the hearing of the
23 jury.)

24 BY MR. DAVIS:

25 Q Is there such a thing in your knowledge as an expert

1 in OBGYN as a posterior shoulder dystocia?

2 A Yes, sir.

3 Q I want you to come down one more time. We've got a
4 table here. Pretend that this is your operating table.
5 Let's put this mat on here. Is this your exercise mat?

6 A (Inaudible.)

7 Q Orient us -- if this were the table and Ms. Patton on
8 the table and McRoberts suprapubic pressure being done,
9 where are you? Let's orient -- are you seated, are you
10 standing?

11 A I think we probably should (inaudible) maybe --

12 Q Okay.

13 A -- so we can sort of show the jury. It is hard --
14 it's hard to do and see it from one angle and not
15 completely understand it. So if, for example, I'm down
16 here and I'm not going to sit there because I think it's
17 easier if I do it here.

18 Q Okay.

19 A Let's do it this way. I'm come back and let you guys
20 see because I'm going to get in the way. This is a test
21 baby. And I actually put the marks so you guys could see
22 the shoulders and delineate the shoulders better. But in
23 this case, this is -- if you are the obstetrician, this is
24 the angle that you have. For us, for orientation, the
25 whole time the right shoulder will be black and the left

1 shoulder will be white. Babies, as everybody knows, they
2 have soft spots on their skull. So the anterior fontanel,
3 which is here, and they have a posterior fontanel, which
4 is here. And what connects these things are sutures,
5 where bones come together. So this suture here is called
6 the frontal suture because these are two frontal bones in
7 the baby. This suture here is called the sagittal suture,
8 okay. This is called -- these are called the coronal and
9 these are called the lambdoid. So if you see back here,
10 see the posterior fontanelle, so when you're trying to do
11 an exam, if you're trying to figure out orientation, this
12 is triangular in shape because there's only three sutures
13 that come together here. This one is diamond-shaped
14 because there's four sutures. So in this case, you could
15 see when we go in there -- and this is if you can't see
16 the baby, you can feel that triangular shape and you try
17 to feel (inaudible) okay, am I just feeling two, which is
18 posterior, or do I feel one in the middle, that means it's
19 the head. So the baby in this case was left occiput
20 posterior and it good orientation with the right shoulder
21 stuck under the pubic symphysis. We did our McRoberts, we
22 did our suprapubic. I cut my episiotomy. But the real
23 thing here is the maneuvers. And as I said before, the
24 first thing I did was I took my right hand. And we're not
25 near the head. There's this idea that somehow we're on

1 the head. We're not near the head. You slide your hand
2 behind the shoulder here and you slip it down where that
3 arm is there. And you try -- and this is sort of the way
4 this baby was. The hand was stuck behind the hip. I'm
5 trying to push that hand up and it doesn't budge. So then
6 I'm going to come across here with my left hand. Now,
7 what I'm going to do is I'm trying to reach. So my hand
8 -- again, the baby is out. The vagina is here. My hand
9 is -- it is completely -- it's not visible. So I'm
10 reaching here and I'm trying to see if I can grab that
11 forearm and lift that forearm. It won't work, that arm is
12 stuck. So I go in the biceps and try to push on the
13 biceps tendon and that doesn't work either. So now I've
14 pretty much resigned that, okay, the posterior shoulder is
15 not going to work, let's go on to the next maneuver. Next
16 maneuver is a rotational maneuver. For me, that was a
17 180-degree move. I'm sorry if I'm getting in the way.
18 But I put my left hand under here, okay? My palm is right
19 on the shoulder. And then what happens is trying to move
20 this baby clockwise like this. And once that baby got to
21 here, okay, ROA, right occiput anterior, so mom's
22 right-hand side here, okay, pubic bone is here. The
23 baby's shoulder is no longer behind the pubic bone. It is
24 below the pubic bone. At this point, all I have to do is
25 just gentle downward traction and the baby delivers. I do

1 want to show one other thing because I think seeing some
2 of the videos, I saw the way Dr. Duboe did a delivery.
3 And I do completely disagree with some of his technique.
4 We were trained -- and you never do what he showed. And
5 he showed -- he put his hands and locked his hands around
6 the head and pulled. That's a no-no. You're always
7 trained you put your hands on the side of the head because
8 you can't get a good grip when you put your hands on the
9 side of the head. You do this, you might not know how
10 hard you're pulling. You do this, you start pulling too
11 hard, it's a slippery situation. Your hands are going to
12 slide right off. So every single delivery -- when I teach
13 medical students, this is what I tell them, you pull like
14 this. Did everybody get a pretty good sense of it?

15 Q Are you done with this?

16 A I think so.

17 Q One other thing, let me just try this. I know you
18 probably don't have any 6'5" nurses, but if you would bear
19 with me and would you --

20 A It would make a good IV pole.

21 Q Would you sit where you would be sitting, assuming
22 the patient is here, legs back, ready to deliver, where
23 are you sitting? I'll pretend like I'm one nurse. You
24 probably don't have any of them six feet either. So is
25 one nurse here holding her leg back?

1 A Actually, you're down closer to me.

2 Q Okay. Are we good?

3 A Yeah.

4 Q Where are the drapes?

5 A So in this case, the surgical drape is still here.

6 Q The tall thing?

7 A There's still the drape here.

8 Q Okay.

9 A That drape, we left that up just in case we had to go
10 -- needed the C-section.

11 Q Okay.

12 A So once we're here, as in this picture, we put
13 stirrups up and the stirrups are attached to the bed.
14 There's a rail they're attached to and they're coming up
15 about like this. So what we do is then I put -- because
16 of the different case, there's a vaginal drape. We drape
17 the stirrups out with the stirrups drapes. We've also put
18 a drape that is right across the stirrups.

19 Q Why?

20 A Because this still, as best we know -- we're trying
21 to keep it as sterile as possible because at any time, we
22 could say, you know, we need to do a C-section. And even
23 in the midst of a shoulder dystocia, you really want to
24 try to keep this as sterile as possible because until that
25 baby is delivered, there are some extreme measures you

1 might have to do. You might have to cut the pubic
2 symphysis, you might have to do (inaudible). You might
3 have to do a (inaudible) rescue. So you want to try to
4 maintain as much sterility as possible.

5 Q So a nurse is here. Is a nurse over on this side as
6 well?

7 A Yes.

8 Q And everything else here is draped?

9 A Uh-huh.

10 Q Is anybody --

11 A My view here, all I see is blue. I can't see Angela.
12 I can't see Antwan. This is my view.

13 Q Is anybody allowed back over where I'm standing?

14 A No, no way.

15 Q How about here?

16 A No.

17 Q How about out here?

18 A No. That is all -- so over here is, as you see in
19 the description, that's where Dr. Mercado is. And, in
20 fact, the nurse who's going to take the baby to Dr.
21 Mercado is also draped and sterile. She's sitting right
22 here. This whole area is a pathway back to the
23 neonatologist.

24 Q Right here?

25 A Yes.

1 Q Thank you. Dr. Miller, as you were demonstrating and
2 trying to help the jury understand what went on there,
3 until the baby is delivered, comes out and is delivered,
4 is that right shoulder visible to you?

5 A No.

6 Q All right, sir. The nurse's notes in evidence, your
7 notes, Dr. Lupo's notes talk about uncoordinated effort of
8 pushing or poor effort, does that in any way mean that
9 anyone was faulting Angela for that?

10 A No, not at all.

11 Q Okay. Are you aware as an OBGYN of maternal forces
12 of labor?

13 A Yes.

14 Q What are those?

15 A Well, there's two, really. There's a maternal force
16 --

17 MR. GRAHAM: Objection, Your Honor. Same point as
18 before.

19 THE COURT: I'm going to allow the question.

20 MR. DAVIS: Thank you very much.

21 BY MR. DAVIS:

22 Q Go ahead, sir.

23 A So there's predominant maternal forces. One is the
24 uterus itself, which in this case, was contracting every
25 two to three minutes. And the other is the mother. And

1 these forces are substantial. They actually do virtually
2 almost all of the work. For example, in this case, when
3 Angela came in, the baby was in a high position above that
4 pelvic inlet. Well, I didn't have anything to do to get
5 that baby to come all the way down for that head to pop
6 out. That baby came all the way down because of
7 contractions and Angela's effort. So those forces are
8 strong.

9 MR. GRAHAM: Objection. Same basis.

10 THE COURT: Counsel, approach the bench, please.

11 (WHEREUPON, a bench conference was held in the
12 presence of the jury, but outside the hearing of the
13 jury.)

14 BY MR. DAVIS:

15 Q Are you finished talking about maternal forces of
16 labor?

17 A Yes, sir, unless you have any other questions.

18 Q That's all I got. What do you mean when you use the
19 term gentle downward traction? What do you mean by that?

20 A Gentle downward traction is just that. It's just
21 gentle downward traction, but it is a feel. And you have
22 -- over time and experience, you learn what that feel is,
23 what is a safe gentle downward traction. You learn the
24 feeling of the resistance if you have a shoulder dystocia.
25 And it is something that you learn early on. You know, I

1 started learning that as a medical student, but then you
2 start to perfect it in your residency and then you do
3 simulators -- not like the current simulators that they
4 have, but you -- also, the first two years when you're in
5 your residency, you have a third or fourth year resident
6 with you every time looking over your shoulders, actually,
7 sometimes putting their hands over your hands saying okay,
8 that's good, that's good, that's good or saying, you know,
9 let me go -- push you aside, let me go ahead and do this.
10 My first year of my residency, I did 493 deliveries. So
11 relatively quickly, I felt like I was getting pretty good
12 at it. And after over 9,000 deliveries and several
13 hundred shoulder dystocias with no documented injury, I
14 think I do have a good idea of what gentle downward
15 traction is.

16 Q How many years of residency at the University of
17 Florida in OBGYN did you complete?

18 A Four years.

19 Q Four years?

20 A Yes, sir.

21 Q And that's four years after four years of medical
22 school?

23 A That's correct.

24 Q The gentle downward traction, is that what you used
25 in this delivery of Alexia?

1 A Yes.

2 Q How do we know that? How do we -- how do we know
3 that, Doctor?

4 A Because I was there. I'm the only person that was
5 there. I put my hand on that Bible to tell the truth and
6 that's what I'm telling. You know, there was a shoulder
7 dystocia in this case. Absolutely, that right shoulder
8 was dystocia. It was stuck. And after applying gentle
9 downward traction, I diagnosed that. I went through my
10 typical protocol and maneuvers and successfully reduced
11 that shoulder. But when you do a woodscrew maneuver,
12 nobody ends up with another shoulder dystocia. By
13 definition, by nature of the movement, there is going to
14 be no second shoulder dystocia. So I was there and I
15 applied gentle downward traction and the right shoulder
16 didn't come out and I applied less than that because I
17 already knew the left shoulder was free and it virtually
18 fell out.

19 Q I'm going through my notes making sure I didn't miss
20 anything. We've got a little bit more to go, but. Dr.
21 Miller, did -- and you were there. You're the one that
22 was there that day?

23 A Yes, sir.

24 Q Did you, sir, ever use more than gentle downward
25 traction on Alexia Lumpkin's head during any aspect of

1 that delivery and, more particularly, at any time during
2 the shoulder dystocia until the baby was delivered, sir?

3 A No, sir.

4 Q How long did that shoulder dystocia last?

5 A 45 seconds.

6 Q You know when a shoulder dystocia begins and you
7 determine -- and I think you said as soon as you feel the
8 resistance, the baby's not coming, do you then take the
9 hands off the head?

10 A Yes.

11 Q From that moment on, you know you've got a shoulder
12 dystocia, 45 seconds, however long it was, do you know on
13 the front end when you determine shoulder dystocia how
14 long it's going to take you to resolve that shoulder
15 dystocia?

16 A No. And that's one of the dangers, you don't know.
17 Now, 45 seconds does not represent at any point that I
18 pulled too hard. 45 seconds represents that my maneuver
19 worked and there was no second shoulder dystocia. I
20 didn't pull too hard. You can't. A woodscrew maneuver
21 reduces that. If you -- and I know there's been some
22 testimony saying well, you can wait or first couple of
23 minutes is not that important and you have this, that, you
24 have more time to wait. You don't wait for the baby. You
25 go through your maneuvers. In a calm, focused fashion,

1 you go through your maneuvers. And I would say if you
2 asked -- polled a hundred OBGYN'S and said would you
3 rather deliver a baby in 45 seconds, you know, your first
4 attempt at your maneuvers or would you rather take two
5 minutes or, heaven forbid, four to five minutes, it would
6 be universally no, the sooner, the better. Go through you
7 maneuvers, be calm, be collected. And I was fortunate
8 enough in this case that's what happened.

9 Q At any point in time from the time that the shoulder
10 dystocia was determined until Alexia was delivered, 45
11 seconds, 90 seconds, however long that was, did you ever
12 panic?

13 A No.

14 Q Did you ever get in a hurry?

15 A No, everything was working well.

16 Q Did you ever jerk on that baby's head?

17 A Why?

18 Q Did you?

19 A No, sir. The maneuver worked perfectly, that's why
20 it only took 45 seconds.

21 Q Doctor, in your opinion, when a shoulder dystocia is
22 determined, you've already told us in your opinion that
23 constitutes an obstetrical emergency; is that right?

24 A Yes, sir.

25 Q Do you have an opinion whether or not at that moment

1 the baby is in any sort of instable or instability --

2 MR. GRAHAM: Objection, Your Honor, the matter we
3 discussed before.

4 THE COURT: (Inaudible.)

5 MR. DAVIS: Thank you.

6 BY MR. DAVIS:

7 Q In your opinion, is there any instability created by
8 a shoulder dystocia for that baby?

9 A Oh, absolutely. In this case, in particular. She
10 had to have over two hours of repetitive variable
11 deceleration cord compression. In that situation, you
12 have no idea knowing what the baby's reserves are. You
13 know for two hours, you know, it's a category 2 strip,
14 reasonable to continue to watch, but you don't know what
15 the baby's reserves are.

16 Q Doctor, do you have an opinion whether or not when a
17 shoulder dystocia occurs whether that poses any sort of
18 immediate risk of harm or serious bodily injury to the
19 baby?

20 A Yes, it does.

21 MR. GRAHAM: Objection.

22 THE COURT: (Inaudible.)

23 BY MR. DAVIS::

24 Q Go ahead.

25 A Oh, absolutely. There are multiple emergencies or

1 complications related to a shoulder dystocia. Certainly,
2 the baby encompasses almost all of them. But this is an
3 emergency. When a shoulder gets stuck, you have a limited
4 amount of time to hopefully and safely fix that. Babies
5 do come out and die. Babies do have serious brain
6 injuries. And that's -- it keeps us up at night. You
7 know, shoulder dystocias keep us up at night because we
8 don't know when it's going to happen. We know we can't
9 prevent it and we know that sometimes injuries can happen
10 regardless of how well you do things.

11 BY MR. DAVIS::

12 Q In your earlier testimony when Mr. Jordan called you
13 as their witness last week, I think it was, he read to you
14 some parts of your deposition at Page 91. I want to go
15 over that and have you review other parts of your
16 deposition if I could. I'll get a copy of your deposition
17 with you. If you would turn with me to Page 91, Line 4.
18 Let me know when you're there, sir?

19 A You said Page 94?

20 Q Page 91.

21 A 91, okay.

22 Q Yes, sir.

23 A Yes, I am there.

24 Q Line 4, question: What do you consider to be the
25 ordinary maneuvers for delivering a baby in a vaginal

1 delivery that is not complicated by shoulder dystocias?

2 Answer: The ordinary maneuvers used by a physician?

3 Question: Yes, sir. Answer: I would say that ordinary
4 maneuvers used by a physician, like McRoberts maneuver is
5 sometimes used, sometimes an episiotomy is cut. Other
6 than that, a delivery is predominantly maternal propulsive
7 effort with some gentle guidance of the fetal head by the
8 physician. And here's the question: What is traction?

9 Your answer, Line 18: Traction is delivering using force
10 or effort. Did I read that correctly?

11 A Yes, you did.

12 Q All right. It's not the only time you talked about
13 force or effort in the terms of this delivery in your
14 deposition, was it?

15 A That's correct.

16 Q Would you look with me at Page 146 of your
17 deposition? Let me know when you're there.

18 A I am there.

19 Q Look with me, please, at Line 4. I'm going to read
20 something and I'm going to ask you a question about it.

21 Question: I said I did and then you said there's a
22 difference between traction, force and effort. What does
23 effort mean to you? Your answer: Well, effort -- and I
24 use that in this note -- means to me in the note where I
25 used it -- And that's your delivery note, is that right,

1 what we're talking about?

2 A Yes, sir.

3 Q Okay. I use that in this note that it means to me in
4 the note where I used it pertaining to the delivery the
5 sum total of the maneuvers that I used. And that's what
6 -- and I used the term moderate effort in that situation.
7 Did I read that correctly?

8 A Yes, sir.

9 Q Look at Page 148, Line 2, sir. You were asked,
10 question: So what does moderate mean? Your answer:
11 Well, moderate means to me I had to do additional
12 maneuvers to get that baby out, that it wasn't -- you
13 know, mild effort is a routine vaginal delivery. And I
14 don't say mild effort because that's what -- that's
15 routine delivery. But moderate, you know, takes into
16 consideration the movements that I do and it does require
17 effort to do those maneuvers. Did I read that correctly,
18 sir?

19 A Yes, sir.

20 Q Thank you. Is that still your testimony today?

21 A Yes, it is.

22 Q Let's look at that note. We have transcribed your
23 note, frankly, so we can read it, so the jury can read it.

24 MR. DAVIS: Your Honor, we offer Exhibit 30 into
25 evidence, which is Dr. Miller's transcribed note of April

1 5, 2007 at 2130 hours.

2 THE COURT: Any objection?

3 MR. GRAHAM: None.

4 THE COURT: It will be entered without objection.

5 MR. DAVIS: Thank you, Your Honor. Thank you, Mr.
6 Graham.

7 (WHEREUPON, Defendant's Exhibit No. 30 was admitted
8 into evidence.)

9 BY MR. DAVIS:

10 Q Let's go over this. This is your note. 2130, and
11 when was the baby born?

12 A I noted 2050, it was ten of 9:00.

13 Q What I'm showing you now is a blowup of one of the
14 fetal monitor strips of this delivery; is that right?

15 A Yes, sir.

16 Q Vaginal delivery for Dr. Miller 2051, according to
17 Julie Bibb; is that right?

18 A Uh-huh.

19 Q Okay. And this was done at 2130?

20 A Yes.

21 Q What were you doing between the time of delivery and
22 2130, Dr. Miller?

23 A In this case, there are two things we're doing. The
24 first, the most important thing was managing Angela's
25 post-partum hemorrhage. Post-partum hemorrhage is one of

1 the leading --

2 THE COURT: Can I see y'all at the bench real quick?

3 (WHEREUPON, a bench conference was held in the
4 presence of the jury, but outside the hearing of the
5 jury.)

6 THE COURT: All right, ladies and gentlemen, this
7 seems like kind of a natural pause in the testimony, so
8 we're going to take a lunch break. And remember, please
9 don't discuss the case. Don't do any outside research.
10 Other than that, please be back at two o'clock.

11 (WHEREUPON, the jury exits the courtroom at
12 approximately 12:44 p.m.)

13 THE COURT: All right, counsel, before we break, let
14 me talk a little on the record about this emergency issue.
15 I have given this considerable thought, section 15-32-230.
16 I mean, before -- let me just double check that my
17 understanding of the facts is correct. This was not pled
18 as an affirmative to defense; is that correct?

19 MR. DAVIS: Correct.

20 THE COURT: I'm not going to make a final ruling
21 right now, but just so y'all know what I'm thinking and
22 you can help me with some research. My inclination is to
23 deny the motion to charge that statute. And the basis for
24 that is, the Byrd case says it's in derogation of a common
25 law, so it is strictly construed. The Byrd case also says

1 it is an affirmative defense. So given that, the first --
2 we had other witnesses that said it was an emergency, any
3 kind of shoulder dystocia. But the first witness that
4 actually went through the statute and said, you know, that
5 it was a genuine emergency, the patient was not medically
6 stable and there was immediate threat of death or great
7 bodily injury, the first person that said that was Dr.
8 Miller. It was objected to. So that means to me the
9 issue is now a Rule 15 issue. I mean, the issue is should
10 I permit an amendment to the pleadings at trial based on
11 that? And it seems to me the Plaintiff is prejudiced.
12 It's the issue -- it is an amendment that would allow an
13 affirmative defense that our case law says is weighing by
14 not being presented when the original answer was made. So
15 that's what I'm thinking right now. I'm open to being
16 convinced otherwise, but that's what my thinking is right
17 now. To me, it's a Rule 15 issue now because I think it's
18 clearly an affirmative defense. It was not made and it
19 was objected to by the Plaintiff.

20 MR. DAVIS: Your Honor, the history is -- the case
21 has been going on a long time. There was, at least, one
22 significant conversation with Judge Dan Hall while he was
23 sort of on this case, if I might refer to that, in
24 chambers years ago where Mr. Graham -- it was getting
25 ready to be set for trial and we were discussing pretrial

1 matters. And Judge Hall in chambers entertained Mr.
2 Graham's request to continue the case pending the Court of
3 Appeals decision on the emergency statute in either his
4 case or the Flowers case. [Judge] Hall at the time in
5 chambers, and Mr. Graham and I were there, decided to
6 allow us to continue this case because he didn't want to
7 have to make a ruling at trial before there was a Court of
8 Appeals decision on either one of those pending cases
9 where the emergency statute was allowed and charged. This
10 is not a surprise to counsel. We delayed the trial of the
11 case, Judge Hall did, and we were all in agreement by that
12 because we didn't want to have to try the case and
13 depending on how the judge ruled on whether he's charging
14 the emergency statute or not without an appellate court
15 guidance, we didn't want to have to try this case again in
16 the event of an appeal that would have reversed whatever
17 ruling he made and depending on the outcome. So the case
18 was delayed for, at least, a couple of years pending the
19 results of either the Flowers case or the one that Mr.
20 Graham was involved in in Florence.

21 THE COURT: The Byrd case?

22 MR. DAVIS: Is that the Byrd case? Okay. I wasn't
23 familiar with that one.

24 THE COURT: No, I -- I may be getting -- hold on.

25 MR. DAVIS: I don't know his case.

1 THE COURT: Okay. A case that already has the Court
2 of Appeals from '19 is Byrd vs. McLeod. And then the GF
3 is the newest one, the more recent one.

4 MR. DAVIS: Right. I guess that's the one I'm
5 referring to. Anyway, so we were all in agreement and all
6 on full notice that we intended to request the charge at
7 the appropriate time on the emergency statute. Mr. Graham
8 was fully aware of that. Judge Hall was fully aware of
9 that. And this is certainly no surprise or prejudice that
10 we at this time are asking for a Rule 15 motion to be
11 granted to conform the evidence to the pleadings and to
12 allow that. So that's the basis of my --

13 THE COURT: Mr. Davis, I'll keep thinking about it,
14 but, again, my -- what I'm thinking is it's not like a
15 witness changing their mind. It's an affirmative defense
16 that was waived in 2009 when the answer was made. So I
17 don't think the surprise issue is dispositive. It's
18 whether it's fair to the Plaintiff or whether it's
19 prejudice to the Plaintiff to allow an affirmative defense
20 that was waived to be resurrected. And I think that's a
21 different issue than the surprise issue. Again, I'm still
22 thinking. But just so y'all know, I've read the Byrd
23 case. I understand -- I mean, I think the issue is more,
24 in the Court's opinion, whether the amendment should be
25 allowed under Rule 15. Dr. Miller testified that the

1 statute was met. The Plaintiff objected to that
2 testimony. That's what I'm thinking now, just so y'all
3 know.

4 MR. DAVIS: I understand that. And I appreciate you
5 giving us a heads-up on that. Again, I would just -- I
6 guess I can argue this later. I don't need --

7 THE COURT: Yes, don't worry, I'll give you a chance
8 to both argue for the record.

9 MR. DAVIS: Thank you.

10 THE COURT: And again, my inclination so the record
11 is complete is I will -- even if that's my final ruling, I
12 plan on letting Mr. Davis and Mr. Traylor ask their other
13 experts those questions. I'm just trying to avoid having
14 to retry this case again. I don't think it's particularly
15 prejudicial to ask the questions about immediate harm and
16 those questions even if my ruling is that I'm not going to
17 charge it and that way, at least, there's a chance that if
18 I'm wrong on that issue, you wouldn't have to retry the
19 case.

20 MR. DAVIS: Thank you, Your Honor.

21 MR. GRAHAM: Your Honor, may we put those matters on
22 the record that we --

23 THE COURT: Yes, sir. Yes, sir.

24 MR. GRAHAM: If Your Honor please, we had a bench
25 conference, as you know, and you kindly agreed to give us

1 an opportunity to put those objections on the record. So
2 without ado, one of our objections was to the shoulder
3 dystocia emergency, which Your Honor has just covered. I
4 won't elaborate on that.

5 THE COURT: Yes, sir.

6 MR. GRAHAM: The second was the photograph of the
7 drapes. Thirdly was the -- there were two medical art
8 boards that Mr. Davis was going to use. You sustained my
9 objection to one, let one in. We object to that, just
10 note it for the record.

11 THE COURT: Mr. Davis, anything you want to put on
12 the record with regard to those issues?

13 MR. DAVIS: No, sir.

14 THE COURT: Thank you, counsel. See you about two
15 o'clock.

16 MR. DAVIS: Thank you.

17 (WHEREUPON, a lunch break was taken.)

18 THE COURT: Counsel, I'm prepared to do argument now
19 if that's okay with y'all on that motion to amend. I
20 spent the lunch break looking at that issue. But if you'd
21 rather continue with your direct, we can do it at the end
22 of the day, Mr. Davis.

23 MR. DAVIS: Could we do it at the end of the day?
24 May it please the Court?

25 THE COURT: Yes.

1 MR. DAVIS: And, Your Honor, before the jury comes
2 back, one of the things that we intended to do and intend
3 to do and plan to do is play a demonstrative animation
4 that was created specifically for this case.

5 THE COURT: Okay.

6 MR. DAVIS: We've already disclosed that to Mr.
7 Graham as soon as we got it done.

8 THE COURT: What does it show?

9 MR. DAVIS: Well, I'm happy to show it to you.

10 THE COURT: Is it short?

11 MR. DAVIS: Yeah, it's about two minutes.

12 THE COURT: Let's play it.

13 MR. DAVIS: Yeah, and let you see it. Anticipating
14 objections, I would rather have a ruling now if we could
15 so we can just keep moving through. Thank you, sir.

16 THE COURT: I can see it on my screen right here, but
17 go ahead and publish it so everyone can see it. There's
18 no jurors in here. Thank you, Ms. Foster.

19 (WHEREUPON, video animation is played for the Court.)

20 THE COURT: Mr. Graham, briefly.

21 MR. GRAHAM: Yes, sir. It's a causation video and
22 this is not a causation expert.

23 THE COURT: The only objectionable part I saw was
24 there was like the second segment, I don't know what the
25 right term is, where it says with the brachial plexus

1 flexing. Is it editable, Mr. Davis? Could you take that
2 part out?

3 MR. DAVIS: I think it goes from, like, ten seconds
4 to 45 seconds. We can just skip forward to that after the
5 first initial part.

6 THE COURT: If that part was taken out, Mr. Graham,
7 is it still objectionable?

8 MR. GRAHAM: I'd have to look at the whole thing
9 again, but the part where the nerves turn red, I don't
10 know if that's the same part you're talking about.

11 THE COURT: This part right here that's on the screen
12 now?

13 MR. GRAHAM: And that part as well.

14 THE COURT: All the part about stretching the
15 brachial plexus I think is -- Mr. Davis, you can use that
16 with other witnesses if they provide testimony, but with
17 this witness, I think we're going to have to edit that
18 portion out.

19 MR. DAVIS: We're prepared when we ask him -- when we
20 would show it to him that we would play it out -- play it
21 through and just skip through. Show the Judge what --

22 (WHEREUPON, video animation is played for the Court.)

23 THE COURT: That looks okay to me. Let me give Mr.
24 Graham and Mr. Jordan a chance.

25 MR. GRAHAM: And those arrows go to causation as

1 well. They've already talked about uterine forces being
2 stronger than -- and they've got the sacral promontory
3 here, which is part of their causation theory.

4 THE COURT: I just don't -- I don't think the jury is
5 going to make that connection when Dr. Miller doesn't make
6 it for them. I mean, they know that there's uterine
7 forces. We've heard that testimony already. So the
8 arrows are the objection?

9 MR. GRAHAM: That's one of them, yes, Your Honor.

10 THE COURT: My inclination is to let them play it,
11 skipping from ten seconds to 45 seconds. Like I said, it
12 may be useable in its entirety with other witnesses,
13 depending on how they testify. But, you know, I'll
14 explain to the jury that this is not evidence. This is an
15 animation that was created based on Dr. Miller's version
16 of events. With that instruction, it does not seem
17 objectionable to me.

18 MR. GRAHAM: Yes, sir, we'd just like to note our --

19 THE COURT: I understand, but I just want to make
20 sure you have a chance -- convince me if I'm missing --

21 MR. GRAHAM: Well, sometimes it hard to draw that
22 line between OB and causation.

23 THE COURT: Right.

24 MR. GRAHAM: And we believe that this one merges OB
25 and causation. Some parts are just causation, some parts

1 merge causation. Their whole theory of the case is that
2 -- I mean, this is a new theory of the case that it was
3 the right shoulder stuck under the pubic bone, then when
4 it rotated -- before it rotated, the left side got injured
5 against the sacral promontory and that that is what caused
6 the injury. And for them to depict what caused the injury
7 and dress it up in a pregnant woman's uterus doesn't
8 change the fact that the whole point of it is to give an
9 alternative theory of causation.

10 THE COURT: It seems to me to be a summary of Dr.
11 Miller's testimony. I know you, obviously, have a
12 completely different view of the facts, but as far as what
13 Dr. Miller said happened, this seems to be a pretty fair
14 summary of that.

15 MR. GRAHAM: Yes, sir. Under Clark vs. Cantrell, I
16 believe the Court should also look at the prejudicial
17 nature and we believe it would be prejudicial.

18 THE COURT: In what way?

19 MR. GRAHAM: As the Court in Clark vs. Cantrell
20 described, there's an extreme vividness and persuasiveness
21 of motion pictures. And I think this is a good example of
22 that. You know, once seen, that would be difficult to
23 remove from one's mind and it's --

24 THE COURT: I'm not familiar with that case. Do you
25 mind handing it up? Off the top of my head. The Cantrell

1 case. I mean, animations are kind of routinely used. I
2 mean, even like in wreck cases now, you get the animation
3 -- the plaintiff and the defense will have animations
4 alleging how the wreck occurs.

5 MR. GRAHAM: Not in all cases and this addresses a
6 wreck case.

7 THE COURT: Thank you.

8 (Pause.)

9 THE COURT: Okay. I'm reading from the case. It
10 says: The fact the animation is inconsistent with
11 testimony or evidence produced by the opposing party
12 should not necessarily lead to the exclusion provided it
13 fairly and accurately portrays the proponent's version of
14 events. So, I mean, this -- Mr. Graham, is there any way
15 that you believe this -- other than the part that we're
16 not going to show, that does not fairly reflect Dr.
17 Miller's testimony?

18 MR. GRAHAM: Only insofar, Your Honor, that he's been
19 disqualified as an causation expert. He admits he's not a
20 causation expert and this -- while this last part that
21 remains doesn't call itself causation, in fact, it is
22 causation. At least, it's a mix between obstetrics and
23 labor and delivery and causation of brachial plexus nerve
24 injuries. I mean, taking out that middle part is helpful
25 to that extent, but still, it creates what we believe to

1 be prejudicial persuasive high quality animation about a
2 subject that the witness is not qualified to help create.
3 It just seems to me that at this point labor and delivery
4 and causation and brachial plexus nerve damage are all
5 just -- they're triplets just interwoven together. And I
6 don't believe it would be fair for this witness who is not
7 qualified on all three of those -- I mean, he testified
8 he's not an expert about neonatal matters, which is the
9 baby. He's not qualified on causation, which is some of
10 these other factors, including the reversal of the
11 shoulders and different theory. I understand it depicts
12 that theory, but it involves neonatal issues, causation
13 issues. It shows his version of labor and delivery, but
14 as to two aspects of it, he's not qualified.

15 THE COURT: I'm going to overrule the objection. I'm
16 going to allow it to be played excluding from ten to 45
17 seconds in the video. And the basis of my ruling is I
18 believe it accurately reflects Dr. Miller's version of the
19 facts, which he's already testified to, that's the basis
20 for my ruling.

21 MR. DAVIS: Thank you very much, Your Honor.

22 THE COURT: Anything else before we get started?

23 MR. GRAHAM: Yes, Your Honor, there was one other
24 thing. Dr. Miller has been addressing the jury and at one
25 point, he went -- at one point, Your Honor, he went so far

1 as to say you are the OB.

2 THE COURT: You're absolutely correct. Dr. Miller,
3 please don't make any more comments directed to the jury,
4 please. Just respond to questions asked by counsel.

5 MR. GRAHAM: And at one point, he said, quote,
6 insurance policy for the mother, end quote.

7 THE COURT: Okay, but that -- tell me what your
8 objection is and I'll make my ruling.

9 MR. GRAHAM: On the one hand, I believe he's opened
10 the door to insurance. On the other hand, I don't want a
11 reversal, so it leaves me in a quandary. I mean, we all
12 know it's inappropriate for anybody to mention insurance.
13 I got a mistrial one time that cost me a lot of money
14 because of something very much like this.

15 THE COURT: I mean, no one likes to hear about
16 insurance in a trial, but that, to me, was a colloquial
17 use of the term, meaning preventing harm or acting
18 cautiously, not in the sense of a cash payout from an
19 insurer. Tell me the context. I may be remembering it
20 incorrectly.

21 MR. GRAHAM: Your Honor, our joint recollection is
22 that the context was talking about the importance of an
23 obstetrician in the context of managing shoulder dystocia.
24 And the witness said we are -- let's see. I lost my
25 place. We are the insurance policy for the mother.

1 THE COURT: I don't think that's using -- it's
2 clearly not a good idea. I will instruct the witness not
3 to use the term again, but, I mean, I don't think that's
4 -- like I said before, that's not using it in the sense
5 of, you know, the Plaintiff's medical bills were paid by
6 insurance. It's using it in the sense of I'm going to put
7 new tires on my car to ensure that I don't have a skid.
8 Isn't that how he's using it?

9 MR. GRAHAM: I don't know, Your Honor. The
10 implications of it concern me. I don't know how the jury
11 might interpret it. It seems to me like it does impact
12 the collateral source rule.

13 THE COURT: Read to me again. I'm not -- I don't
14 hear that at all. He's not talking about payments, is he?

15 MR. GRAHAM: No, sir, but talking about we are the
16 insurer of the mother. It sounds as though they have
17 reimbursed -- or it could be construed by a juror that
18 they have reimbursed the mother in some fashion. We are
19 the insurance policy for the mother.

20 THE COURT: Mr. Davis.

21 MR. DAVIS: Thank you very much, Your Honor. My
22 recollection was Dr. Miller said in the part of the
23 delivery where everything is resolved and the baby is
24 coming out of the birth canal that the doctor at that
25 point, basically, is there just as insurance for the baby,

1 almost as to catch the baby so the baby doesn't fall on
2 the floor or something like that. He wasn't implying in
3 context anything about insurance payments, insurance
4 policies or this case at all. It was just sort of a
5 generic we're just sort of there sort of an insurance for
6 the baby so the baby just doesn't fall out, that the mom
7 could just push the baby out. That's the context.

8 THE COURT: Do you want a mistrial? Are you actually
9 requesting it?

10 MR. GRAHAM: Me?

11 THE COURT: Yes, sir.

12 MR. GRAHAM: No, sir.

13 THE COURT: Do you want me to give a curative
14 instruction or what do you want me --

15 MR. GRAHAM: Well, here's the problem. I think it
16 could be misconstrued. I'm afraid that if in closing I
17 try to put it in its proper context that I would get a
18 mistrial, which I don't want. But it's out there. It
19 can't be clarified or rebutted unless Your Honor does it
20 or Mr. Davis does it.

21 THE COURT: I think anything I say is going to make
22 it worse. I'll be happy to listen if you have a proposed
23 curative instruction that you think I should give, but I
24 thought it was an innocuous comment when it was made. I
25 think anything I say that calls attention to it is going

1 to get the jurors thinking in a way you don't like.

2 MR. GRAHAM: Your Honor, what we propose is that the
3 witness be admonished not to do that anymore.

4 THE COURT: Sure. I'll be happy to. Dr. Miller,
5 again, just please don't use the word insurance. Anything
6 else?

7 MR. GRAHAM: No, Your Honor.

8 THE COURT: Mr. Davis?

9 MR. DAVIS: No, sir. Thank you.

10 THE COURT: Mr. Davis, are you going to start with
11 the animation, is that going to be the first thing?

12 MR. DAVIS: No, sir. It's coming. We're getting to
13 it.

14 THE COURT: Give me a heads-up so I can give the jury
15 a brief instruction before you start playing.

16 MR. DAVIS: Yes, sir. I will let the Court know that
17 we're intending to show an animation so you can give the
18 instruction.

19 THE COURT: Thank you, sir.

20 MR. DAVIS: Thank you.

21 THE COURT: Let's bring them in.

22 (WHEREUPON, the jury enters the courtroom at
23 approximately 2:31 p.m.)

24 THE COURT: Mr. Davis, you can continue with your
25 direct.

1 MR. DAVIS: Thank you, Judge.

2 BY MR. DAVIS:

3 Q Dr. Miller, I think when we left that we were getting
4 into talking about your note that you made as soon as you
5 could after the delivery of Alexia?

6 A Yes, sir.

7 Q And can you see that okay? Do you have the
8 transcribed note in front of you in evidence? Here you
9 go. It's Exhibit 30.

10 A Thank you.

11 Q So let me ask you, patient pushing poorly with lack
12 of coordinated effort. We've addressed that. That's not
13 a criticism of --

14 A No, it is not.

15 Q Okay. Cervix now complete at zero station. Heart
16 rate decreased to 60 to 90, is that seconds? Heart rate.

17 A That's heart rate. And the time is actually probably
18 -- in the note, there was probably, I suspect, a cross
19 meeting for eight to ten minutes.

20 Q Okay.

21 A Not times eight to ten minutes.

22 Q For eight to ten minutes, is that what you meant by
23 that?

24 A Yes. The length of time was eight to ten minutes.

25 Q Okay. Vacuum applied times one. What does that

1 mean?

2 A So the vacuum -- at zero station, you don't want to
3 put a vacuum on, you prefer the baby's lower. But in this
4 situation when you have something as dangerous and
5 potentially life threatening as bradycardia, when the
6 mother is not making the progress in a timely fashion you
7 think that's safe enough for the baby, you use maybe an
8 extraordinary measure and say okay, I'm going to step in,
9 I'm going to try to help. I'm going to try to place the
10 vacuum and see if I can't help bring that head down a
11 little bit. Because as -- I think we've talked about this
12 before. A lot of times when a mother feels the pressure
13 of the baby descending, they start pushing much more
14 effectively. You know, unfortunately, I attempted to put
15 the vacuum on and it just wouldn't seal. And we'll find
16 that sometimes when a baby has a lot of hair. That might
17 have been the case.

18 Q So your note says vacuum applied times one to help
19 facilitate delivery, however, would not hold effectively.
20 Is that what you were explaining?

21 A Yes, sir.

22 Q Patient encouraged vigorously to push more
23 effectively because of fetal safety. And the fetus is
24 Alexia?

25 A Yes.

1 Q However, her pushing remained poor. Again, is that a
2 criticism of Ms. Patton?

3 A No. You know, there's different ways to judge how
4 well somebody is pushing. As the obstetrician, you try to
5 make an objective measure and that is, the most important
6 thing, is that baby descending? Is that baby getting
7 closer to being delivered? And the baby wasn't
8 descending, wasn't getting closer.

9 Q Warned that she would need a C-section if effort did
10 not improve and still did not improve. Again, is that a
11 criticism of --

12 A No, no. I mean, I think that happens with good
13 mothers, yes.

14 Q When you say warned that she would need a C-section,
15 have we already talked about how you addressed that with
16 Ms. Patton?

17 A Yes, sir.

18 Q Therefore, consent signed for what?

19 A For a cesarean section.

20 Q And patient taken to the operating room. We've
21 talked about that. Now, we're in the operating room?

22 A Yes, sir.

23 Q And it takes up, the next paragraph. In operating
24 room, heart rate increased to 130s. What does that mean?

25 A So that's 130 beats per minute. And that's

1 reassuring tracing.

2 Q When you say reassuring, is that good, bad or
3 indifferent?

4 A Good.

5 Q Okay. Increased to 130s with good acceleration.
6 You've talked about that. It's where the heart
7 accelerates?

8 A Yes. The heart responds suggesting there's good --
9 the baby is doing well.

10 Q Okay. Decision made to allow her to labor. Whose
11 decision was that?

12 A Well, in that situation, I'm deciding not to do the
13 C-section, but I'm also counseling the patient to make
14 sure they're okay with that.

15 Q And was she okay with that?

16 A She didn't have any problem with that.

17 Q Okay. Baby descended with pushing. So now she is
18 pushing and the baby is coming down?

19 A Yes. There's effective pushing at this point.

20 Q Head delivered LOP, left occiput posterior?

21 A Yes, sir.

22 Q The right shoulder would not deliver. McRoberts
23 maneuver. Suprapubic pressure and third degree episiotomy
24 tried without success?

25 A That is correct.

1 Q Could not deliver the posterior shoulder. And that
2 was posterior arm, posterior shoulder attempt --

3 A Yes, sir.

4 Q -- that did not resolve the dystocia? Time is still
5 ticking all through this, right?

6 A Yes, it is.

7 Q Therefore, woodscrew maneuver performed and rotation
8 of 180 degrees occurred to right occiput anterior?

9 A That's correct.

10 Q You turned the baby?

11 A Yes, sir.

12 Q Anterior left shoulder delivered?

13 A Yes.

14 Q Using McRoberts -- I mean, she was already in
15 McRoberts?

16 A That's correct.

17 Q That didn't have to be redone, did it?

18 A No.

19 Q Suprapubic pressure and moderate effort?

20 A Yes.

21 Q Did you say moderate traction?

22 A No. No.

23 Q Do you mean moderate traction?

24 A Absolutely not.

25 Q This is your note?

1 A It's gentle downward traction. There was hardly any
2 traction needed at that point.

3 Q All right. Baby subsequently given to Pediatric
4 Services immediately. Cord ph 7.208. What is a cord ph?

5 A You take a blood sample from the arterial blood.
6 There are a few places in the human body where the
7 arterial blood is the deoxygenated blood. This happens to
8 be one of them. This is more representative of the baby.
9 It's carrying the -- the vein actually carries the
10 oxygenated blood to the baby, it carries it away from the
11 baby in the umbilical cord. So that's arterial blood.
12 And that's a reassuring cord ph.

13 Q Baby weighed nine pounds six ounces, less than the
14 last baby she delivered?

15 A Yes.

16 Q With APGAR of 4 and 7. What's an APGAR of 4 and 7?
17 What does that mean?

18 A That suggest that although the cord ph did not show
19 significant evidence of acidosis, the APGAR 4 and 7
20 suggest that the baby was probably a little depressed, you
21 know, the labor had been a long labor and the baby was a
22 little depressed when it came out.

23 Q What is tone?

24 A Tone is just -- it's flexion and extension, you know,
25 how flaccid or sort of strong extremities and fingers and

1 toes are.

2 Q Okay. The next paragraph, post-partum hemorrhage
3 secondary to uterine atomy that occurred, which responded
4 to Pitocin, massage, Cytotec and Methergine. Estimated
5 blood loss 800 cc's. The OB was Dr. Miller, anesthesia
6 local for repair. What is post-partum hemorrhage, what
7 happened?

8 A A lot of time when you have a big baby, the uterus
9 gets stretched and overstretched. The mechanism for --
10 once the placenta detaches from the uterine side wall,
11 there's multiple large vessels. Some of these vessels are
12 as big as your finger. Human being's clotting factors or
13 cascade is insufficient to stop that bleeding. The only
14 thing that stops that bleeding is the contractile effort
15 of the uterus. So if the uterus was stretched from having
16 a large baby, sometimes the uterus will be reluctant to
17 start contracting to stop the bleeding. So she was given
18 several medicines as well as -- one of the best treatments
19 we have still, despite all the medicine we have is manual
20 massage. You put -- for me, I put my right hand in the
21 vagina, you know, stabilize the cervix and my left hand is
22 on the top, massaging, trying to squeeze out any blood,
23 making sure there's no blood clot which would prevent the
24 uterus from shrinking, but trying to stimulate the uterus
25 to contract. So using that, the Cytotec, Pitocin and

1 Methergine, we were able to get her uterus to contract
2 down.

3 Q How long do you estimate in your opinion -- from the
4 records or anything else, in your opinion, how long did
5 the shoulder dystocia last from the time that you
6 determined there was a shoulder dystocia until Alexia was
7 delivered?

8 A The right shoulder dystocia lasted 45 seconds.

9 Q Okay. Now, I want to talk about -- I want you to
10 explain to the jury -- let's break down these two words,
11 moderate and effort. First, what does moderate mean to
12 you in your note, sir?

13 A Observing reasonable limits and avoiding extremes of
14 behavior or calm.

15 Q Effort, what do you mean when you wrote on this note
16 effort?

17 A That was to include the posterior shoulder attempt
18 and the rotational maneuver.

19 Q Together?

20 A Yes. Some maneuvers or measures, I would consider
21 extreme and we did not have to use any of those in this
22 situation.

23 Q Doctor, in your opinion, is some effort required to
24 attempt a posterior arm delivery?

25 A Yes, sir.

1 Q In your opinion, is there some effort required to
2 attempt a rotational maneuver, sir?

3 A Yes, sir.

4 Q Altogether, in your opinion, is there some effort
5 required to do the McRoberts, suprapubic pressure,
6 episiotomy, posterior arm attempt and then a rotational
7 maneuver, sir?

8 A Absolutely, yes.

9 Q Did you mean when you wrote moderate effort that you
10 pulled excessively hard on Alexia's head as you finished
11 the delivery?

12 A Absolutely not.

13 Q Did you do that, sir?

14 A No, sir.

15 Q During the resolution of the shoulder dystocia or any
16 time before in this labor and delivery of Alexia, did you
17 ever lose your ability to be aware of how much traction
18 you were actually applying?

19 A No. There was gentle downward traction to diagnosis
20 the original shoulder dystocia on the right shoulder, but
21 there was almost minimal to no downward traction to
22 deliver the left shoulder because it was already
23 underneath the pubic symphysis and there's virtually no
24 traction or very little traction on doing the posterior
25 shoulder or a rotational maneuver.

1 Q Dr. Miller, did you become so concerned that your
2 efforts early on were not working to resolve this shoulder
3 dystocia that you just pulled too hard on her head when
4 applying traction, sir? Did that happen?

5 A No. I mean, the maneuvers -- first of all, my hands
6 are not on her head, they're on her shoulders. And
7 secondly, the maneuvers worked really well. That's why
8 the baby was delivered in 45 seconds.

9 Q Okay.

10 MR. DAVIS: Your Honor, at this time, we'd like to
11 show the jury an animation prepared that the Court has
12 already looked at before the jury came in, sir.

13 THE COURT: All right. Ladies and gentlemen, the
14 Defense is about to play you an animated video, okay. I
15 just want to make sure you understand this is not
16 evidence. This is an animation company that's been paid
17 by the defense and they have created an animated video
18 that shows what Dr. Miller says happened. Obviously,
19 there is a different version of the facts that the
20 Plaintiff says. I want to make sure you understand this
21 is not evidence. This is an illustration of what Dr.
22 Miller has testified to. Does that make sense to
23 everybody?

24 (No audible response.)

25 THE COURT: Okay. Go ahead, Mr. Davis.

1 MR. GRAHAM: Note our --

2 THE COURT: Your objection is noted, yes, sir.

3 (WHEREUPON, video animation is played for the jury.)

4 BY MR. DAVIS:

5 Q Can you see it, Dr. Miller?

6 A Yes, I can.

7 Q At any point if you wish us to pause this --

8 A Pause it right there. So just as I said earlier,
9 that's not the placement of my hands. They don't reach
10 down underneath the neck. They're side by side on the
11 baby's head.

12 Q Ready to go forward?

13 A Yes.

14 (WHEREUPON, video animation continued for the jury.)

15 BY MR. DAVIS:

16 Q Is that the right shoulder that is anterior?

17 A Yes, sir.

18 Q Left shoulder down posterior?

19 A Yes, it is.

20 (WHEREUPON, video animation continued for the jury.)

21 THE WITNESS: I would stop it right there if you
22 could. I have two criticisms of this. The first, you
23 know, in this situation, the baby's legs -- the baby is
24 not in an Indian-style sitting position. The legs are
25 extended at that point. And then secondly, the left arm

1 is not across the baby's chest. It is extended down below
2 and behind the baby's left hip.

3 (WHEREUPON, video animation continued for the jury.)

4 BY MR. DAVIS:

5 Q What are you trying to do here?

6 A That would be -- you know, at that point, you're
7 trying to either lift that forearm up and then, again,
8 it's extended or down by the hip at that point or do that
9 brachial -- try to push on the biceps tendon.

10 Q Is this the maneuver?

11 A That is a woodscrew maneuver.

12 Q Where is now the left shoulder?

13 A The left shoulder is anterior at this point, yes.

14 Q Is it behind, below, in front of, even with the pubic
15 bone?

16 A It is below the pubic bone.

17 Q That's what happened in this case?

18 A Yes, it is.

19 Q Can you see the right shoulder here? Can you see it?

20 A No.

21 Q You can't see it?

22 A No, no, no.

23 (WHEREUPON, video animation continued for the jury.)

24 BY MR. DAVIS:

25 Q The right shoulder was down. The left shoulder that

1 was injured is up?

2 A That's correct.

3 Q Did you see Ms. Patton in the hospital after the
4 delivery, sir, prior to her discharge?

5 A Yes, I did.

6 Q What would have been the purpose for that?

7 A That's a post-partum visit to check on Ms. Patton.
8 She had had a post-partum hemorrhage. One of the things
9 we want to make sure is she's not having any continued
10 bleeding. Sometimes with uterine atomy, it can recur.
11 Her hemoglobin and hematocrit, which we measure for blood,
12 were reasonable.

13 Q Do you have an opinion, Dr. Miller, whether -- and
14 you were there, whether or not you met the standard of
15 care of a reasonably prudent obstetrician in the same or
16 similar circumstances in your care and delivery of Alexia
17 on April 5, 2017, in spite of her permanent injury, sir?

18 A Yes, I did.

19 Q Tell the jury, Dr. Miller, what you've learned from
20 this case.

21 A It's been a long time coming, 2007. We've had
22 several start-ups and stops. I've reviewed this case, I
23 don't know how many times. You never want anything bad to
24 happen to any patient, whether it's a mother or a baby or
25 a GYN patient. You just don't -- you don't want that to

1 happen. So you do -- in any case where there might be an
2 outcome that's not necessarily perfect, you do review and
3 revisit it and revisit it. And I did the right thing with
4 the right shoulder. My maneuvers speak for themselves.
5 There was no left impacted shoulder afterwards. The
6 woodscrew maneuver, it's clear that that fixes that every
7 time. So from that standpoint, I've looked at it and I've
8 thought about it and wondered why that could have
9 happened. I have children, too, and we all love our kids
10 dearly and I wish Alexia's arm was not injured. But
11 pregnancy is not perfect and sometimes bad things happen
12 to good people.

13 MR. DAVIS: Thank you, Dr. Miller.

14 THE COURT: Cross-examination, Mr. Graham.

15 MR. GRAHAM: Your Honor, we're going to need to get
16 some technology set up. Can we have a short break?

17 THE COURT: Ladies and gentlemen, they're going to
18 need to set up some technology, so I'll give you a short
19 -- we'll give a ten-minute break so everyone can use the
20 restroom or whatever they need to do.

21 (WHEREUPON, the jury exits the courtroom at
22 approximately 2:52 p.m.)

23 THE COURT: Dr. Miller, you may step down if you
24 like. Don't discuss your testimony.

25 (WHEREUPON, a short recess was taken.)

1 THE COURT: (Audio picks up in middle of sentence)
2 when deliberation will begin. Are we still on track? Do
3 you think you'll finish up Dr. Miller today?

4 MR. DAVIS: I fully expect we'll get through with him
5 today. I mean, that is not up to me right now, but we
6 have our experts testifying tomorrow and we're going to be
7 done.

8 THE COURT: Two experts, Mr. Davis? [MR. DAVIS:
9 Yes, sir.

10 THE COURT: Mr. Graham, what do you think?

11 MR. GRAHAM: I think we'll finish. Unless there's a
12 long redirect, we'll be finished.

13 THE COURT: So I think we're still shooting for a
14 charge and close tomorrow?

15 MR. GRAHAM: Well, I have no idea how long his
16 experts will be. I was talking about Dr. Miller.

17 MR. DAVIS: I wouldn't anticipate them taking the
18 entire morning, but it may, but I don't think so.

19 THE COURT: Okay. That's fine.

20 MR. GRAHAM: (Inaudible.)

21 MR. DAVIS: I don't think so. I mean, they're kind
22 of -- their opinions are what they are.

23 THE COURT: In the event we finish before lunchtime,
24 I will not do charge and close before. We'll just pick up
25 after lunch with charge and close.

1 MR. DAVIS: Okay.

2 THE COURT: I'll just say that my practice is not
3 normally to keep jurors late in a situation like this. I
4 would typically -- say we finish charge and close at 4:30
5 tomorrow, I will bring them back Thursday morning to
6 deliberate rather than keep them late into the night on
7 Wednesday. I'll be happy to hear argument on that if
8 y'all disagree tomorrow. Anything else? Mr. Davis,
9 anything before I bring the jury back in?

10 MR. DAVIS: Just one thing, Your Honor. I don't know
11 who's going to do the cross-examination of Dr. Miller, but
12 I would point to Rule 43(h) examination of a witness at
13 trial --

14 THE COURT: Hold on one second. Let me pull it up
15 myself.

16 MR. DAVIS: Yes, sir.

17 THE COURT: All right. I'm there.

18 MR. DAVIS: Since we are proceeding under a
19 reservation after Plaintiff called Dr. Miller under
20 questioning by Mr. Jordan in their case in chief, we are
21 picking up from that at this point and it would be our
22 position that it would be Mr. Jordan that is now required
23 to continue the cross-examination, not Mr. Graham.

24 MR. GRAHAM: Your Honor, two points. Number one,
25 this is the equivalent of direct in their case in chief,

1 so as far as I'm concerned, it's a whole new ballgame.
2 But the other point is they've waived any argument about
3 that because they did not object to my objecting during
4 direct. If only one attorney were allowed to be involved
5 with respect to the cross-examination of a witness, then
6 only that attorney is allowed to make objections. As Your
7 Honor knows, I made the objections. There was no
8 objection to my making objections and we believe that
9 would constitute a waiver of any claim that they would
10 have under that rule.

11 THE COURT: This is not an issue I've ever
12 encountered before. Give me just a moment.

13 (Pause.)

14 THE COURT: While I'm looking, if counsel has any
15 authority you can direct me to, I'll be happy to hear it,
16 either side.

17 MR. DAVIS: Your Honor, other than the Rule, I do not
18 have any. I'm not aware of any.

19 (Pause.)

20 MR. GRAHAM: And, Your Honor, whenever you're ready,
21 I do have one more.

22 THE COURT: Counsel, there does not seem to be a
23 single reported case in South Carolina interpreting or
24 giving any kind of guidance with regard to Rule 43(h).
25 There are apparently a couple of cases, one from 1882 and

1 one from 1914 dealing with this issue, but those way
2 predate the Rules of Civil Procedure, so I don't think
3 they have any bearing at all. Were you able to find
4 anything, Mr. Graham?

5 MR. GRAHAM: No case law, Your Honor, but the way we
6 interpret the Rule is that -- from the context, it's
7 really trying to protect the witness from being double
8 teamed, you know, two lawyers in one cross-examination,
9 you know, back and forth like a tag team match.

10 THE COURT: Right. Mr. Davis, I know you said
11 earlier you hadn't been able to find anything. Anything
12 in the interim?

13 MR. DAVIS: I can't find any. If His Honor can't
14 find any cases on point more recent than 1914, I promise
15 you I would never be able to.

16 THE COURT: That's not, of course, even about the
17 Rule. That's an issue with -- you know, it says the Court
18 has the discretion to allow multiple attorneys to examine
19 a witness.

20 MR. DAVIS: I would certainly absolutely agree it's
21 well within your discretion to permit that, but I'm
22 lodging my objection because Brad Jordan cross-examined
23 him in their case. That's their choice. I reserved my
24 right. This is as if I went through my whole direct on
25 him, not in their case, now in my case, which I have the

1 right to do and now, they're going to say well, it's not
2 really -- it's a different cross-examination. It's a
3 different point in time. Under the scenario, it's as if I
4 just went through my whole direct with him in their case,
5 which I could have done, and they would not -- Graham
6 would not be able to get up and recross -- or redirect.
7 That would have been improper. I think that's kind of
8 where we are and I think that's the intent of the Rule. I
9 mean, Mr. Graham himself concedes that the purpose of the
10 Rule is not allowing a witness to be tag teamed by two
11 different lawyers on cross. That's exactly what they're
12 doing here. They're separating it by days. I don't think
13 there's any difference.

14 THE COURT: I'm going to allow Mr. Graham to
15 cross-examine the witness. I think that the intent of the
16 rule, though it's not the most clearly worded, is, as Mr.
17 Graham said, on one particular examination, you can't call
18 up multiple lawyers to tag team the witness. And given
19 the witness has been recalled as part of the Defense's
20 case, I'm going to permit Mr. Graham to cross-examine him.

21 MR. DAVIS: Thank you very much, Your Honor.

22 THE COURT: Yes, sir. Let's bring them in.

23 (WHEREUPON, the jury enters the courtroom at
24 approximately 3:13 p.m.)

25 THE COURT: Cross-examination.

1 MR. GRAHAM: May it please the Court?

2 THE COURT: Yes, sir.

3 CROSS-EXAMINATION

4 BY MR. GRAHAM:

5 Q Good afternoon, Doctor.

6 A Good afternoon, Mr. Graham.

7 Q Is patient safety important to you?

8 A Yes, it is.

9 Q Is it asking too much for you to give safety priority
10 over finishing a job as soon as you can?

11 A First off, can you define safety in your words?

12 Q You need me to define safety?

13 A I just want to be clear on what you're asking.

14 Q So are you telling us you don't know what safety is?

15 A I know my definition.

16 Q Then tell us.

17 A Safety is trying to do the right thing for the
18 patient and take care of them.

19 Q So with that definition, is it asking too much for
20 you to give safety, patient safety priority over finishing
21 the job as soon as you can?

22 A I think that happens every time. I don't think you
23 ever try to finish a job any faster based on patient's
24 safety. You're going to have to take patient's safety as
25 priority.

1 Q Is it reasonable for my client and me to expect you
2 to give safety priority over finishing the job quickly?

3 A Yes.

4 Q It would be wrong to cut corners when it comes to
5 safety, true?

6 A It depends. If cutting corners improves safety, you
7 might do that.

8 Q When it comes to optimizing patient's safety, it's
9 wrong to cut corners, true?

10 A No, you always got to try to optimize patient's
11 safety.

12 Q And when trying to provide obstetrical care safely,
13 do you believe that an obstetrician should use all tools
14 at his fingertips?

15 A Can you say that again?

16 Q Yes, sir. Do you believe -- when it comes to patient
17 safety, do you believe that an obstetrician should use all
18 tools available to him?

19 A I think an obstetrician does take advantage of
20 everything that he has at his disposal.

21 Q Well, I asked about you, you answered about an
22 obstetrician. Do you believe --

23 A Oh, I'm sorry. That was my mistake.

24 Q I'm certainly not trying to play word games. I just
25 want to make sure. Do you believe that it would be wrong

1 for you to cut corners when it comes to patient safety?

2 A I would never cut corners.

3 Q And do you believe that it would be reasonable for
4 patients, such as Alexia and her mom to expect you to use
5 all tools at your fingertips to manage an obstetrical
6 emergency safely?

7 A I would do everything in my power to manage an
8 obstetrical emergency safely.

9 Q Do you believe that an obstetrician should keep
10 patients in the loop or keep them in the dark?

11 A Oh, no, you absolutely want to try to keep them in
12 the loop. It's a team approach. If you have a patient
13 that knows what's going on -- an informed patient is a
14 good patient.

15 Q What is a good Samaritan to you?

16 A Good Samaritan is somebody that does something good
17 and they don't expect anything in return.

18 Q You're not a good Samaritan, are you?

19 A I think I've been a good Samaritan, yes.

20 Q Are you saying you did not expect anything in return
21 for delivering this child?

22 A You said am I, in the generic form, a good Samaritan.
23 I would say yes, I am.

24 Q First, I asked you to define what a good Samaritan
25 means to you, you told me it means somebody doing good

1 with no expectation of anything in return?

2 A Correct.

3 Q Using your definition, you're not a good Samaritan,
4 are you?

5 A Yes, I am.

6 Q All right. Did your office send out a bill for your
7 services in this case? Did you expect to be paid for your
8 work on this case?

9 A We expect to get paid when we provide services, yes.

10 Q Okay. That's not what a good Samaritan does, is it?

11 A I have done a lot of work for free.

12 Q All right. Well --

13 A It's to take care of people and in that situation, I
14 have no trouble doing that.

15 Q Well, I haven't asked you if you've been a good
16 Samaritan a few years ago or something like that, I'm
17 asking you with respect to Alexia's delivery. You
18 expected to be paid for your work, fair?

19 A Well, we entered into a contract, so that's part of
20 the contract, yes.

21 Q You did have an expectation to get paid in exchange
22 for your work?

23 A To be honest, I never know when and if I do get paid.
24 That's not really high on my priority list.

25 Q When an obstetrician might under some circumstances

1 do less, do you believe that the obstetrician should
2 reduce their charges?

3 A I'm unclear as to what you mean by do less.

4 Q Fail to meet the applicable standards of obstetrical
5 care under the same or similar circumstances?

6 A So I think you're mixing two different things that
7 don't really mix together. You're talking about one, a
8 contractual agreement, and you're talking about one, the
9 standard of care.

10 Q So you believe a doctor who charges for providing
11 services the patient expects to be within the standard of
12 care should still get paid in full even if he falls short
13 of the standard of care?

14 A Well, I didn't fall short of the standard of care in
15 this case.

16 Q I know you're -- I'm not going to try to get you to
17 change your testimony about that. I know that's
18 fruitless. I'm just asking generically if an obstetrician
19 were to charge a patient for services that the patient
20 rightly expected to be up to the generally accepted
21 standards of care, but the doctor fell short of those
22 standards of care, do you believe that the doctor should
23 reduce the billing?

24 A That didn't happen in this case.

25 Q I didn't ask about this case. I asked about an

1 obstetrician, okay? For this question, I'm not asking
2 about you, sir. I'm asking about your beliefs about a
3 hypothetical obstetrician who fails to meet the standard
4 of care, do you believe he should discount his rates, his
5 billing rates?

6 A Hypothetical situation when an obstetrician fails to
7 meet the standard of care and then should discount their
8 rate?

9 Q I'm asking if you believe that.

10 A That's not the system that's currently in place.

11 Q If an obstetrician, okay, I'm not talking about you
12 because I know what the answer would be --

13 A Another hypothetical.

14 Q An obstetrician were to cause injury by violating the
15 applicable standards of care, do you believe that patient
16 safety would be enhanced if that obstetrician learns from
17 his mistakes?

18 A I'll answer that in two parts. In this case, I
19 didn't have any mistakes and I delivered the right
20 shoulder correctly and there was no subsequent left
21 shoulder dystocia. And you're saying, generically, should
22 somebody who does something wrong, doesn't meet the
23 standard of care, should seek help or guidance?

24 Q No, sir.

25 A Okay. I'm sorry.

1 Q I'm asking if an obstetrician fails to meet the
2 standard of care, thereby causing severe injury to a
3 patient, should, at least, learn from that shortcoming?

4 A So I know that -- for example, in my residency at the
5 University of Florida, we had a physician at the
6 neighboring hospital who kept doing bilateral tubal
7 eruptions, and he had several failures. So the chairman
8 of the department at University of Florida called him in
9 and said listen, you need to learn. You need to do
10 something better. And I was put in charge of teaching him
11 how to do a bilateral tubal ligation. In that sense, I
12 think that's reasonable that somebody try to learn from
13 something and get better at it.

14 Q How many times had that doctor made that shortcoming
15 in his practice?

16 A Six times.

17 Q Six times. Then you tried to make him learn from his
18 mistakes?

19 A No, no, the chairman of the department suggested he
20 considered doing this. One of my current partners had
21 three tubal failures in the last three years. I finally
22 asked him, I said, you know, you're putting those Titanium
23 clips on it, they're not working. You should think about
24 a different technique. And he changed.

25 Q So in both examples you gave, the doctor that messed

1 up six times didn't seek to learn from his mistakes on his
2 own, it took the chairman of the department to make
3 suggestions for him to learn from his mistakes --

4 A It did --

5 Q -- after he made six mistakes?

6 A It did in his case.

7 Q And then in the other case you described, your
8 partner, colleague, made three mistakes on the same topic
9 and he chose not to learn --

10 A He didn't realize --

11 Q Let me finish the question.

12 A I'm just trying to make it easier for you.

13 Q Well, interrupting my question makes it --

14 A We would have been done by now.

15 Q You told me in your second example that your
16 colleague -- that you suggested to your colleague that he
17 learn not to use the Titanium clips after he had messed up
18 on three different occasions, correct?

19 A I'm not sure -- I'm not necessarily sure he messed
20 up. The Titanium clips have a much higher failure rate.
21 To be honest, I don't know that he knew that they had
22 failed. I was bringing it to his attention in letting him
23 know that was the case.

24 Q Sure. But your colleague didn't try to figure out
25 why he had messed up that first go round? He didn't try

1 to figure out if it was him using a bad product that had a
2 bad reputation in the market for failure or if there was
3 something else? He just kept doing the same thing over
4 and over three times --

5 A No.

6 Q -- before you suggested that he reconsider, correct?

7 A No, that's not correct. That's what I was trying to
8 say. He didn't know. You know, unfortunately, sometimes
9 when you have patients come in and out of your practice
10 and you might do a surgery on somebody and three or four
11 years later, they come back in with a different problem.
12 So somebody else might actually identify the problem. And
13 my problem, I'm pretty sure he didn't know and I brought
14 it to his attention.

15 Q But he didn't learn on his own from his mistakes.
16 After he did it three times, he learned from you he was
17 using the wrong product. But he made no effort to learn
18 his own -- he made no effort to himself. He had to make
19 repeated mistakes until you called his mistake to his
20 attention, true?

21 A No, that's not true.

22 Q So let me go back to my first question. Do you
23 believe that a doctor who falls short of the generally
24 accepted standards of care should learn from his mistakes,
25 whether it's the first mistake or the third or the sixth?

1 A I think that if you have outcome which might have
2 deviated below the standard of care and you have an
3 opportunity to review that, you should try -- if you made
4 a mistake, you should try to improve your skill set.

5 Q Thank you. Let's talk about training. You told us
6 that you were a resident down in Florida. Did they train
7 you from very early in your first year of residency the
8 proper way to manage shoulder dystocia?

9 A Yes, sir.

10 Q They trained you what to do and what not to do?

11 A Yes, sir.

12 Q One of the things they trained you not to do is to
13 use more than gentle traction, correct?

14 A They trained that there were rare exceptions, but you
15 tried to use gentle downward traction.

16 Q So rare exceptions you did try to use gentle downward
17 traction?

18 A There are rare exceptions where you might have to use
19 more than gentle downward traction.

20 Q Oh, sure, if it's five minutes or whatever. You said
21 four or five, other people say five or six. Anyway, 45
22 seconds is nowhere close to four or five minutes?

23 A No, 45 seconds is a success.

24 MR. GRAHAM: Alexia, would you mind standing up.

25 MR. DAVIS: Objection, Your Honor.

1 THE COURT: Counsel, can y'all approach.

2 (WHEREUPON, a bench conference was held in the
3 presence of the jury, but outside the hearing of the
4 jury.)

5 MR. GRAHAM: Alexia, please remain seated.

6 BY MR. GRAHAM:

7 Q Doctor, you told us that this 45-second shoulder
8 dystocia delivery by you was a success?

9 A Yes.

10 Q Is Alexia what a success looks like in your how-to
11 book?

12 A Unfortunately, in this situation, it does. Alexia
13 has a permanent neonatal brachial plexus injury to her
14 left arm. In her delivery, her right shoulder was the one
15 that developed the shoulder dystocia. I did all the
16 proper maneuvers to release that right shoulder and it
17 only took 45 seconds. I would consider that a success.
18 The left shoulder never was stuck, okay. So, you know, I
19 had nothing to do with that left shoulder. I'm very happy
20 the right shoulder wasn't injured, but I didn't have
21 anything to do with that left shoulder injury.

22 Q Nothing?

23 A I had -- what I had to deal with was -- what I was
24 responsible for was the fact that I successfully reduced
25 the right shoulder dystocia and there was no left shoulder

1 dystocia after that.

2 Q In your training, you were taught never to use more
3 than gentle traction?

4 A We are trained to --

5 Q Except for those --

6 A There were extenuating circumstances where you could,
7 but you tried to always use gentle downward traction.

8 Q So whether it's four minutes or five minutes or six
9 minutes, we'll use the four-minute rule, you had three
10 minutes and 15 seconds before you ran into the four-minute
11 rule, correct?

12 A So, unfortunately, in shoulder dystocia cases, it's
13 not like you -- once it starts, you don't know how long
14 it's going to take. There's no way of parsing, well, I'm
15 going to try a little bit here or I'll try a little bit
16 there, but if it gets to four minutes, I'm going to try a
17 lot harder. You develop a routine, a protocol that's been
18 developed over years -- in my case, 33 years, over 9,000
19 deliveries, 150 to 250 shoulder dystocias -- and you start
20 that routine. You don't know when you start how long it's
21 going to take. But, typically, when I'm running through
22 my maneuvers the first time, it's usually somewhere
23 between 45 seconds to a minute before I have to move on to
24 sort of Plan B.

25 Q Plan B would be to repeat your maneuvers rather than

1 increase traction?

2 A Yes, sir. So Plan B for me, depending on whether I
3 tried to turn the baby clockwise or counter-clockwise, I
4 would do the opposite direction. And then if that doesn't
5 work, then I'm going to go back to the posterior shoulder.
6 Because sometimes just a little movement on the baby will
7 help release that posterior shoulder.

8 Q So when you realize that there's a shoulder dystocia
9 and you call for McRoberts, suprapubic and a diagnostic
10 degree of traction to see if the baby will come out?

11 A Gentle downward traction, yes.

12 Q Then at that point, you should not increase traction?

13 A No.

14 Q You should move to another maneuver, your choice, but
15 posterior arm delivery or Woods --

16 A Yes.

17 Q -- Rubin?

18 A Yes.

19 Q Any of those, except you use posterior arm first?

20 A That's correct.

21 Q And if that doesn't succeed, you should not apply
22 more traction, you should go to a rotational maneuver,
23 correct?

24 A In my protocol, yes.

25 Q And if the rotational maneuver and gentle traction

1 doesn't work, then you should move on to an opposite
2 rotational maneuver or repeat some of the other maneuvers,
3 check on whether McRoberts is being done correctly, check
4 on whether suprapubic is being done correctly, any of
5 those things, but not increase the traction, the downward
6 traction on the baby's head, true?

7 A That is true.

8 Q To increase traction and bending of the neck rather
9 than moving on to the next maneuver in the first 45
10 seconds or two minutes would be a violation of your
11 training, correct?

12 A Bending the neck is not going to help you. We steer
13 away from the head and the neck. It's a shoulder
14 dystocia, so we're focused on the shoulder. You could do
15 -- you know, manipulate the head or the neck and that's
16 not going to work, so we just don't do that.

17 Q So are you telling me it would be a violation of your
18 training to bend the baby's neck at all?

19 A Baby's neck can bend slightly, but that's ever so
20 slightly. Babies have the capacity to bend their own
21 neck. They're alive.

22 Q The question is about your training, sir.

23 A Yes, sir.

24 Q Were you trained not to use your hands on the baby's
25 head to bend the neck?

1 A We were trained to use gentle downward traction along
2 the axial plane, which is the cervical thoracic spine,
3 staying within that plane.

4 Q If you failed to do that, then that would violate
5 your training, correct?

6 A That would go against how I was trained.

7 Q It would be a violation of the generally accepted
8 standards of care, true?

9 A Yes.

10 Q I'm curious to ask you this, I know you're a great
11 tennis player, obviously, do you keep up with football at
12 all? Did you watch the game last night?

13 A No, I did not.

14 Q Have you heard the expression that sometimes a
15 professional athlete when moving up the ranks from top
16 amateur to the professional level sometimes struggles
17 despite his talent just because things get so much faster?

18 A I've heard that, yes.

19 Q Since you were first exposed to the four-minute rule
20 for shoulder dystocia, has time slowed down for you in
21 terms of various maneuvers to use rather than traction and
22 bending?

23 A Well, I've never used traction or bending of the
24 neck. What I would say is I have a routine or protocol
25 that helps me relax during delivery, that helps me stay

1 calm. I mean, the first thing I do is you call out to the
2 team and say we've got a shoulder dystocia. And then you
3 put everybody in position to do what they need to do. And
4 then you start.

5 Q The question, sir, has time slowed down for you since
6 you first started as an obstetrical resident? Has time
7 slowed down? In the beginning, did that four minutes seem
8 intimidating?

9 A No. I'll get back to your sports analogy. I think
10 you do do things in life that prepare you for other
11 things. As I said, I'm certainly not big enough to play
12 football, but I have been over the years in situations,
13 put myself in situations that enable me to be really calm
14 under pressure. A tennis player was one, being in the
15 military was another, being a good student throughout my
16 career. You know, I've been in pressure cookers my whole
17 life. I've had to perform under pressure. So I'm not
18 sure I ever remember oh, gosh, I finally understand or
19 shoulder dystocia is easy. I think if you don't have that
20 good working protocol and you don't have maybe that
21 confidence that you can get the job done, maybe it takes
22 time for some people to build that, but I think I built
23 that confidence in myself in other avenues. So I think
24 almost from the get-go I felt pretty good about what I was
25 doing.

1 Q So compared to one of us who might think four minutes
2 is a pretty big challenge to do something that we're not
3 trained to do, do you believe your training and your
4 calmness from other activities leads you to have plenty of
5 time to use those four minutes effectively?

6 A Yes, I do.

7 Q And it gives you plenty of time to deliberate and
8 plan your course of action, right?

9 A Yes. So, again, as I said earlier, typically, you
10 get through the first round of maneuvers in approximately
11 45 seconds to a minute. And that's where we were with
12 Alexia. You know, she rotated really easily. It took
13 five to ten seconds to get her to move 180 degrees and at
14 that point, the shoulder is below the pubic symphysis and
15 the rest of the delivery is very simple.

16 Q My question, sir, is with four minutes and your
17 training and your calmness from other activities, four
18 minutes is plenty of time for you to go slowly and plan
19 what you're going to do, take as much time as it needs
20 without stressing out or panicking, true?

21 A I would say I do not panic.

22 Q The question, sir, is given your calmness and your
23 training, four minutes is not a challenge, is it?

24 A Oh, every shoulder dystocia is a challenge.
25 Unfortunately, it is not playing a tennis match or a tie

1 breaker or trying to get a good grade on a test. Every
2 shoulder dystocia is a challenge in that sense because the
3 stakes are certainly much higher. You know, I feel like
4 I'm able to manage that with a calmness, but it doesn't
5 mean that I think that it's not significant or a serious
6 emergency.

7 Q But you were -- did you deliver a baby when you were
8 in medical school?

9 A 20 or 21 of them, yeah.

10 Q When you were in medical school, would it have seem
11 intimidating to you to only have four minutes to resolve a
12 shoulder dystocia?

13 A No, because you weren't the person in charge. You
14 know, medical school, you're the medical student. You
15 have the first and second year resident. You have the
16 third year resident. There's even an attending behind
17 them. So in medical school, you really feel -- no, you're
18 like -- you're given the low hanging fruit. You're given
19 the very easy deliveries and if anything changed, if it
20 was shoulder dystocia, you were kicked to the side.

21 Q You were just to be a bystander?

22 A Then it would be a learning experience.

23 Q Well, once you got to resident, four minutes was a
24 lot longer time for you than it would be for anyone who
25 was untrained, fair?

1 A Time is time. It clicks by the same for somebody
2 that's trained as somebody who's untrained.

3 Q So do you believe a four-minute rule would be no more
4 challenging for any of us than it would be for you as a
5 trained, experienced obstetrician?

6 A I certainly hope that people who are untrained are
7 not trying to do it.

8 Q Why is that, Doctor?

9 A Because it takes a level of skill and expertise.

10 Q And in that regard, do you believe that four minutes
11 for you in the shoulder dystocia situation gives you an
12 abundance of time to reflect, plan, to stay calm and get
13 the job -- take the time it takes to do the job right?

14 A I think that you know that you have up to four to
15 five minutes before risk of brain injury substantially
16 increases, but bad things happen, unfortunately, with
17 shoulder dystocias before that four-to-five-minute rule.

18 Q You've got 45 seconds for one set of maneuvers?

19 A Yes, sir.

20 Q In four minutes, how many times could you repeat and
21 improve those maneuvers?

22 A It depends on what the fetal heart rate is doing. So
23 after each set of maneuvers, you're going to look at the
24 fetal heart rate. The concern is cord compression and/or
25 carotid vessels in the neck being compressed. If each

1 time you turn or attempt to do a posterior shoulder or
2 woodscrew maneuver the heart rate still looks reassuring,
3 then you keep going. But I only recently about a year ago
4 had the first time where either posterior shoulder or
5 woodscrew did not resolve a shoulder dystocia.

6 Q The question was how much time did you have to repeat
7 a set of 45-second maneuvers?

8 A So I would say, you know, in four minutes, maybe up
9 to four.

10 Q There was plenty of time -- when you did the last
11 hands on the head traction, there was plenty of time to
12 repeat the maneuvers, to correct any flaws in the
13 McRoberts or the suprapubic?

14 A There was no need to. The shoulder dystocia was
15 resolved.

16 Q Do you believe that when shoulder dystocia is
17 diagnosed -- by the way, was there a turtle sign in this
18 case?

19 A No, there wasn't.

20 Q So in that case -- well, just so we're all in the
21 loop, a turtle sign is when the baby's head pokes out and
22 then goes back in?

23 A Yes, it does.

24 Q That's one way to diagnose shoulder dystocia,
25 correct, if it happens?

1 A No, that's sort of a -- there's a lot of false
2 positives with the turtle sign. The true test is to try
3 your gentle downward traction and see. Turtle shell
4 maneuver could be just related to the uterus contracting.
5 It could be related to the mother pushing. Really, you
6 have to decide that on your own.

7 Q So sometimes what some people might think is a turtle
8 sign is just the uterus pushing, you know, one step
9 forward, half step back, that kind of thing? That's how
10 the uterus works, right? Yes?

11 A Well, not a half step back. The uterus is either --
12 it's either contracting and it's typically in a
13 crescendo/decrescendo pattern where you'll get the
14 contractions started and it will increase, increase,
15 increase until it reaches a maximum and then it will begin
16 to decrease. Often, the contraction looks similar on both
17 sides.

18 Q Fine, but I'm talking about the baby's descent
19 through the birth canal.

20 A Okay.

21 Q In that situation, the uterus and the mother is
22 pushing to make the baby go down, but then it goes back a
23 little, goes down more, goes back a little, et cetera,
24 correct?

25 A No. I think there's lot of different paths and

1 progresses that the baby takes going through the birth
2 canal. I don't think it's two steps down, one step back,
3 two steps down. Some babies just keep progressing.

4 Q Sure. I'm not saying that every baby does that, but
5 I was following up on your explanation about turtle sign
6 may not mean shoulder dystocia. I think you were
7 suggesting that when it's not a sign of shoulder dystocia,
8 it's just the uterus pushing down and the head coming back
9 like that, correct?

10 A Either that or the mother pushing down.

11 Q Sure. So the way you diagnose shoulder dystocia was
12 putting your normal traction on the baby's head, normal
13 gentle downward traction, right?

14 A Yes, in the axial plane.

15 Q Anterior shoulder didn't come, so a light bulb went
16 off, we've got a shoulder dystocia. So from that point
17 forward, I want you to tell us what you did every second
18 of those 45 seconds. You said you remember this delivery,
19 right?

20 A Yes, I do. I think we've gone over this multiple
21 times already. Do you want me to get my model? Do you
22 want me to write it down or you want me just to discuss
23 it?

24 Q I'd like you to answer my question, sir. What did
25 you do each second of those 45 seconds?

1 A Well, so I -- we don't really write a record about
2 first second, I did this, the second second, I did this
3 and the third second, I did this and the fourth second, I
4 did that, but I can tell you the maneuvers sequentially.

5 Q Excuse me. We know that. You've told us that. How
6 long did it take you to ask the nurses for McRoberts?

7 A We need to put a McRoberts. You got a clock?

8 Q One second?

9 A One to two.

10 Q How long did it take the nurses to put her in
11 McRoberts?

12 A Well, she was already in semi-McRoberts already. She
13 already had her legs back. When we do McRoberts, we do a
14 full flexion with her legs back.

15 Q And you've said those things. My question is, how
16 long did it take the nurses to carry out your order to put
17 the patient in McRoberts? Real McRoberts, not half
18 McRoberts, real McRoberts?

19 A To actually physically move those legs, we'll say a
20 couple of seconds.

21 Q And how long did it take for the nurse to start
22 applying suprapubic pressure?

23 A That's probably closer to about five to ten seconds
24 because she had to get a stool.

25 Q All right. And that was, I think you said Julie Bibb

1 who got the stool?

2 A Yes.

3 Q How tall is Julie Bibb?

4 A She's probably about 5'4."

5 Q And you told us she had the bed raised pretty high,
6 right?

7 A No, no, the bed's not raised high because I'm seated.

8 Q You said the arm holders or whatever you called it --

9 A Stirrups, yes, but the bed is not high.

10 Q So the stirrups are high keeping the mom's legs high.
11 There's a nurse on each side holding the legs back, kind
12 of like this?

13 A Sort of like that.

14 Q And then is there a third nurse?

15 A Yes.

16 Q Doing the suprapubic or one of the ones --

17 A No, Julie did the suprapubic.

18 Q Did she also have one of the legs?

19 A No, you had the circulating nurse doing that.

20 Q Who was that?

21 A That, I don't remember. I don't know.

22 Q So how much room was there between the legs being
23 held back in McRoberts by a nurse on each side of the bed
24 and the end of the bed where -- you said it had dropped
25 down?

1 A Yes.

2 Q How far from the edge of where it dropped down to the
3 mother's pubic bone?

4 A We don't really look at it that way. We look at
5 where the mother's bottom is. The mother's bottom is on
6 the edge of the bed.

7 Q So how far -- when the nurses are holding the legs in
8 McRoberts, how far are they from the end of the drop down
9 table?

10 A Maybe a foot to two feet.

11 Q Was this a relatively small operating room?

12 A When you have that many people, every operating room
13 is small. It's a normal size operating room. Operating
14 rooms for -- using the Da Vinci Robot tend to be larger
15 because there's more equipment.

16 Q We drew a picture earlier of a pretty skinny bed,
17 right, pretty narrow bed?

18 A Well, the bed's only 20 inches wide.

19 Q Right.

20 A That's a typical OR bed. I was trying to do the best
21 I could.

22 Q Sure. And you showed it being pretty long, right?

23 A Well, remember, initially, the bed has to be long
24 enough because most patients -- before you drop the lower
25 part of the bed, I want to say the beds are probably --

1 and this part, I don't know, I'd have to go look. They're
2 probably well over six feet, probably somewhere between
3 six and eight feet if I had to guess.

4 Q All right. So how far -- you say you remember who
5 was doing the suprapubic? Julie Bibb?

6 A Yes, Julie was doing the suprapubic.

7 Q You told us she was 5'4". I hate to ask about a
8 woman's --

9 A Don't you go there. Don't you go there.

10 Q Just a general description of the body configuration
11 of Nurse Bibb.

12 A Well, since she's not here, but she was normal size.
13 I would say 160, if I had to guess. She was a relatively
14 normal size.

15 Q So five to ten seconds for Julie, get the stool and
16 get in a position for suprapubic. After that, did you try
17 traction to see if that was enough?

18 A So sort of while Julie was getting her stool and
19 getting in position, I was cutting the third degree
20 episiotomy.

21 Q Before you even tried to see if McRoberts and
22 suprapubic and gentle traction would deliver?

23 A No, I was worried about the size of this baby.

24 Q But --

25 A It takes a split second to do an episiotomy.

1 Q My question is simply this, did you do the episiotomy
2 before you did traction to see if McRoberts and suprapubic
3 were enough to solve the problem?

4 A Yes -- well, simultaneously. I didn't wait to do
5 that and then do the episiotomy. You know, when you're
6 doing a shoulder dystocia, again, you have your protocol
7 and routine. And my protocol and routine is to do those
8 three things first and then you're going to try gentle
9 traction again.

10 Q So it took how long to do the episiotomy?

11 A A split second.

12 Q After you did that, is the next thing you did put
13 your hands on the baby's head and apply traction?

14 A So once I've done those three maneuvers, I'm going to
15 try again to see if the baby -- if. You know, sort of put
16 the baby in full McRoberts and/or cut an episiotomy and
17 suprapubic is going to allow the baby to deliver. So
18 gentle downward traction then.

19 Q That takes how much time?

20 A Two to three seconds.

21 Q You told us that didn't work, so you tried -- I
22 believe you said you went in on the right side of the
23 baby's head and tried to do a posterior arm delivery that
24 way, but failed to accomplish that?

25 A The posterior arm delivery is the difficult -- can be

1 difficult. There's sort of three components to try to do
2 the posterior arm delivery. The first is you -- you know,
3 in this case, I reached with my right hand --

4 Q Just tell us how long did that take?

5 A Oh, I'd say close -- maybe somewhere around 30
6 seconds.

7 Q And then that didn't work, then you went to the left
8 side of the baby's head to put your hand --

9 A Not the head. I went behind on the back on the left
10 side of the left shoulder.

11 Q Again, attempting to see if you could manage a
12 posterior arm delivery?

13 A I thought we already finished the posterior arm
14 delivery. I thought we were talking about the rotational
15 maneuver.

16 Q I was asking about the three different parts --

17 A Oh, okay, I'm sorry. I'm sorry.

18 Q The first part was 30 seconds?

19 A No, no, no, no, the sum total for the attempted
20 posterior arm is approximately 30 seconds. Do you want me
21 to break it down?

22 Q No, that's okay.

23 A Okay.

24 Q So next you attempted what you wrote in your notes as
25 a woodscrew maneuver, 180 degrees?

1 A Yes, sir.

2 Q How long did that take?

3 A I think that's listed in the note that that took
4 between five to ten seconds.

5 Q And then the next thing you did was -- you already
6 had McRoberts and suprapubic, they were in place the whole
7 time?

8 A Yes.

9 Q So when you were attempting the what you were calling
10 a woodscrew maneuver, the suprapubic pressure was pushing
11 down?

12 A Yes, it was.

13 Q And have you read Nurse Bibb's deposition?

14 A No, no, I haven't.

15 Q Well, would it surprise you to know that just a foot
16 or so in front of you, she was pushing down on the bone --
17 I mean, down on the shoulder instead of trying to push it
18 around the bone?

19 A There's no -- that's not the way it's listed or
20 written or taught to do, suprapubic.

21 Q You're saying what I described is not the right way
22 to do it?

23 A So what I'm saying is, typically, in an emergency,
24 the nurse is going to push straight down. Julie was on
25 the patient's left-hand side, so she was going to be

1 pushing -- because this was LOP, she was going to be
2 pushing on that right shoulder a little bit because that's
3 where she's pushing, but she's pushing -- she's just
4 trying to push straight down.

5 Q And that's what you told her to do, right?

6 A Yes.

7 Q So as she is pushing down, was it like this, like
8 this? Was she using one hand or two hands?

9 A Typically, it's two hands with the elbows locked.

10 Q Do you remember what she did?

11 A That's the way that we train the nurses to do it, but
12 do I have visible memory of that, no.

13 Q Well, you said earlier, you were telling us how good
14 your memory is, is there anything you don't really have a
15 memory of?

16 A No, we're good.

17 Q (Inaudible)?

18 A Yes, sir.

19 Q So you had her -- if she did what you wanted her to
20 do and you have no reason to doubt it, she would have been
21 pushing down on the shoulder bone -- the shoulder. At
22 that point, it would have been -- well, initially,
23 according to your testimony, it would have been the right
24 shoulder she was pushing down on, then the left shoulder
25 she was pushing down on, but she was doing that while you

1 were trying to rotate the shoulders, right?

2 A So she's on the patient's left-hand side. So she's
3 trying to push down just in the midline. So --

4 Q Sure.

5 A Oh, I didn't know if you had something you wanted to
6 say.

7 Q Well, there's the pubic bone and the shoulder, right?

8 A I don't know your reference there.

9 Q Well --

10 A They're not in that position. The pubic bone is
11 here, the shoulder is here.

12 Q Whatever the orientation may be, she's pushing down
13 on the shoulder toward the floor?

14 A Well, not like that, though. People don't do that.
15 They get on and it's just sort of a constant pressure.
16 It's not something like this, they're not pumping
17 something.

18 Q I wasn't pumping, just (inaudible). So she's -- you
19 had her bending over and doing this?

20 A She is bending over the patient, yes.

21 Q So how much of her body was over the mother's body?

22 A Maybe -- you want to guess at that?

23 Q I don't want to guess.

24 A You want me to guess?

25 Q No, I want you to tell me. You told me you had a

1 perfect memory except for one thing.

2 MR. DAVIS: Your Honor --

3 THE WITNESS: That's somewhat of a guess to try to
4 estimate --

5 MR. DAVIS: Hold on a second.

6 THE WITNESS: Oh, I'm sorry.

7 MR. DAVIS: That's me objecting. Your Honor, with
8 all due respect, I object to the argumentative nature of
9 this particular line of questions.

10 MR. GRAHAM: It's cross-examination.

11 THE COURT: I'm going to allow it for the moment. Go
12 ahead.

13 MR. GRAHAM: Thank you, Your Honor.

14 BY MR. GRAHAM:

15 Q So there is pushing down on the shoulders, straight
16 down toward the floor and you're trying to rotate the
17 shoulders while she is pushing on them straight down
18 toward the floor. Do you believe that that effort on her
19 part helped you, hurt you or had no effect?

20 A Oh, it helped. You know, it's hard -- she's on the
21 patient's left-hand side and she's trying to be, more or
22 less, midline, but she's most likely not going to be
23 reaching to the midline. She's going to be somewhat
24 differentially on the patient's left side. So she's
25 pushing down on that right shoulder while I'm trying to

1 lift the left shoulder. That's all good. And the 45
2 seconds that it took in total and, in particular, the five
3 to ten seconds that it took to do the rotation, certainly,
4 she wasn't interfering with my delivery.

5 Q You say it took ten seconds for you to do what you're
6 calling a Woods?

7 A Yes. I think in the chart it says five to ten
8 seconds, yes.

9 Q Well, does your memory tell you it was five or ten?

10 A My memory says that it's listed in the chart five to
11 ten seconds.

12 Q Then after that, how long did it take you to apply
13 more -- to put your hands on the baby's head, apply more
14 traction to bring the baby down?

15 A So at that point, the left shoulder is down and below
16 pubic symphysis and there's almost no traction I have to
17 apply. I mean, Angela could have pushed the baby out
18 without me there. She could have sneezed the baby out.
19 At that point, there's minimal gentle downward traction
20 and that takes another second or so. That doesn't take
21 any time at all, one to two seconds.

22 Q All right, we were talking about what you call Woods.
23 You've learned since then, of course, that that was
24 actually a Rubin's you were doing, except for the
25 180-degree part?

1 A No. In my -- you know, in my residency, we looked at
2 the Woods maneuver, named after Dr. Woods, the Rubin
3 maneuver, and we put them into one category and called the
4 whole thing a woodscrew maneuver. So I was saying
5 woodscrew. You know, if you look at some of the
6 textbooks, they'll say a Rubin maneuver is when you put
7 the hand behind, and that's what I was doing in this case.
8 But the way I learned and the way I was trained is that
9 you put both of them in the same category and it's called
10 a woodscrew maneuver.

11 Q You put them both in the same category. But one of
12 them calls for 180-degree rotation, correct?

13 A No, both of them do.

14 Q Your testimony today under oath is that a Rubin
15 requires a 180-degree rotation?

16 A My testimony today under oath is that any woodscrew
17 maneuver can utilize a 180-degree turn, yes.

18 Q The question is about Rubin's, Doctor?

19 A Well, my answer is about a woodscrew because in my
20 mind, they're synonymous.

21 Q Have you learned how to do a Rubin?

22 A I did one on Alexia.

23 Q Have you learned how to do a woodscrew?

24 A I do, but I like the Rubin better.

25 Q You prefer Rubin over Woods, but you use a 180-degree

1 turn?

2 A Yes, which is well documented in literature and even
3 on some instructional videos.

4 Q Now, you've sat and listened to a bunch of testimony
5 about pushing, encouragement to push. Your notes say that
6 mom was not pushing effectively and the nurses were
7 encouraging the mom to push. Were you also encouraging
8 mom?

9 A Oh, absolutely.

10 Q Did you continue encouraging the mother to push until
11 you finally got the whole baby out?

12 A Typically, while you're doing the woodscrew maneuver,
13 you won't have the mom push at that time.

14 Q Well, in that 45 seconds you talked about -- I'm
15 going to call out each maneuver. You tell me whether you
16 had her push, okay? When you called for suprapubic and
17 McRoberts, did you ask mom to push?

18 A She was not pushing at that time.

19 Q When McRoberts was performed, did you call for her to
20 push?

21 A When McRoberts and suprapubic and the episiotomy were
22 cut and I applied gentle downward traction at that point,
23 yes, we asked her to push at that point.

24 Q But not before?

25 A No, not until we got those three maneuvers

1 accomplished.

2 Q All right. What did you do after McRoberts,
3 suprapubic, the next thing was downward traction?

4 A No, the episiotomy was sort of concurrently, but you
5 asked me to put a time on that.

6 Q So episiotomy and then you applied traction for two
7 or three seconds, you said?

8 A Probably two to three seconds. You know, it's not
9 long. It's gentle downward traction, one one thousand,
10 two one thousand, maybe two seconds.

11 Q Did you and the nurses continue encouraging the
12 mother to push at that time?

13 A Yes. We're trying to utilize maternal effort as
14 well.

15 Q Then you did your -- the three versions of the
16 posterior arm delivery method?

17 A Yes, sir.

18 Q Did you encourage the mom to push during those?

19 A No.

20 Q No?

21 A No.

22 Q You had her stop?

23 A Yes.

24 Q That was -- you had her stop during the posterior
25 arm?

1 A Yes.

2 Q What about the McRoberts -- what about what you're
3 calling Woods, did you have her push or stop?

4 A No, we stopped at that point as well.

5 Q You stopped. Then when you applied more traction,
6 did you encourage her to push more?

7 A So once the woodscrew was successful and the left
8 shoulder was under the pubic symphysis, I applied almost
9 no traction, but she pushed at that point. We asked her
10 to push and the baby came out easily.

11 Q You're aware, of course -- well, let me ask you. In
12 your training, did you learn that during a shoulder
13 dystocia situation, it is improper to encourage the mom to
14 push?

15 A Not until you relieve the shoulder dystocia.

16 Q Until when?

17 A You've relieved the shoulder dystocia. It's not
18 improper, it just makes the maneuvers harder.

19 Q Sure. It makes a stuck shoulder stuck much harder
20 and harder to -- harder to manipulate it and get it
21 unstuck, right?

22 A I don't think you would say stuck, the shoulder is
23 pinched behind the pubic symphysis and if somebody is
24 applying force to keep it there, it does make it harder.

25 Q So --

1 A But I don't think it's stuck much more.

2 Q Maybe stuck is a bad word. What did you say hinged
3 or pinched?

4 A Just pinched behind that.

5 Q Okay. So the shoulder is pinched behind the pubic
6 bone. As long as it's pinched, your training was not to
7 let the mom push, correct?

8 A My training is to go straight to my maneuvers.
9 Again, once I did the first three maneuvers, McRoberts,
10 suprapubic and the episiotomy, we do then ask the patient
11 to push at that time just to see with gentle downward
12 traction and what you describe as axial force along the --
13 that the mother is generating to see if it slips
14 underneath. At that point, she'll try and then once it
15 still doesn't happen, then you move on to your next set of
16 maneuvers. Then once that freed up the right shoulder,
17 which was anterior, and the left shoulder, which is now
18 anterior, below the pubic symphysis, then you can have her
19 push for sure.

20 Q So sure, you get a test gentle traction and tell the
21 mom not to push while you're doing that, but then, if the
22 test shows you that she does, in fact, have shoulder
23 dystocia, from that point forward, you should have her
24 stop pushing unless you're doing another test traction,
25 right?

1 A She did not push during the attempted posterior
2 shoulder delivery or the rotational maneuver.

3 Q I'm asking, sir, what your training was. Is that
4 your training?

5 A Yes, sir, that's my training.

6 Q To stop --

7 A Yes, sir, that's my training.

8 Q -- pushing?

9 A Yes, sir.

10 Q I want to switch to asking about an emergency. You
11 said something earlier about an emergency situation. And
12 I just want to ask you if you see any difference between
13 --

14 A Sorry, Mr. Graham.

15 Q No worries. Let me know when you're ready.

16 A All right.

17 Q Is a stroke an emergency?

18 A An actively progressing stroke, one that's currently
19 occurring, absolutely, in an emergency room, yes. Is a
20 preexisting stroke an emergency, no.

21 Q Well, wherever it is, is a stroke an emergency?

22 A Well, you have to qualify that.

23 Q Can you give me an example of a stroke that isn't an
24 emergency?

25 A Yeah, I have the cutest little lady who comes in

1 every three months for a pessary and she's had a stroke.
2 She has difficulty moving. She has difficulties with her
3 memory. That's not an acute stroke.

4 Q The question, sir, was can you give me an example of
5 a stroke that you do consider to be an emergency?

6 A Oh, okay, I'm sorry. Yeah, I think that -- I'll give
7 you a good example. This goes back to one of my partners.
8 His wife called me early one morning to say that he was
9 speaking in garbled language. She couldn't understand
10 why. And I told her, you take him to the emergency room
11 right now.

12 Q Does he live far away from you?

13 A No.

14 Q Why didn't you go over there and take care of it
15 yourself?

16 A I don't take care of strokes. And, actually, nobody
17 can take care of a stroke at somebody's house.

18 Q Not even if it's your partner or colleague?

19 A He was my partner and I knew the safest place for him
20 was be in the emergency room. He got air lifted to MUSC.

21 Q You believe that an emergency stroke is different
22 level of emergency for a neurologist than for an
23 obstetrician?

24 A I think it's an emergency whether you're a
25 neurologist or an obstetrician.

1 Q Even if you're trained (inaudible)?

2 A Absolutely.

3 Q And if you've got a woman that goes in the emergency
4 room or is in the hospital parking lot with a
5 traumatically amputated leg, is that an emergency?

6 A So you're saying a woman who's in the hospital
7 parking lot --

8 Q Parking lot?

9 A Pardon me?

10 Q In the hospital parking lot --

11 A In the hospital parking lot and she --

12 Q -- with a traumatically amputated leg, freshly
13 amputated?

14 A Yes, I would consider that an emergency.

15 Q And do you believe that emergency would be better
16 handled by an obstetrician or by an orthopedic surgeon or
17 emergency room physician?

18 A That would probably be a vascular surgeon.

19 Q Or a vascular surgeon. And do you believe it would
20 be the same level of emergency for all of the above?

21 A Absolutely.

22 Q Whether they're trained in how to handle it?

23 A An emergency is an emergency, regardless of your
24 training.

25 Q I know you're going to tell us that all you used was

1 gentle downward traction, but -- and I know you didn't
2 intend to harm this girl, but did you use the amount of
3 traction you intended to use?

4 A So to answer that question, I did not harm this girl.

5 Q The question was, did you use the amount of traction
6 that you intended to use?

7 A I used gentle downward traction, which I've used --
8 well, over 9,000 deliveries multiple times successfully.
9 So if that's did I intend to use that traction, yes,
10 gentle downward traction, I intended to use gentle
11 downward traction.

12 Q So that sounded like a yes, you intended to use the
13 amount of traction that you used?

14 A I used gentle downward traction, which was the
15 intended traction I wanted to use.

16 Q There was nothing accidental about how much traction
17 you used?

18 A No, no.

19 Q Nothing accidental about how much you bent the neck?

20 A I didn't bend the neck, so.

21 Q It was your choice? I mean, it was not a matter of
22 discussion with the patient about how much traction should
23 I use for 45 seconds? It was your choice, you made it?

24 A That's a strange question. We never ask the patient
25 how much traction we can or can't use.

1 Q You're the one in charge? You're the one, nobody
2 else? No nurse, no healthcare provider, no tech, no
3 patient. You're the one that makes the choice about how
4 much traction and bending to use?

5 A I'm the one that used gentle downward traction, yes,
6 sir.

7 Q I know that you say you didn't do this, but if an
8 obstetrician in the same or similar circumstances used
9 more than gentle traction in the same situation that you
10 found yourself in with respect to Angela and Alexia, would
11 they have violated the standard of care?

12 A At which stage are you talking about?

13 Q 45 seconds.

14 A After 45 seconds, you literally can't use more than
15 gentle downward traction. The shoulder is beneath the
16 pubic symphysis.

17 Q So if another obstetrician, in fact, used more than
18 gentle traction and bending of the neck, he would be in
19 violation of the standard of care?

20 A After the 45 seconds?

21 Q Within the 45 seconds?

22 A While you --

23 Q At or around the 45 seconds?

24 A So after the 45 seconds, that head is released, you
25 physically can't -- I mean, you know, gentle downward

1 traction is going to cause the baby to come out. If
2 Angela pushes hard, the baby is gonna actually probably
3 fly out. You can't use more than that, the baby would be
4 out. There's no resistance to the shoulder. There's
5 nothing holding the baby in at that point.

6 Q In light of your position on that, let me back up.
7 At 35 or 40 seconds, if the obstetrician in question used
8 more than gentle traction and bent the baby's neck, that
9 would be a violation of the generally accepted standards
10 of care, right?

11 A In the middle of the woodscrew maneuver? Because I
12 would have been in the middle of the woodscrew maneuver at
13 that time and your hands are on the shoulder, so you just
14 -- you really can't.

15 Q At the time -- let me rephrase, all right. Assume
16 that we've got an obstetrician who is managing a shoulder
17 dystocia. He goes through the same maneuvers that you say
18 you did, but that at the end of what you're calling a
19 woodscrew, the left shoulder, now anterior, is stuck
20 behind the mother's pubic bone. If at that time, the
21 obstetrician uses more than gentle traction and bends the
22 neck, that violates the standard of care, right?

23 A I honestly can't agree with that statement.

24 Q What's wrong?

25 A Because you said with the maneuvers I used and that

1 shoulder would not be stuck with the woodscrew maneuver.

2 Q I was talking about -- I knew you were going to say
3 that, so that's why I prefaced it by saying not you, but
4 if it was another obstetrician in the same circumstances
5 as you and my client? And if you went through the
6 maneuvers you say you went through, but the left shoulder
7 is now anterior, stuck behind the pubic bone, for an
8 obstetrician, any obstetrician in that circumstance to use
9 more than gentle traction or to bend the neck would
10 violate the standard of care, correct?

11 A No.

12 Q Why not?

13 A Well, again, you said using those maneuvers. You
14 know, it's well reported that when you do a woodscrew
15 maneuver, there's two movements, but it is a screw
16 maneuver. So, again, we talked about this before. It's
17 like the cross threads of a nut through a bolt and it's
18 down below the pubic bone. So if you use those maneuvers,
19 whether it's me or another OBGYN, you really cannot use
20 more than gentle downward traction at that point.

21 Q I agree with you if woodscrew is done correctly, but
22 I'm assuming a situation where woodscrew is not done
23 correctly and, in fact, Rubin's is used as though it's
24 Woods and turned 180 degrees like a steering wheel instead
25 of a screw and the left shoulder now anterior can't come

1 down with gentle traction. In that situation, do you
2 believe it would violate the standard of care for the
3 doctor to use more than gentle traction and to bend the
4 neck?

5 A There's no such thing as a steering wheel maneuver.

6 Q I know if you do the maneuver correctly, there's not?

7 A Correct or incorrect, the maneuver itself corrects
8 the problem. You're asking me something that can't
9 happen. I can't answer a question when you're asking me
10 something that can't happen.

11 Q If a baby's top shoulder is the right shoulder and
12 it's stuck behind the mom's pubic bone and the doctor
13 turns the baby 180 degrees without screwing the baby out,
14 that's a steering wheel direction, true?

15 A There's no such thing.

16 Q There's such a thing as a steering wheel, obviously.
17 If that were to happen and if the left shoulder then got
18 stuck behind the pubic bone and the doctor applied more
19 than gentle traction and bent the neck, that would violate
20 the standards of care, true?

21 A There's no such thing. There's no such thing as a --
22 I can't -- you're asking me to answer a hypothetical
23 that's just blatantly wrong.

24 Q Whatever. Let me rephrase to see if I can get you to
25 answer. If we've got -- let's just forget about all the

1 preliminary stuff. If you've got a baby whose left
2 shoulder is the top shoulder stuck behind the mother's
3 pubic bone and gentle traction won't deliver that baby, if
4 the doctor uses more than gentle traction and bends the
5 neck, that violates the standard of care, right?

6 A So you're changing the parameters and suggesting that
7 we have a basic left shoulder dystocia behind the pubic
8 symphysis; is that correct?

9 Q Left shoulder behind the --

10 A Yes. There's no right shoulder that was stuck. No
11 maneuvers done. We just have a basic left shoulder
12 dystocia; is that correct?

13 Q I just ask you a simple question, Doctor. I left out
14 all the other stuff. If you've got a left shoulder stuck
15 behind the pubic bone, gentle traction won't release the
16 shoulder, if the doctor pulls harder and bends the neck,
17 that violates the standard of care, correct?

18 A I've never seen a doctor do that.

19 Q Can you imagine a doctor ever breaking the standards
20 of care?

21 A Yes.

22 Q But you can't imagine a doctor breaking the standards
23 of care in that fashion?

24 A Honestly, I can't.

25 Q It would just never happen?

1 A We're all trained the same way, the people that I
2 know, that's how we're trained.

3 Q Do you believe that all doctors follow their training
4 a hundred percent of the time?

5 A I think that all doctors try to, yes.

6 Q Doctor, do you remember when we took your deposition
7 back on February 22nd, 2011?

8 A I remember the date, yes.

9 Q Your lawyer was there?

10 A Pardon me?

11 Q Your lawyer was there with you?

12 A Yes.

13 Q And you were sworn to tell the truth?

14 A Yes.

15 Q Do you have a copy of your deposition?

16 A I do, yes.

17 Q I'm going to ask you, sir, if you could kindly watch
18 the video that we're getting ready to play starting at
19 102?

20 A Do you know what page that is.

21 Q Yes. Page 102, Lines 2 through 23 and Lines --
22 excuse me, Page 103, Lines 4 to 25 and Page 104, Lines 1
23 through 12. Please watch the video and tell me if this
24 was your --

25 MR. DAVIS: Your Honor --

1 THE COURT: Hold on, there's an objection. Hold on.

2 MR. DAVIS: I'm slow. I need to write all those
3 references down. Mr. Graham, would you give those to me
4 again, please, sir?

5 MR. GRAHAM: Of course.

6 MR. DAVIS: Thank you.

7 MR. GRAHAM: Page 102, Lines 2 through 23. Page 103,
8 Lines 11 to 25. Page 104, Lines 1 through 12.

9 MR. DAVIS: Thank you.

10 BY MR. GRAHAM:

11 Q Please follow along, Doctor, as we play the video and
12 tell me -- I'll ask you a question.

13 (WHEREUPON, video deposition was played for the
14 jury.)

15 THE WITNESS: Can you tell me the next line that
16 we're going to? I didn't get all three of the places I
17 need to look at.

18 THE COURT: Can you tell him the next reference?

19 THE WITNESS: That was Page 102, what are the other
20 two pages?

21 MR. GRAHAM: May I approach, Your Honor?

22 THE COURT: Yes, sir.

23 MR. GRAHAM: Would you like a copy, too, Mr. Davis?

24 MR. DAVIS: No, sir, I'm fine. Thank you. You've
25 already given them to me.

1 (WHEREUPON, video deposition continued to be played.)

2 BY MR. GRAHAM:

3 Q Doctor, let me get you to please turn to that page.

4 We're having a technical difficulty there. 104.

5 A 104?

6 Q Page 104, Lines 11 through 12.

7 A Yes.

8 Q Oh, I'm sorry, 104, 1 to 12. I believe the last two
9 clips were played together, so I'm going to move on.

10 We're heard you say over and over that this is an
11 emergency and all of that. Do you claim that you did
12 anything differently because of this emergency?

13 A Did anything differently from what?

14 Q From what you say you normally do?

15 A Did I change my protocol or maneuvers?

16 Q Because you were so concerned about the emergency
17 that you did some effort beyond your ordinary routine,
18 which you say involves gentle traction and no neck
19 bending?

20 A No, I did not do anything more than the routine, the
21 protocol we've discussed using gentle downward traction.

22 Q So you've been saying over and over about the
23 emergency, but the emergency didn't cause you to do
24 anything different?

25 A No. No.

1 Q Let me ask you, you mentioned your daughter earlier.
2 And I wish her no ill, certainly, but can you imagine that
3 if your daughter suffered the same type of permanent
4 brachial plexus nerve damage with her left arm and
5 including multiple nerve root evulsions, how would you
6 feel about that?

7 A Knowing the facts of the case, I would be --

8 Q I'm not asking about a case, sir, I'm asking about
9 your daughter. Under whatever circumstances, how horrible
10 the result is, under whatever circumstances, if you can
11 imagine her being in that situation, how would that make
12 you feel?

13 A I have had a daughter not with brachial plexus
14 injury, but in a life-threatening situation and it hurts.

15 Q Sure. And do you believe it would hurt worse if the
16 cause of the injury was professional wrongdoing?

17 A No, it hurts. It just hurts because you don't want
18 to see your loved one hurt.

19 Q You were here when we played the video deposition of
20 the lifecare planner, Darlene Carruthers?

21 A Yes.

22 Q You heard her go through the various recommendations
23 for surgeries and therapies and assistance with household
24 chores, et cetera. Do you believe that Alexia does not
25 need any of those?

1 A Oh, no, not at all.

2 Q You believe she needs every item on the lifecare
3 plan?

4 A No, I'm not -- I didn't get a chance to review the
5 lifecare plan. I'm not here to judge the lifecare plan,
6 but I'm sure she needs help.

7 Q There were three surgeries mentioned. Do you contend
8 that she doesn't need any of those surgeries?

9 A Oh, no, absolutely not.

10 MR. DAVIS: Your Honor, I'm going to -- it's already
11 been asked and answered, but I'm going to object to this
12 line of questioning. He's never been offered as an expert
13 on damages, future prognostic care or surgery, lifecare
14 plan. He's not an expert in that. He's never been asked
15 that.

16 MR. GRAHAM: He's a human being --

17 THE COURT: Hold on. I'm going to overrule the
18 objection.

19 BY MR. GRAHAM:

20 Q You understand, Doctor, I'm not asking you for a
21 professional opinion about anything. I'm asking you as a
22 human being, as a father, as you listen to the
23 recommendations for the three surgeries and the therapies
24 and the other major items on the plan, you would not deny
25 Alexia any of those, would you?

1 A I'm not in a position to deny or not.

2 Q Let me rephrase it. Would you contend that any of
3 those are not medically necessary?

4 A I would think that they're medically necessary.

5 Q You've told us that shoulder dystocia is not
6 foreseeable, not preventable, et cetera, et cetera. Do
7 you believe it could happen randomly to just about any
8 mother and any baby?

9 A Absolutely. You know, shoulder dystocia, by
10 definition, is unforeseeable, unpredictable, unpreventable
11 and often injuries are unavoidable. Over 50 percent of
12 shoulder dystocias -- excuse me, 50 percent of brachial
13 plexus injuries happen in non-shoulder dystocia cases.

14 Q Remember my question, sir?

15 A I think I did, yes.

16 Q So their random, they can occur to people of any age,
17 any size, any national origin, any race, any -- anybody?

18 A Most shoulder dystocias happen without any ability to
19 predict them. In fact, most shoulder dystocias happen in
20 normal-size babies, in mothers who are not diabetic. So
21 they are unpredictable.

22 Q Do you believe doctors should be put on a pedestal or
23 be accountable for negligence just like the rest of us?

24 A Oh, I think doctors should not be put on a pedestal.

25 Q If a doctor doesn't take time to do his job right,

1 what kind of bad things could happen?

2 A Well, in this case, I certainly took my time to do my
3 job correctly, having visited her six times during that 12
4 hours that she was in the hospital during her labor,
5 spending over an hour and a half with her once the first
6 bradycardia happened. But you're saying if a doctor
7 didn't spend the proper time?

8 Q Yes, sir. I'm not asking about you. If any doctor
9 did not take the time to do the job right, what sort of
10 bad things could happen?

11 A Boy, that's a wide open hypothetical.

12 Q Any number of bad things could happen, right?

13 A Bad things can happen. Just as if anybody doesn't do
14 their job, bad things can happen. A truck driver doesn't
15 drive properly, he drives under the influence, bad things
16 can happen.

17 Q Breaking a safety rule foreseeable may cause harm,
18 fair?

19 A Okay.

20 Q Earlier today, you told us that microsomia is
21 something that can't be diagnosed until after a baby is
22 born?

23 A No, I didn't.

24 Q You didn't say that?

25 A No, sir. Now, what I would say, if you want a

1 definition of macrosomia, or the way that ACOG,
2 particularly when it comes to shoulder dystocia and trying
3 to prevent shoulder dystocia, which they say is
4 unpreventable, the definition of macrosomia is a baby that
5 weighs over 5,000 grams, which is roughly 11 pounds in a
6 nondiabetic. In a diabetic, they use the number 4500
7 grams. Now, I want to say that Alexia's ultrasound when
8 she -- the last ultrasound, she was 8-15, that is about
9 4,054 grams. And her final weight was about 4,250 grams.
10 So neither -- her final weight didn't reach the definition
11 by ACOG's standard saying she was macrosomic to the extent
12 that she warranted, at least, a discussion with a primary
13 C-section.

14 Q But you did diagnose macrosomia before you started
15 with any hands-on care, correct?

16 A There was a concern. There was a concern that the
17 baby was getting larger. And that was based on the
18 ultrasound that was done -- you know, I had ordered one
19 ultrasound at 36 weeks because her fundal height was 40.
20 And I think at that time, she was seven pounds, seven
21 ounces, which is 93rd percentile. I recommended to get
22 another ultrasound, not necessarily because of the baby's
23 weight, but because of the polyhydramnios. Then Alexia
24 weighed 8-15 at that time. I did not set her up for the
25 induction. My partner, Joe Robinson, set her up for the

1 induction. The assumption was -- and he didn't list, you
2 know, the reason was he was worried about the baby getting
3 large.

4 Q Earlier, you told us that you do an episiotomy to
5 give more room for the baby to come out?

6 A More room for the baby to come out and more room for
7 you to get in. Just more room.

8 Q Please turn to Page 106 --

9 A Yes, sir.

10 Q -- of your deposition. And follow along with the
11 video.

12 MR. DAVIS: What line, please?

13 MR. GRAHAM: 19 through 25.

14 MR. DAVIS: Thank you.

15 (WHEREUPON, video deposition was played for the
16 jury.)

17 BY MR. GRAHAM:

18 Q You gave some testimony --

19 MR. DAVIS: Excuse me just a minute. He played a
20 part of his deposition. Is there a question?

21 THE WITNESS: Can I make a comment on that?

22 THE COURT: What was the question?

23 BY MR. GRAHAM:

24 Q You gave your testimony about --

25 A We talked about this --

1 THE COURT: Hold on. Don't talk over the attorney,
2 please. Go ahead. Yes, sir, Mr. Graham.

3 MR. GRAHAM: (Inaudible.)

4 THE COURT: Let's just move on. Counsel, let me see
5 y'all at the bench for a moment.

6 (WHEREUPON, a bench conference was held in the
7 presence of the jury, but outside the hearing of the
8 jury.)

9 THE COURT: Ladies and gentlemen, the issue I'm
10 discussing with the attorneys is when we should break for
11 the evening. It is almost five o'clock, which is
12 typically when I break. However, we could continue. I
13 know that y'all would probably rather get the case over
14 sooner in the week than later. How many people would like
15 to stay later than 5:00 today that can continue until this
16 witness is finished testifying? Raise your hand if you'd
17 like to stay later than 5:00 today. You've got to raise
18 your hand a little bit higher. Raise your hand if for
19 child care issues or some other issue you cannot stay past
20 five o'clock? Okay. Thank you. Counsel, if y'all would
21 approach one more time.

22 (WHEREUPON, a bench conference was held in the
23 presence of the jury, but outside the hearing of the
24 jury.)

25 THE COURT: All right, ladies and gentlemen, that

1 brings us to the end of the testimony for today. So,
2 again, please remember the instructions I've given you.
3 Please don't do any outside research or discuss the case
4 with anyone else or otherwise. I'll see you back at 9:30
5 tomorrow morning.

6 (WHEREUPON, the jury exits the courtroom at
7 approximately 4:55 p.m.)

8 THE COURT: Counsel, let's go ahead and knock out the
9 argument on the amendment issue. But before we get to
10 that, is there anything else we need to take up, Mr.
11 Graham?

12 MR. GRAHAM: No, Your Honor.

13 THE COURT: Mr. Davis, anything else we need to take
14 up?

15 MR. DAVIS: Not that I can think of at the moment,
16 Your Honor.

17 THE COURT: Mr. Davis, if you want to start. It's
18 your motion to amend your answer.

19 MR. DAVIS: Thank you, Your Honor. Your Honor, I
20 make a motion to amend my pleadings and answer pursuant to
21 Rule 15, subparagraph B, amendments to conform to the
22 evidence when issues not raised by the pleadings are tried
23 by expressed or implied consent of the parties, they shall
24 be treated in all respects as if they had been raised in
25 the pleadings. Such amendment of the pleadings as may be

1 necessary to cause them to conform to the evidence and to
2 raise these issues may be made upon motion of any party at
3 any time even after judgment. But failure to so amend
4 does not affect the result of the trial of those issues.
5 If evidence is objected to at the trial on the ground that
6 it is not within the issues made by the pleadings, the
7 Court may allow the pleadings to be amended and shall do
8 so freely when the presentation of the merits of the
9 action will be subserved thereby and the objecting party
10 fails to satisfy the Court that the admission of such
11 evidence would prejudice him in maintaining his action or
12 defense on the merits. Your Honor, the issue of the
13 emergency statute has been discussed with Judge Hall in
14 chambers at length years ago with Mr. Graham and myself.
15 There's no possible prejudice to Mr. Graham or the
16 prosecution of his case or the evidence that has been
17 established so far that this was an obstetrical emergency.
18 That the child was in immediate harm of serious bodily
19 injury or death and was unstable because of the shoulder
20 dystocia is not a secret to Mr. Graham. It does not
21 prejudice him if the Court omits that amendment. And I
22 think it should be liberally granted within the spirit of
23 Rule 15. Again, there is no prejudice whatsoever and no
24 surprise. That's the only thing I can argue at this
25 point, Your Honor. Thank you.

1 THE COURT: Thank you. Mr. Graham.

2 MR. GRAHAM: Yes, sir. Your Honor, under Rule 15 and
3 under various case law, I believe the Byrd case is pretty
4 much right on point. I don't know how you could get more
5 closely on point. But it's an affirmative defense and it
6 wasn't pled. And under Rule 15 and the rules cited
7 therein, it's been waived. We've been prejudiced in terms
8 of -- we started this case a long time ago, before any one
9 of my cases had ever raised this affirmative defense. As
10 we started this case -- if I had known that this defense
11 would have been raised, all of the party depositions, the
12 nurse depositions, virtually, all of the depositions
13 before, say, 2013 or '14, I would not have even known the
14 defense bar was going to raise those as a defense in any
15 case, so we would have handled the case differently. You
16 know, we started off with the hospital as Defendants. We
17 made a tactical decision there. We had made some other
18 decisions about which experts to hire, what we would have
19 them address. There would just be so many different
20 avenues that we would have pursued earlier if we had known
21 that this would be raised.

22 THE COURT: Mr. Davis.

23 MR. DAVIS: He knew it was going to be raised, at
24 least, three or four years ago.

25 THE COURT: So one of the factors in the Rule 15 is

1 surprise, but the other one is prejudice. The definition
2 of prejudice, I'm looking at the Patton V. Miller case,
3 which is a 2017 case from the Supreme Court, and that case
4 says, a prejudice puts the nonmoving party at a
5 disadvantage which they would not have faced if the -- I'm
6 sorry, I totally lost my train of thought. Rule 15
7 prejudice is a result flowing from the amendment that puts
8 the nonmoving party at a disadvantage, which they would
9 not have faced had the amended claim been included in the
10 original pleading. In the Court's opinion, that is the
11 case here. I mean, this is a maximally prejudicial
12 amendment because it's changing what the Plaintiffs have
13 to prove. It's shifting from ordinary negligence to gross
14 negligence, which would mean the Plaintiffs would have to
15 redo their -- the experts would have to opine all of them
16 on the issue of gross negligence. The Plaintiffs -- I
17 mean, the Plaintiffs might have even made a different
18 decision about the resources they put into the case. They
19 would have to redo their entire case. So for that reason,
20 I find that allowing an amendment at this point would be
21 severely prejudicial to the Plaintiff and I'm going to
22 deny the request.

23 MR. DAVIS: Thank you, Your Honor.

24 THE COURT: Anything else we need to take up before
25 we break for the day?

1 MR. GRAHAM: No, sir.

2 THE COURT: Mr. Davis?

3 MR. DAVIS: I can't think of a thing right now, Your
4 Honor.

5 THE COURT: Let's, to the extent we can, try to move
6 through Dr. Miller's cross quickly tomorrow morning.
7 Counsel, I appreciate it. See you tomorrow morning at
8 9:30.

9 JANUARY 12, 2022

10 THE COURT: (Audio begins) Juror 254, who says he is
11 sick. The good news is he says his only symptom is
12 vomiting. He thinks he has food poisoning. He has no
13 COVID symptoms at all. So that's the good news. I
14 believe -- yeah, he is an alternate. I don't think that
15 affects anything. He is one of our four alternates. That
16 Mr. Smathers, Juror 254. You can just tell him he's
17 excused. Thank you. Can you e-mail him? If you'll ask
18 her to call him or e-mail and tell him he's excused and
19 thank him for letting us know. Yes, sir.

20 MR. GRAHAM: Yes, sir, Your Honor. We are hoping to
21 get photographs of the child at different ages introduced.
22 Also, Your Honor, we have the original deposition of Mr.
23 Miller. I'm not sure if we've been marking these as
24 Court's Exhibits or what.

25 THE COURT: You can mark it as a Court Exhibit. Mr.

1 Davis, do you want to take a look at the photos?

2 MR. DAVIS: Yes, sir. Thank you.

3 (Pause.)

4 MR. DAVIS: I don't have any objection.

5 THE COURT: Plaintiff's 31?

6 MR. GRAHAM: Is a baby picture of Alexia.

7 THE COURT: Plaintiff's 31 -- how many photos are
8 there?

9 MR. GRAHAM: Well, I was going to do them separately.

10 THE COURT: That's fine. I just wanted to see --

11 MR. GRAHAM: Three.

12 THE COURT: So 31, 32 and 33 are photos of Alexia?

13 MR. GRAHAM: Yes, sir.

14 THE COURT: All right. Into evidence without
15 objection.

16 (WHEREUPON, Plaintiff's Exhibit Nos. 31, 32 and 33
17 were admitted into evidence.)

18 MR. GRAHAM: 32 is Alexia as a child. 33 is Alexia
19 as an adolescent or, I guess, teen.

20 THE COURT: Mr. Graham, anything else from the
21 Plaintiff before we get started?

22 MR. GRAHAM: Well, I was just a little confused about
23 Court Exhibits and the originals.

24 THE COURT: Okay.

25 MR. GRAHAM: None of the others are marked as far as

1 I can tell.

2 THE COURT: I mean, we can mark them at the end of
3 the case.

4 MR. GRAHAM: Okay.

5 THE COURT: Anything from the defense?

6 MR. DAVIS: Yes, Your Honor, at the close of business
7 yesterday before we left the courtroom, I was advised by
8 my paralegal that I inadvertently played the wrong version
9 of the animation. There was a subsequent revision. The
10 subsequent revision was not loaded on my computer
11 correctly, that was my fault. I played the second to last
12 revision.

13 THE COURT: Okay.

14 MR. DAVIS: The one I need to replay on redirect is
15 almost the same. There's a little difference at the end.
16 The final, final revision that I didn't play yesterday
17 inadvertently is the one we sent to Ed Graham last week.

18 THE COURT: What is the difference between the two
19 videos?

20 MR. DAVIS: The only difference is the last five or
21 six or ten seconds, the rotational maneuver, it was
22 revised to -- I think January 3rd is when the last
23 revision was finally made. Over the holidays, it was
24 difficult to get everything done with the company we had
25 been working with. So I need to be able to on redirect

1 ask Dr. Miller just to explain to them, you know, was the
2 last video, the animation, was it the final animation that
3 we had done. He already -- he'll say no because he knows
4 it wasn't exactly the same. Everything is the same except
5 for the last few seconds. And I'm happy to show the
6 Court. The final version is what we sent to them.

7 MR. GRAHAM: I mean, he authenticated the one
8 yesterday.

9 MR. DAVIS: It's not an authentication. It was a
10 demonstrative piece of evidence and I think I have the
11 right to correct my error.

12 THE COURT: I think you do. The video was played
13 over the Plaintiff's objection, so I think we'll just play
14 the part that was different. I mean, it's powerful.
15 Animations are effective. I think replaying the whole
16 video, we don't need to do that.

17 MR. DAVIS: I'm happy to show that last, I don't know
18 how many seconds.

19 MR. GRAHAM: Your Honor, may we play the last six
20 seconds of each one so we can see?

21 THE COURT: Sure. Let's go ahead and put them up.
22 Ms. Foster, can we play the original one first and then
23 we'll just see the one that was played in front of the
24 jury?

25 MR. DAVIS: This is what we played yesterday.

1 (WHEREUPON, the video animation was played for the
2 Court.)

3 THE COURT: All right. And the new one -- or the
4 most recent version.

5 MR. DAVIS: See it's noted final 2.

6 THE COURT: Right.

7 MR. DAVIS: We had final 1 and final 2. That was my
8 mistake.

9 (WHEREUPON, video animation was played for the
10 Court.)

11 THE COURT: Mr. Davis, is the difference the way the
12 hand is positioned?

13 MR. DAVIS: Yes, sir.

14 MR. GRAHAM: If I'm not mistaken, Your Honor, I think
15 one was clockwise and one was counter-clockwise.

16 MR. DAVIS: Correct. That's correct.

17 THE COURT: Okay.

18 MR. DAVIS: The last one is the one we sent to Mr.
19 Graham, so it's no surprise to him.

20 THE COURT: Mr. Graham, you want to be heard on that
21 issue?

22 MR. GRAHAM: Could you give me just a moment, Your
23 Honor?

24 THE COURT: Yes, sir.

25 (Pause.)

1 MR. GRAHAM: Your Honor, may we see those last six
2 seconds one more time?

3 THE COURT: Yes, sir. Mr. Traylor, would you mind
4 playing them one more time?

5 MR. GRAHAM: And you're playing yesterday's first?

6 MR. TRAYLOR: Which one do you want to see first?

7 MR. GRAHAM: Yesterday first.

8 (WHEREUPON, the video animation was played for the
9 Court.)

10 MR. TRAYLOR: That's yesterday's. And then today's.

11 (WHEREUPON, the video animation was played for the
12 Court.)

13 THE COURT: Just for the record, it appears the two
14 differences are, in the first video, the hand starts
15 anterior and the baby is rotated counter-clockwise. In
16 the second video, the hand starts posterior and the baby
17 is rotated clockwise. Is that correct?

18 MR. DAVIS: That's correct.

19 THE COURT: Mr. Graham.

20 MR. GRAHAM: Since he sent it to me, we have no
21 objection.

22 THE COURT: All right.

23 MR. DAVIS: I can just do that on redirect?

24 THE COURT: Absolutely. Yes. Just lay a foundation
25 and ask Dr. Miller to explain the wrong foundation was

1 played.

2 MR. DAVIS: I will. Thank you, Your Honor. And
3 we'll just show that segment.

4 THE COURT: Yes, sir. Anything else from the
5 Defense?

6 MR. DAVIS: No, sir. Thank you.

7 THE COURT: Let's bring them in.

8 (WHEREUPON, the jury enters the courtroom at
9 approximately 9:50 a.m.)

10 THE COURT: Good morning, ladies and gentlemen,
11 welcome back. Has everyone been able to follow the rules
12 I've given you overnight?

13 (Affirmative response.)

14 THE COURT: Thank you very much. I appreciate that.
15 The first thing, I need to apologize to you. You gave me
16 a note yesterday and I forgot to answer it, so I'm very
17 sorry. So the first question was: Any thoughts on the
18 last day of trial or when deliberation will begin? We
19 will definitely finish the evidence today. The witnesses
20 will end today. My hope is we will also be able to finish
21 the attorney's closing argument and my explanation of the
22 law today. But for sure, we'll finish the evidence today.
23 So depending on whether or not we're able for me to
24 explain the law to y'all and whether or not the attorneys
25 do their closing argument today, that will depend on how

1 long the trial goes. Again, I would plan for the whole
2 week, but I don't see any way it would go into the second
3 week -- into a third week, I mean. And the second
4 question is: Will the alternates be excused before or at
5 deliberation? That's a very good question. At the end of
6 the jury charge and then after the attorneys have done the
7 closing argument, all that's completed, at that point, I
8 will identify who the alternates are and excuse them.
9 Alternates are not permitted to participate in jury
10 deliberations. And I have some good news, bad news. The
11 bad news is, Juror No. 254, Mr. Smathers, you can see is
12 not with us. He is sick. We're sorry to hear that Mr.
13 Smathers is sick. The good news is, from our perspective
14 is Mr. Smathers told the clerk of court's office that he
15 was up all night vomiting, but has no other symptoms. He
16 does not have a fever. He does not have any cold
17 symptoms. He does not have a cough. So he believes he
18 ate something bad for dinner last night, but no COVID
19 symptoms at all. Dr. Miller, if you will take the stand,
20 please. And you're welcome to take the pitcher up there
21 if you'd like, Dr. Miller.

22 (Witness takes the stand.)

23 THE COURT: Dr. Miller, you are still under oath.
24 Mr. Graham, you can continue your cross.

25 MR. GRAHAM: Thank you, Your Honor.

CONTINUE CROSS-EXAMINATION

BY MR. GRAHAM:

Q Good morning, Doctor.

A Good morning, Mr. Graham.

Q With your cooperation, I'm going to try to go through the rest of this much quicker than we did yesterday. So

--

A Yes, sir.

Q Do you believe that zero -- that applying a vacuum at zero station is applying vacuum at what is in obstetrics called the low vacuum extraction?

A I think in my deposition 11 years ago, we got -- we had some confusion -- I shouldn't say we, me. The use of the words high, mid, low and outlet really are archaic at this time. Those were terms that were designed or used in the days of using forceps. And forceps are metal devices as opposed to a vacuum that the OB puts around the head and facilitates delivery of the baby. Those things were almost routinely used on almost every delivery back in the early 19th century. We have evolved and stopped doing that because there were lots of issues with putting these big metal devices on a baby's head causing trauma. So those terms were popularized back then. Unfortunately, vacuums -- or forceps had gone out of favor by the time I started medical school and residency. In fact, we weren't

1 even trained on forceps in medical school and residency.
2 I actually learned how to do forceps on my own with some
3 other residents. So when we talked about it last time, I
4 tried by using my memory what those terms were and I was
5 wrong. Currently, we just use zero, plus one, plus two,
6 minus one. So I think I misspoke or I was wrong at that
7 time.

8 Q All right. Please turn to Page 124, Line 2 of your
9 deposition through Page 126, Line 22 of your deposition.

10 A Can you tell me that first page?

11 Q Yes, sir, 124.

12 A 124, okay.

13 Q Line 2. And please read along with the transcript
14 there as we play the video.

15 (WHEREUPON, the deposition video is played.)

16 BY MR. GRAHAM::

17 Q Doctor, yesterday, you guys presented a photograph of
18 an operating room.

19 MR. GRAHAM: Was that introduced in evidence, Mr.
20 Davis?

21 THE COURT: It was a demonstrative. It was not in
22 evidence.

23 BY MR. GRAHAM:

24 Q Do you recall that photograph, sir?

25 A Yes, sir.

1 MR. GRAHAM: Do you mind playing it again?

2 MR. DAVIS: If I can find it.

3 MR. GRAHAM: Well, just let me know. If you can't
4 find it, we'll move on.

5 MR. DAVIS: I have to turn it over to my technician.

6 THE COURT: It's up, Mr. Graham.

7 MR. GRAHAM: Okay.

8 BY MR. GRAHAM:

9 Q Doctor, you said that this conveyed some kind of
10 information relevant to this case. Help me understand why
11 that's true. That's not you in the picture, is it?

12 A No.

13 Q That's not Angela Patton -- that's not Angela
14 Patton's belly we see, is it?

15 A This depicts a normal obstetrical OR setup.

16 Q All right. So is that OR setup for a cesarean -- a
17 planned cesarean delivery?

18 A That OR setup is for virtually any cesarean delivery.

19 Q That's not an emergency delivery, is it?

20 A The setup is the same whether it's an emergency or
21 not.

22 Q Looking at those healthcare providers in the picture,
23 do they appear to you to be performing a primary or a
24 planned C-section or an emergency C-section?

25 A I think we'd have to video to see, you know, that.

1 That's a cesarean section.

2 Q Are there any -- at least, while you're looking at it
3 now, you can't vouch for it being an emergency?

4 A No. No.

5 Q And are there stirrups in that photograph?

6 A No, the stirrups only are applied when we move to a
7 vaginal case.

8 Q All right. Is there a shoulder dystocia in that
9 case?

10 A Well, I guess we don't know.

11 Q Well, is there -- there may have been the shoulder
12 dystocia before a C-section was called, but we see no
13 evidence of a shoulder dystocia in the image, true?

14 A We have no operative report on this particular case.

15 Q As far as we know, as far as we can tell from the
16 picture, that's an ordinary, planned cesarean delivery,
17 right?

18 A That is a cesarean section. I don't think we can
19 determine whether that's ordinary or not.

20 Q All right. But even though it's a planned cesarean,
21 do you believe that doctors will frequently apply traction
22 to the baby's head to pull the baby out of the uterus?

23 A For a planned C-section?

24 Q Yes, sir.

25 A So are you asking if there's a dystocia at the time

1 of the C-section?

2 Q No, sir. I'm asking you about traction.

3 A Okay.

4 Q Babies don't just jump out of the uterus and you
5 catch them, do they?

6 A Boy, I wish they did.

7 Q You have to pull on them?

8 A But they don't. We go through maneuvers as you would
9 in a vaginal delivery.

10 Q So you pull on the head to get them out?

11 A No, no, you don't.

12 Q And sometimes you'll use an instrumental delivery
13 like a vacuum?

14 A I've never used a vacuum on a C-section.

15 Q You know that well-trained obstetricians sometimes
16 use a vacuum?

17 A I think they can, but I don't. And I don't pull on
18 the head -- so there's no shoulder dystocia. There's no
19 impaction of a shoulder in a C-section, so there's not any
20 substantial, as you would call, traction. In fact, unlike
21 a vaginal delivery where it's absolutely imperative you do
22 not put what's called fundal pressure, which is pressure
23 on the top of the uterus because you can impact the
24 shoulder. In a C-section, you actually do put fundal
25 pressure because what you're trying to do is push that

1 baby down to the incision --

2 Q Excuse me --

3 A Typically, I'm sorry, I'm not --

4 MR. GRAHAM: Yesterday, we had nonresponsive
5 speeches. Would you kindly admonish the witness to answer
6 my question instead of making nonresponsive speeches?

7 MR. DAVIS: With all due respect to my friend, he
8 asked a question, I think the Doctor has a right to
9 explain his answer.

10 MR. GRAHAM: If it's responsive.

11 THE COURT: Counsel. Doctor, please just answer the
12 question and you can explain your answer if you'd like to
13 after you answer.

14 THE WITNESS: Will he give me a chance to explain?

15 THE COURT: Yes, sir, I'll make sure.

16 THE WITNESS: So, again, you don't grab the head at
17 the end, you grab the shoulder.

18 BY MR. GRAHAM:

19 Q Was the dad there during your delivery, your shoulder
20 dystocia vaginal delivery?

21 A Was the father during -- was Antwan there during the
22 reduction of the right shoulder dystocia and the delivery
23 of the left shoulder, yes, he was.

24 Q Whatever the vaginal delivery is, we disagree on the
25 maneuvers, but whatever that vaginal delivery was, was Mr.

1 -- was Antwan there?

2 A Yes, he was.

3 MR. GRAHAM: Would you please play Page 15, 1 through
4 22?

5 Q And please follow along in your deposition.

6 MR. TRAYLOR: I'm sorry, would you please tell me
7 that again?

8 MR. GRAHAM: Page 15, Lines 1 through 22.

9 Q You listed for me the people present at delivery.
10 You didn't list any friends or family members of Angela.
11 Do you claim to remember whether or not she had any
12 friends or family members present?

13 A To my best recollection before this morning, I did
14 not remember. Now, during Angela's testimony, she
15 mentioned -- do you want me to finish the reading of that?

16 Q No, sir, we're get the video going.

17 (WHEREUPON, video was played.)

18 THE WITNESS: And that's correct.

19 (WHEREUPON, video was continued.)

20 BY MR. GRAHAM:

21 Q Is that what you said in answer to my questions?

22 A Yes, sir.

23 Q Dr. Miller, I hold in my hands a certain page that is
24 in evidence from the hospital labor and delivery. It's
25 entitled delivery summary?

1 A Yes.

2 Q Is that your signature?

3 A Yes, that's my signature.

4 Q Down here, I'm going to read this and you tell me if
5 I'm reading it accurately. This is --

6 THE COURT: Mr. Graham, I think you may need to grab
7 a microphone if you don't mind. The witness microphone is
8 not picking you up there.

9 BY MR. GRAHAM::

10 Q This is a delivery summary that the nurses fill out,
11 correct?

12 A It's printed by a nurse, but I think probably the
13 clerk actually puts in a lot of the details.

14 Q All right. But at any rate, you review it and then
15 you sign it approving to the accuracy?

16 A You sign it, you're sort of busy, you sign off on it.
17 You might not review it that much.

18 Q So when you're in the hospital signing documents, do
19 you read them first or just (inaudible)?

20 A Depending on how many you sign, which could be
21 sometimes hundreds, sometimes you just sign off on them.
22 For example, this says Robert McClellan is the attending.
23 Technically, he should have to sign this because he's an
24 attending, but he wasn't the attending at the delivery.
25 So you sort of sign off on a lot of things because the

1 chart becomes hundreds of pages over a period of time.

2 Q Sure. And under assessment for other physical
3 findings, it list left arm weakness, correct?

4 A That's correct.

5 Q Then under congenital anomalies, it states none
6 apparent, true?

7 A True.

8 MR. GRAHAM: And for the record, this one is Bates
9 stamped RHGYNOB0031.

10 Q Doctor, can you -- do you have any evidence of this
11 injury to Alexia occurring before her head delivery?

12 A I know when the -- I'm sorry. I know when the injury
13 did not occur. It did not occur during the right shoulder
14 dystocia and it did not occur after the woodscrew maneuver
15 with the delivery of the left shoulder.

16 Q Do you have any evidence, sir, as to whether or not
17 the injury occurred before the delivery?

18 A Yes, I do. And this -- because this case has gone on
19 for so long, it's been delayed three or four times, I've
20 had a chance to review this chart numerous times and try
21 to come up with evidence when it might have occurred. So
22 I do have -- to a reasonable degree of medical certainty
23 know when it happened. Would you like me to tell you
24 about that?

25 Q Well, you say you have an idea of when it possibly

1 could have happened, correct?

2 A Yes.

3 Q Do you have any evidence to support the proposition
4 that the injury occurred after delivery?

5 A In the newborn nursery?

6 Q Anywhere after the injury?

7 A No, I have no evidence that it happened after the
8 delivery.

9 MR. GRAHAM: Let's please play the video for Page
10 137, 18 through 138, Line 8.

11 Q And please read along as the video plays, sir.

12 (WHEREUPON, video deposition is played.)

13 BY MR. GRAHAM::

14 Q Were those your answers to my questions, sir?

15 A Absolutely. I just had a lot more hair. But what I
16 would like to --

17 Q I --

18 A No, because I'd like to qualify my statement because
19 you asked me something --

20 THE COURT: He gets to explain.

21 THE WITNESS: And I said even before you played that,
22 that since there's been 11 years and I have reviewed this
23 chart multiple times --

24 MR. GRAHAM: Your Honor --

25 THE WITNESS: -- that my opinion has changed at this

1 point.

2 THE COURT: Counsel, you can approach.

3 THE WITNESS: And I'd be happy to tell you that
4 opinion.

5 MR. GRAHAM: But you're not a causation expert.

6 THE WITNESS: This is not the causation. You asked
7 me timing.

8 (WHEREUPON, a bench conference was held in the
9 presence of the jury, but outside the hearing of the
10 jury.)

11 BY MR. GRAHAM:

12 Q Doctor, do you know of any obstetrician who has ever
13 confessed in the medical records to using more than -- to
14 using excessive traction?

15 A No, no, I do not.

16 Q You do not know of any --

17 A Honestly --

18 Q -- obstetrician that's ever charted I used too much
19 traction?

20 A I don't read other people's charts, so the charting
21 is limited to, I think, just to me, but I don't know of
22 anybody that's charted that, no.

23 MR. GRAHAM: No further questions.

24 THE COURT: Redirect, Mr. Davis.

25 MR. DAVIS: Yes, sir.

REDIRECT EXAMINATION

BY MR. DAVIS:

Q Dr. Miller, you were asked about the vacuum attachment. Where was that done? Where was this method done?

A It was done -- so, the location of the baby's head was at zero station.

Q Where was Ms. Patton at the time?

A She was in the OR -- excuse me, excuse me, no, she was in the labor and delivery room, I'm sorry.

Q That was before going to the OR?

A Yes.

Q And why did you do that vacuum attempt? What was the purpose of that?

A So, again, the whole scenario gets somewhat confusing because we didn't use the terminology mid-low and in my previous deposition, I realized that after the fact and went back and looked at it. We were just using the zero to plus five or zero to minus five and high. So that terminology really doesn't matter. Zero tells you exactly where the vacuum was. And in that other terminology, that's considered a mid position. But the vacuum was put on there for the extenuating circumstance that the baby's life was on the line.

Q Okay. Did the vacuum -- there's a cup on the end of

1 that vacuum and then you pump up the vacuum when it
2 attaches. Did it ever attach to the head?

3 A No, it never attached. We couldn't even use it. The
4 purpose for using the vacuum that time -- back in the day
5 when people used forceps, once you put the forceps on the
6 baby's head, you didn't take it off. So you would put the
7 forceps on -- and they would put forceps on at very high
8 locations, very dangerous locations. They would literally
9 pull the baby all the way down through the birth canal.
10 Those gentlemen were good, but they had lots of injury to
11 babies and mothers. With the vacuum, the attempt for --
12 my thinking for Angela was, I knew that she could deliver
13 that baby. I felt like she was strong enough to do it,
14 but her pushing effort was not effective. And I felt like
15 that was because maybe the baby was still a little bit too
16 high. And I was hoping that I could change the position
17 of the baby and get the baby to drop down one or two
18 centimeters to a station where she would actually be able
19 to feel it and organize and coordinate her pushing better.
20 And at that point, I would take the vacuum off and let her
21 do the rest. But the vacuum never worked. I couldn't get
22 it to attach. You try once -- and there's different
23 reasons why it might not attach. Sometimes, it's the
24 shape of the baby's head. Sometimes, it's the amount of
25 hair on the baby. But it just wouldn't seal, so we didn't

1 even use it.

2 Q What kind of time frame are we talking about from the
3 time you attempted the vacuum until you realized well,
4 this isn't going to work, it doesn't attach?

5 A It's probably five to ten seconds, 15 seconds max.

6 Q Doctor, in your opinion, did that attempt with the
7 vacuum when it never attached to the head and no pulling
8 was done with the vacuum on the fetal head, did that --

9 MR. GRAHAM: Objection to leading, Your Honor.

10 THE COURT: The witness can answer.

11 MR. DAVIS: If I can finish my question.

12 BY MR. DAVIS::

13 Q Dr. Miller, do you have an opinion whether or not
14 that vacuum attempt that you just described led to, caused
15 or contributed to any injury to Alexia, including a
16 brachial plexus injury, sir?

17 A No, it did not.

18 Q In the record that Mr. Graham showed the jury just
19 now, that was a nursing document, correct?

20 A Yes.

21 Q And the nurse documented on that record, vertex
22 position left occipital anterior, LOA, was that accurate?

23 A No. No. It was LOP.

24 Q Right. And that's what you documented in your note?

25 A Yes, I did.

1 Q LOP?

2 A Yes.

3 Q Okay. Mr. Graham asked you just now do you have any
4 evidence of when the injury happened prior to delivery --

5 A Yes, he did.

6 Q -- and you explained your answer --

7 THE COURT: Counsel, approach the bench, please.

8 (WHEREUPON, a bench conference was held in the
9 presence of the jury, but outside the hearing of the
10 jury.)

11 BY MR. DAVIS:

12 Q Dr. Miller, yesterday, I made a mistake. It's
13 probably not the first mistake I've made nor will it be
14 the last. But I played -- we had two what we call final
15 versions of the animation --

16 A Yeah, I noticed that.

17 Q I think you knew that, didn't you?

18 A Yes.

19 Q I didn't. There's a final 1 and a final 2, and I
20 inadvertently played to you the final one instead of the
21 final two.

22 A I know.

23 Q You knew that, right?

24 A Yeah, I didn't want to say anything to you and hurt
25 your feelings.

1 Q You're too kind.

2 MR. DAVIS: At this time, if it please the Court, I'd
3 like to just show the portion of the final version that I
4 meant to play yesterday only as to the last few seconds
5 where it shows your rotational maneuver.

6 THE WITNESS: That's correct.

7 Q Okay. Can we just show that and I'll ask you a
8 couple of questions about it and then be done.

9 A Sure.

10 THE COURT: Ladies and gentlemen, as counsel and the
11 witness said, the wrong video was played yesterday and it
12 differs only at the very, very end of the video in a few
13 seconds of footage. So we're going to replay that video.
14 Before that happens, I just want to remind you, this is
15 not evidence. This is an animation prepared by one side
16 showing their version of what happened. It is not
17 evidence, but it's used to illustrate what the witness'
18 testimony is. Mr. Davis.

19 MR. DAVIS: Thank you, Your Honor. And if you want
20 us to pause this as we're going along, Doctor, let us
21 know.

22 (WHEREUPON, video animation is played.)

23 MR. DAVIS: Let's pause it right there.

24 BY MR. DAVIS:

25 Q Doctor, what does this show that you're doing?

1 A That was the rotational maneuver I did to rotate the
2 left shoulder from a posterior to an anterior and release
3 the right shoulder, which had been dystocia. You can also
4 see -- this depicts nicely the circular rotation, but also
5 the corkscrew maneuver where that shoulder anteriorly is
6 below the pubic symphysis at that time.

7 MR. DAVIS: Thank you, Dr. Miller. Thank you, Your
8 Honor.

9 THE COURT: Any recross, Mr. Graham?

10 MR. GRAHAM: Yes, sir.

11 RECROSS-EXAMINATION

12 BY MR. GRAHAM:

13 Q Doctor, you were here yesterday when your lawyer
14 played the first animation, right?

15 A That's correct, yes.

16 Q When did you decide that animation was not correct?

17 A When I saw it.

18 Q All right. When did you tell us that you did not
19 believe it to be an accurate representation of your
20 version of the facts?

21 A I mentioned it to my attorney this morning.
22 Yesterday, honestly -- I'm not a lawyer. As you can
23 imagine, things seem to not make sense to me a lot of
24 times the way a court works. So I'm trying not to step on
25 anybody's toes or do anything wrong, which I seem to still

1 do. So I thought the best thing to do was mention it to
2 my attorney this morning.

3 Q But yesterday, you presented that video, that highly
4 professional animation --

5 A I didn't present it.

6 Q Well, your lawyer presented it on your behalf, true?

7 A Sure.

8 Q How much did that animation cost?

9 A I have no idea. I can tell you how much that pelvis
10 cost because I bought that. I can tell you how much I had
11 to rent my baby for because I did those things, but I
12 don't know.

13 Q You know how much everything cost except the
14 animation we're talking about?

15 A I didn't pay for that, no, sir.

16 Q At any rate, you vouched for that video yesterday,
17 correct, that animation?

18 A I didn't vouch for it. I tried to correct the
19 situation this morning, yes.

20 Q Yes, sir, but yesterday is what we're talking about?

21 A Sure.

22 Q Yesterday, you didn't say oh-oh, this is not right.
23 My lawyer is presenting it to the jury like this is a
24 depiction of my testimony of what I did and what happened
25 to the baby and how the baby came out, right?

1 A Sir, if you'd like, we can show both so you can see
2 that the only change is, for the most part, the rotation,
3 which is clockwise in one and counter-clockwise in the
4 other. And I just thought I would mention to my attorney
5 this morning. I didn't think it was significantly
6 different for other people.

7 Q All right.

8 A I mean, you didn't recognize it and my attorney
9 didn't recognize it. I was the only one that recognized
10 it, so I didn't think it was that big of a deal.

11 Q Did I have anything to do with the preparation of
12 that animation, sir?

13 A You know about this case.

14 Q I know some things about this case, yes, sir.

15 A Yes, sir.

16 Q You were the one in a position, you represented that
17 was an accurate or reasonably accurate depiction of your
18 story about what happened?

19 A I think it was reasonably accurate. And I think just
20 by the fact that -- I think you don't give yourself enough
21 credit. I think you're very knowledgeable about this
22 case. I think all the attorneys are. And the fact that
23 you didn't -- I just mentioned to my attorney saying, you
24 know, if this goes into the record, maybe we want to have
25 the depiction that was -- that actually depicted what I

1 did.

2 Q In your lawyer's file, was this listed as final
3 animation?

4 A You'd have to ask him. I don't know what his files
5 on his computer reads.

6 Q You were present a few feet away when we just had a
7 discussion with His Honor about how they had been titled?

8 A I try not to listen to your discussions. I don't
9 feel like I'm privy to what you discuss with the Judge.

10 Q Do you have any reason to doubt, sir, that the video
11 you played yesterday was called final animation?

12 A I have no -- I can't tell you whether it was final
13 animation or not final animation. Again, I think the
14 person you can ask is Ashby or Drew. Drew sort of seems
15 to be the tech whiz. You can ask either one of them, but
16 I don't know. It's Ashby's computer. That's their
17 responsibility. I don't know.

18 Q You were also present in court while the jury was out
19 when there was a discussion about the one you brought in
20 today being final number two?

21 A Sir, my job is not -- that's not my job. My job is
22 to give accurate and truthful testimony and that's what
23 I'm here to do. And it's not to manage the case in any
24 way, shape or form. It's just to sit here and tell the
25 truth.

1 Q Yes, sir. Yes, sir. You say the one yesterday was
2 reasonably accurate?

3 A If you want to, we can go over both of them and you
4 can show it to the jury.

5 Q I'll be happy to in a moment, sir, but right now, I
6 want to verify. You believe yesterday's version --
7 yesterday's animation version of what you say happened was
8 reasonably accurate?

9 A I would say that that showed a rotational maneuver
10 with the posterior shoulder rotating 180 degrees to
11 anterior position and being below the pubic symphysis. So
12 that's what I would say.

13 Q Do you remember the question?

14 A I think I answered it.

15 Q Do you believe yesterday's animation to be a
16 reasonably accurate depiction of your testimony?

17 A I just answered that.

18 Q You believe it was?

19 A No, I told you what I said.

20 Q Well, first, you said it was reasonably accurate?

21 A I'm saying -- what I'm saying right now is that it
22 depicted -- again, if you want to clear it up, we can just
23 show it to them. Because I'm not sure if --

24 Q Right now, sir, I get to ask the questions, all
25 right?

1 A I wasn't asking a question.

2 Q Please listen to my questions and answer my
3 questions, sir.

4 THE COURT: Dr. Miller, just please answer the
5 question yes or no whether you believe it was reasonable
6 accurate and then you can explain.

7 THE WITNESS: Go ahead and define reasonably
8 accurate.

9 BY MR. GRAHAM:

10 Q What does reasonably mean to you, sir?

11 A Reasonable.

12 Q What does accurate mean to you, sir?

13 A Accurate.

14 Q Using your definitions, was yesterday's animation,
15 final animation reasonably accurate?

16 A Yesterday -- the change in the two videos, there was
17 a difference. Now, your definition of reasonably
18 accurate, it does show the various maneuvers, but it is
19 not the accurate representation of what I did.

20 Q First of all, sir, I'm not using my definitions, I'm
21 using yours. Earlier, you said it was reasonably
22 accurate. Are you now saying it's not reasonably accurate
23 or are you sticking with the prior testimony that it was
24 reasonable accurate?

25 A Well, I would say that it's accurate in the sense

1 that it's not -- it's reasonably accurate, but not
2 completely accurate. Does that help you?

3 Q I'm just asking for your testimony, sir.

4 A Then that's my testimony.

5 Q I'm trying to pin down whether you believe it's
6 reasonably accurate?

7 A So I would say it's reasonably accurate, but not
8 completely accurate.

9 Q But you didn't express any of that yesterday?

10 A No, I brought it up with my attorney this morning.

11 Q Do you believe the animation that just got played is
12 reasonable accurate?

13 A Yes.

14 Q All right.

15 MR. GRAHAM: Mr. Davis, would you mind playing the
16 last six seconds of yesterday's video?

17 MR. DAVIS: You mean final 1 or final 2?

18 THE COURT: Counsel, can y'all approach, please?

19 MR. GRAHAM: Final 1, yesterday's.

20 (WHEREUPON, a bench conference was held in the
21 presence of the jury, but outside the hearing of the
22 jury.)

23 THE COURT: Just to make sure I understand and the
24 jury understands, Mr. Graham, you're wanting to replay the
25 portion from yesterday that was incorrect or that was

1 changed?

2 MR. GRAHAM: That was changed.

3 THE COURT: So this is yesterday's video.

4 MR. DAVIS: Your Honor, just to be clear, it wasn't
5 changed. This was done January 3rd.

6 THE COURT: That's correct, the incorrect older
7 version that was played in error yesterday.

8 (WHEREUPON, video animation was played.)

9 BY MR. GRAHAM:

10 Q Doctor, on yesterday's version of this animation
11 final number 1, you used your left hand to go in to grab
12 the left shoulder, correct?

13 A On this one right here? Which one are we looking at
14 here?

15 Q Final one.

16 A This is the final final one or the final final two?
17 Is this the one you want me to look at and explain?

18 Q This is the one that you identified as final one.

19 THE COURT: Counsel, let's call them earlier and
20 later. I think that will be clearer.

21 BY MR. GRAHAM:

22 Q Focusing on the earlier one that we saw yesterday --

23 A Okay.

24 Q -- do you believe that animation depicted your left
25 hand going in and rotating --

1 A No.

2 Q It was your right hand that went in?

3 A This depiction shows my right hand and it shows
4 turning the baby counter-clockwise starting on the -- it
5 looks like the baby's right shoulder.

6 Q All right. So you would agree that final -- I mean,
7 the earlier version shows your right hand going in and
8 pressing against the right shoulder and rotating it
9 counter-clockwise, correct?

10 A The right hand is behind the right shoulder turning
11 the baby in a counter-clockwise rotation.

12 Q And that -- after your rotation, the earlier
13 animation shows the left shoulder emerging from the
14 rotation on the side of the pubic bone, correct?

15 A Below or beneath the suprapubic bone, yes.

16 MR. GRAHAM: Mr. Davis, would you kindly play the
17 later version?

18 MR. DAVIS: Yes, sir.

19 (WHEREUPON, later version of video animation was
20 played.)

21 BY MR. GRAHAM:

22 Q In that later version, is that your left hand going
23 in?

24 A Yes, sir.

25 Q And is it placed behind the baby's left shoulder?

1 A It's not -- if we're talking about depictions, that
2 shows fingers there. Actually, it's your hand behind it.

3 Q So this shows fingers, but it's really your hand?

4 A It's your hand.

5 Q And does it show you making the rotation clockwise or
6 counter-clockwise?

7 A That's a clockwise rotation.

8 Q And does it show the left shoulder -- after the
9 rotation, does it show the left shoulder downstream of the
10 pubic bone to the same extent as yesterday's?

11 A I believe so, yes.

12 MR. GRAHAM: Could we play those last few seconds?

13 MR. DAVIS: Of the earlier one?

14 MR. GRAHAM: Earlier one.

15 (WHEREUPON, earlier version video animation was
16 played.)

17 BY MR. GRAHAM:

18 Q So that shoulder is well underneath the pubic bone,
19 the left shoulder --

20 A Yes, it is.

21 MR. GRAHAM: Now would you play the later version?

22 (WHEREUPON, later version video animation was
23 played.)

24 BY MR. GRAHAM:

25 Q Although that's certainly not a left shoulder

1 dystocia, but did you notice that in the later version,
2 that left shoulder does come out adjacent to the pubic
3 bone instead of beneath it?

4 A No, I didn't really notice that.

5 MR. GRAHAM: Would you play the later one again?

6 (WHEREUPON, later version video animation was
7 played.)

8 MR. GRAHAM: I'm going to ask that you stop it right
9 there. Could we do it again and be ready to stop it when
10 I ask you to stop it.

11 (WHEREUPON, later version video animation was
12 played.)

13 MR. GRAHAM: Stop it. Well, no, let's try it again.

14 (WHEREUPON, later version video animation was
15 played.)

16 MR. GRAHAM: Right there.

17 BY MR. GRAHAM:

18 Q Can you look at it now, Doctor, and tell us if you
19 showed the same shoulder position relative to the pubic
20 bone as you did yesterday?

21 A I guess I'm not sure what I'm comparing what to.

22 MR. GRAHAM: No further questions.

23 THE COURT: Mr. Davis.

24 MR. DAVIS: Very, very briefly, Your Honor.

25 REDIRECT EXAMINATION

1 BY MR. DAVIS:

2 Q In real time -- this is an animation. In real time,
3 were you there?

4 A Yes, this is definitely Bugs Bunny animation, yes.

5 Q Doctor, tell the jury in real time -- we don't have a
6 video, of what happened. Tell the jury in real time, when
7 you did your rotational maneuver, what happened to the
8 left shoulder that was first down and rotated up, what
9 happened?

10 A So a woodscrew maneuver, as has been told numerous
11 times in the last two weeks, is a rotational maneuver,
12 which not only rotates the baby circular, but in a
13 corkscrew fashion, and that's why it's called a corkscrew
14 maneuver. So the baby rotates and rotates down and out.
15 This case started with the left shoulder down. I had
16 tried to release the posterior shoulder doing a posterior
17 shoulder delivery, that was unsuccessful. I stuck my left
18 hand behind with -- again, talking about animation not
19 being accurate, it shows fingers. You can't move a baby
20 with your fingers. My hand was behind -- the palm of my
21 hand behind that shoulder, and turn that baby in five to
22 ten seconds 180 degrees so that the left shoulder now,
23 which had been low and down, was now anterior and well
24 below the pubic bone. There was no second shoulder
25 dystocia after that.

1 Q Thank you, Dr. Miller. Were you aware that the final
2 version was sent to Mr. Graham before this trial started?
3 Were you aware of that?

4 A I found that out this morning.

5 MR. DAVIS: Nothing further. Thank you.

6 THE COURT: Any recross?

7 MR. GRAHAM: No, sir.

8 THE COURT: All right. Dr. Miller, thank you. You
9 may step down. Mr. Davis, you can call your next witness.

10 MR. DAVIS: We're going to call Dr. Chauhan. He's,
11 obviously, outside the courtroom. Can we have just a
12 short break?

13 THE COURT: Ladies and gentlemen, would y'all like a
14 ten-minute bathroom break? We'll take a ten-minute
15 recess.

16 MR. DAVIS: Thank you, Your Honor.

17 (WHEREUPON, the jury exits the courtroom at
18 approximately 10:46 a.m.)

19 (WHEREUPON, a short recess was taken.)

20 THE COURT: Mr. Davis, I think you wanted some time
21 to put on the record your objection to my ruling about
22 opening the door?

23 MR. DAVIS: Yes, sir. Thank you very much, Your
24 Honor. Are you ready now?

25 THE COURT: Yes, sir.

1 MR. DAVIS: Thank you very much, Your Honor. In
2 cross-examination, Mr. Graham asked Dr. Miller do you have
3 any evidence that this injury happened prior to the
4 shoulder dystocia. It's my respectful contention that
5 that opened the door to, at least -- and he tried to
6 answer. He said well, yeah, I've thought about this a
7 long time and I do have some opinions. I do have some
8 evidence. And he was not allowed to answer anything
9 further by the Court. I attempted to do that on redirect.
10 Not disrespecting this Court's ruling, but I think it's
11 important that Dr. Miller should have had the opportunity
12 to answer Mr. Graham's question and give his thoughts and
13 reflections over the years about this case since his
14 deposition in 2011. And I respectfully take exception to
15 the Court's ruling.

16 THE COURT: Yes, sir. Again, for the record, the
17 basis for the Court's ruling was that Dr. Miller testified
18 at his deposition that he did not have any evidence as to
19 when the injury might have occurred and I thought it was
20 fair for Mr. Graham to try to elicit that testimony
21 without opening the door to causation testimony, that that
22 had already been ruled on.

23 MR. DAVIS: Thank you, Your Honor.

24 THE COURT: Anything from the Plaintiff before we
25 begin?

1 MR. GRAHAM: Yes, sir, Your Honor. And I'm troubled
2 to make this comment, but I have a duty, I believe, under
3 the lawyer's Code of Professional Conduct. As we all
4 know, there's not supposed to be -- can you hear me?

5 THE COURT: Yes, sir, I can hear you. Actually, I'm
6 not sure it's coming over the mic, though. You want to
7 just bend it up a little bit. Okay, it's working. Yeah.

8 MR. GRAHAM: Your Honor, I've never been in this
9 position before and I hope I never am again, but South
10 Carolina lawyers are bound by the Code of Professional
11 Conduct to report violations of ethical rules. And Dr.
12 Miller, to the best of my knowledge, was admonished not to
13 talk to his lawyer during a break in the testimony and he
14 testified, at least, once that he spoke with Mr. Davis
15 between his testimony yesterday and his testimony today
16 and as a result of that conversation, they presented a
17 totally -- well, not totally different, but, in my mind,
18 significantly different animation. And I just want to
19 call that to the Court's attention. Respectfully, I think
20 there's a similar provision for judges. I don't want to
21 make a judgment on that. I mean, I certainly have --

22 THE COURT: Putting Dr. Miller aside, I mean, the
23 reporting obligation is to the attorney's conduct. And I
24 understand that -- are you alleging that Mr. Davis did
25 something improper?

1 MR. GRAHAM: The last thing I want to do is accuse
2 Mr. Davis of anything. I don't know precisely what
3 transpired. All I know is that his client testified under
4 oath that he had a discussion with Mr. Davis that was, at
5 least, not terminated by Mr. Davis before enough
6 substantive information was provided that led to a
7 materially different animation being played today. And
8 when I say materially different, I'm talking about from my
9 point of view as a Plaintiff's advocate. I would just as
10 soon not have uttered these words, but I'm concerned that
11 I might be violating the Code of Professional Conduct
12 myself if I don't. It puts me in an awkward position, but
13 there's a record of these things. And I just mention that
14 to the Court, you know, with no animosity or disregard.
15 It's just an awkward situation where I feel obligated to
16 do something I'm uncomfortable doing.

17 THE COURT: I appreciate that. Based on what Dr.
18 Miller says, it seems like he did what he thought was
19 right. So let's just clear it up. Dr. Miller, if you
20 don't mind taking the stand really briefly just on this
21 issue. I'm just going to ask you about --

22 DR. MILLER: Do I need to be sworn in again?

23 THE COURT: No, sir, you're still under oath. You
24 can have a seat. Dr. Miller, just tell us how you came to
25 have a conversation with Mr. Davis or Mr. Traylor

1 yesterday about the video.

2 DR. MILLER: This morning, I just mentioned that I
3 thought they showed the wrong video, that's all I said.

4 THE COURT: Did you have any other conversation with
5 Mr. Davis about your testimony?

6 DR. MILLER: No, no, no, sir.

7 THE COURT: I'm satisfied -- Mr. Graham, is there
8 anything you'd like me to ask?

9 MR. GRAHAM: No, Your Honor. I just appreciate Your
10 Honor's ruling so that I can rely on that and not be
11 obligated to take any steps that would be unpleasant.

12 THE COURT: I understand. Mr. Davis, is there
13 anything you'd like me to ask for the record?

14 MR. DAVIS: No, sir, but I'd like to make statement
15 since I'm the one who has become the center of this recent
16 storm. I will make it very clear, as I did to the Court
17 this morning, that it came to my attention last night
18 after court was over in the courtroom that we had played
19 the wrong video. It wasn't Dr. Miller that told me that
20 yesterday. And I brought that to the Court's attention
21 and then Mr. Graham's attention prior to us going on the
22 record. So I've had no conversation with my client about
23 any of his testimony while he's been on the witness stand
24 at any time. He mentioned to me I think you played the
25 wrong video and I did tell him, I said, we found that out

1 yesterday when we finished. That's the extent of it.

2 THE COURT: Thank you, Mr. Davis. Thank you, Dr.
3 Miller. You can step down. The Court is satisfied --
4 Yes, sir, Mr. Graham?

5 MR. GRAHAM: I'd just like to put one thing on the
6 record, Your Honor.

7 THE COURT: Yes, sir.

8 MR. GRAHAM: I just turned to Mr. Davis and said as
9 far as I'm concerned, it's over. He looked at me with a
10 sharp tone and said as far as I'm concerned, it's not
11 over. I'd just like to put that on the record. It
12 surprised me, but I think it could be important.

13 THE COURT: Counsel, let's not get into this.

14 MR. DAVIS: Your Honor, I've never been called out by
15 any attorney in 40 years of practice and I resent it. I
16 need to have that on the record, too.

17 THE COURT: Counsel, I appreciate this is a heated
18 trial, but in the Court's opinion -- I appreciate you
19 bringing this to my attention. The Court is satisfied
20 that Dr. Miller did what he believed to be right, that Mr.
21 Davis had already noticed the issue and there was no
22 conversation -- the extent of the conversation was Dr.
23 Miller saying I think we played the wrong video. I don't
24 see any violation of the Rules of Professional Conduct.

25 MR. GRAHAM: And as I said, Your Honor, I appreciate

1 that ruling just to clear up any ambiguity about whether
2 there are any ethical responsibilities on my part.

3 THE COURT: Yes, sir, I appreciate that. Mr. Davis,
4 anything we need to take up before we bring the jury back
5 in?

6 MR. DAVIS: No, sir.

7 THE COURT: Okay. Let's bring them in.

8 (WHEREUPON, the jury enters the courtroom at
9 approximately 11:11 a.m.)

10 THE COURT: Mr. Davis, call your next witness.

11 MR. DAVIS: We'd like to call Dr. Suneet Chauhan.

12 THE COURT: All right.

13 THE CLERK: Please your left hand on the Bible and
14 raise your right.

15 Dr. Suneet Chauhan, being
16 first duly sworn, testified as follows:

17 THE CLERK: Thank you, please be seated.

18 THE WITNESS: Thank you.

19 MR. DAVIS: You may take your mask off, please, sir.

20 DIRECT EXAMINATION

21 BY MR. DAVIS:

22 Q Dr. Chauhan, would you please introduce yourself to
23 the jury, please, sir.

24 A My name is Suneet, S-U-N-E-E-T, middle initial P,
25 last name Chauhan, C-H-A-U-H-A-N.

1 Q Would you just give the jury just a brief overview of
2 your educational background as a medical doctor?

3 A I went to medical school at Thomas Jefferson in
4 Philadelphia, after which I was in the Navy on Navy
5 scholarship. I did my internship at Portsmouth Naval
6 Hospital in Virginia. Subsequently, I was assigned to
7 Camp Lejeune with the Marine Corp, where I served infantry
8 for two years. I returned back to Portsmouth Naval
9 Hospital to complete my three years of training in OBGYN
10 residency. And, subsequently, I did two-year of
11 fellowship in Mississippi, Jackson, Mississippi focusing
12 just on high risk pregnancy.

13 Q Are you board certified in any particular field of
14 medicine?

15 A Yes, sir. I'm board certified in general OBGYN and
16 emphasis or focus on high risk pregnancy or maternal fetal
17 medicine is the official name of our subspecialty.

18 Q Let me ask you some other background questions about
19 your job experience and things you've done. I've got your
20 50-something page CV. I'm not going to go over every
21 page, I promise. You've been an assistant professor at
22 the University of Illinois College of Medicine in Peoria,
23 Illinois?

24 A Yes, sir.

25 Q Assistant professor at the Medical College of Georgia

1 in Augusta, Georgia?

2 A Yes, sir.

3 Q Director of OBGYN ultrasound and antenatal fetal
4 testing laboratories?

5 A Yes, sir.

6 Q Director of fetal -- maternal fetal medicine in
7 Spartanburg, South Carolina at Spartanburg Regional
8 Medical Center?

9 A Yes, sir.

10 Q How long were you in Spartanburg?

11 A Seven years, sir.

12 Q You were licensed in the State of South Carolina at
13 that time?

14 A Yes, I was.

15 Q Currently, there are several states that you have
16 held licenses in. What are those states, if you remember?

17 A I believe I do, sir. I think the very first one was
18 in North Carolina, Mississippi, Illinois, South Carolina,
19 Wisconsin, Virginia and, currently, in Texas.

20 Q And your current licenses are where?

21 A Only in Texas, sir.

22 Q All right. Director of maternal fetal medicine
23 fellowship at the Eastern Virginia Medical School, is that
24 in Norfolk, Virginia?

25 A Yes, sir.

1 Q Professor at the University of Texas Health Science
2 Center at Houston, Texas currently?

3 A Yes, sir.

4 Q Adjunct professor Department of Bioengineering, Rice
5 University, is that in Houston?

6 A Yes, sir.

7 Q What's that about?

8 A So Rice University in Houston, Texas is one of the
9 more famous ones. They approached me about doing clinical
10 research, not only in Africa, but also in America. And my
11 focus, because they were bioengineering, had to do with
12 shoulder dystocia in measuring the force applied during
13 normal delivery. So it's a collaboration in doing
14 research both in Houston and in Malawi, Africa.

15 Q Couple things that peaked my interest as I was
16 reading through here. Combat casualty care core, San
17 Antonio, Texas, jungle operations readiness training in
18 United States operations both in 1984. What was that
19 about?

20 A As part of serving the Marine Corp at Camp Lejeune,
21 we were sent to San Antonio on how to prevent and manage
22 casualty in time of war. Jungle operation readiness was
23 when Marines are deployed or if they go for technical war
24 in a jungle how to be prepared from my point of view, from
25 medical-related casualty in a jungle as compared to some

1 other place.

2 Q How long were you on active duty in the Navy?

3 A Eight years, six months, 17 and a half days.

4 Q In 1992, you obtained the rank of lieutenant
5 commander United States Naval Reserve Medical Corp; is
6 that right?

7 A Yes, sir.

8 Q Is that -- in Army terms or military terms, is that
9 an 04 or 05, I can't remember?

10 A 04, sir. Medical major in Army, sir.

11 Q Major, all right, sir. Thank you. Some of your
12 professional experience, not all of it, but Italian
13 surgeon second Marine division, Italian surgeon third
14 Marine division, Italian surgeon second Marine division,
15 Camp Lejeune, U. S. Navy Hospital, Department of
16 Obstetrics and Gynecology in Naples, Italy. Tell me about
17 that.

18 A So once I finished my training as in general OBGYN in
19 Portsmouth, Virginia, I spent two years in Naples, Italy
20 taking care of active duty and people who were stationed
21 in Europe, their dependent or members of NATO, so British,
22 Greek and their members. So anyone who was pregnant in
23 the area of Naples, Italy, I took care of both OB and GYN
24 problems.

25 Q I will not go over all your awards, but a couple I

1 want to highlight and ask you about. One is the best oral
2 presentation at the American College of Obstetrics and
3 Gynecology District Four annual meeting, Norfolk,
4 Virginia, 1997. And it's entitled Clinical and
5 Sonographic Estimate of Uterine Weight. Do you remember
6 that?

7 A Yes, sir.

8 Q Second prize in Richmond County Medical Society's
9 Resident Research Award competition entitled Clinical and
10 Sonographic Estimate of Uterine Weight, 1998. What were
11 those about?

12 A So before we do hysterectomy, we would like to know
13 how much the uterus weighs when not pregnant. So with
14 ultrasound, we can measure the uterus and we were trying
15 to come up with a mathematical formula based on simple
16 ultrasound measurement of the uterus after you take it out
17 during a GYN surgery, what would be the actual weight. It
18 can help guide clinicians on the route and what to expect
19 during hysterectomy.

20 Q Another one, Riselback (ph) Distinguish Paper in
21 2007, Scientific Day for Aurora Healthcare entitled
22 Shoulder Dystocia With and Without Brachial Plexus Injury,
23 experience from three centers. What was that about?

24 A One of the things in science we like to know is not
25 just what happens in your hospital, but what happens in

1 different hospitals. The more hospitals you can gather,
2 the more generalizable the answer is. So we were one of
3 the first ones to get experience with shoulder dystocia in
4 Spartanburg, Jackson, Mississippi and Arkansas where we
5 looked at shoulder dystocia and what happens with shoulder
6 dystocia at three center. I think it was because it was a
7 multi-center study on the topic, which hadn't been done
8 until then to my knowledge, was one of the reasons we were
9 given that award.

10 Q 2013, award for best poster at the Central
11 Association of Obstetric and Gynecology 80th annual
12 meeting at Napa, California, neonatal brachial plexus
13 injury with cesarean delivery, a case controlled study.
14 What was that about?

15 A So though some people have reported, we have, by now,
16 I think the largest case series that you can get brachial
17 plexus palsy or an injury to one of the nerves going down
18 your right or left arm in absence of shoulder dystocia.
19 So it was a report on women who undergo C-section and
20 their children have brachial plexus palsy was the focus of
21 that study.

22 Q You have listed consultant. You're a consultant for
23 -- and there's things listed here and I want you to
24 explain what these are, obstetrics and gynecology, the
25 Journal of Maternal Fetal Medicine, the Journal of

1 Perinatology and the American Association of Obstetrics
2 and Gynecology. What are those things that you list
3 there?

4 A So this is what we call peer-reviewed journals. So
5 when I or anyone submits a manuscript, it goes to, let's
6 say, three to five reviewers, at least, one of them has
7 published on it. And they anonymously comment about the
8 merit. Then we, as a consultant, help decide what ought
9 to be published or not published in the journals listed.
10 So I consult about the publication on OB or high risk
11 pregnancy peer-reviewed article.

12 Q I left a few of those out, the Journal of
13 Reproductive Medicine, the Journal of Post-Graduate
14 Medicine, and the British Journal of Obstetrics and
15 Gynecology, you're consultants for all of those?

16 A Yes, sir.

17 Q What is an editorial board for or something like the
18 Journal of Maternal Fetal and Neonatal Medicine or the
19 British Journal of Obstetrics and Gynecology? What's an
20 editorial board?

21 A So let's say there are -- I'm making up this
22 approximate number, there are like 200 reviewers and you
23 manage them. Editorial board is like the board of those
24 professions, so there are about eight or ten of us who
25 decide not only what happens day-to-day, but the policy

1 and long-term way to go. So it's the next level above
2 just managing an individual article. It's looking at the
3 policy and the overview and what we should be doing in
4 publications.

5 Q For me, could you just pull yourself a little bit
6 closer to the microphone?

7 A I'm sorry.

8 Q It's just my ears.

9 A The chair doesn't move, sir.

10 Q Oh, I'm sorry. Thank you. You have listed
11 publications, 280 abstracts. What's an abstract?

12 A Abstracts, when you want to present something, you
13 write -- we usually allow anywhere from 250 words to 800
14 words, which is a summary of your finding. It goes to
15 several judges based on what you have summarized. We call
16 it the Cliff Note version of your research. They review
17 it and then they give thumbs up or thumbs down on whether
18 it should be presented or not. So it's like a Cliff Note
19 version of the research you have done.

20 Q I understand that this CV that I have is dated 2018
21 when your deposition was taken in this case, but the next
22 item on your CV are journal articles. What's a journal
23 article, sir?

24 A Sir, journal article, as I was mentioning being
25 consultant, those are so now you have taken the Cliff

1 Notes, you have expanded to anywhere on average, I would
2 say, ten to 15 double-spaced typed referenced articles,
3 tables, figures and then you submit it to the journal.
4 The editor will send it out to three to five people. They
5 will opine on the merit, whether it's worth publishing or
6 reject, that's the first decision. If accept, make the
7 following ten, 15, sometimes 20 changes times three
8 reviewers, so sometimes, you can get anywhere from 10, 20
9 to 60 suggestions. You resubmit it and then it gets
10 published in a peer review. That's the peer review
11 process.

12 Q Some of those include the American Journal of
13 Obstetrics and Gynecology, the Journal of Reproductive
14 Medicine, the New England Journal of Medicine, the Journal
15 of Perinatology, the Journal of Maternal Fetal Medicine
16 and there are others. How many are there today, sir?

17 A 419 as of yesterday.

18 Q Thank you. Also, you've written book chapters in
19 medical books?

20 A Yes, sir.

21 Q How many?

22 A I think it's approximately 30, in the neighborhood of
23 30, sir.

24 Q One of the things listed is workshop member of the
25 American College of Obstetricians and Gynecologists

1 Neonatal Brachial Plexus Palsy, Washington, D.C., American
2 College of Obstetrics and Gynecology 2014. Tell me about
3 that.

4 A So when I was in Virginia, we get an invitation that
5 ACOG, that's our national society for all OBGYN, about
6 50,000 members, that they are going to convene a focus
7 group, which would be more than the usual articles on
8 topics, I think they've convened, at least, two that I'm
9 aware of. In this one, it was on brachial plexus palsy.
10 I got invited to be one of the members, which convened in
11 Washington. Then we went home, wrote out assignment, then
12 we reconvened, I think three times and extensively edited,
13 let's say 12 to 14 chapters is what my involvement was.

14 Q How long did that workshop go on with the American
15 College of Obstetrics and Gynecologists?

16 A My approximation is about 18 months to 24 months. It
17 was one of the more extensive involvements.

18 Q You're the number two doctor listed on this. I'm
19 holding up the Neonatal Brachial Plexus policy published
20 by the American College of Obstetricians and
21 Gynecologists. This is what you were talking about?

22 A Yes, sir.

23 Q What is the American College of Obstetricians and
24 Gynecologists, sir?

25 A It's a national organization, which we start getting

1 involved with when we are a resident and they give our
2 written and oral examination. And then we become member
3 of ACOG. What I like about it is the educational aspect
4 of it. It keeps every clinician up to date on any major
5 publication. It could be hypertension twin. It can be on
6 GYN. I don't read them, but anything that has to do with
7 OB, they have an opinion or a guideline or practice
8 bulletin, we call it, and, infrequently, a monograph like
9 on brachial plexus palsy.

10 Q Chapters in this work, according to the contents,
11 Chapter 1, Incidents of Neonatal Brachial Plexus Palsy.
12 Chapter 2, Risks and Predictive Factors. Chapter 3,
13 Pathophysiology and Causation. Chapter 4, Neonatal
14 Brachial Plexus Palsy and Shoulder Dystocia. Number 5,
15 Chapter 5, Anatomy and Clinical Presentation of Neonatal
16 Brachial Plexus Palsy. Chapter 6, Patterns of Neonatal
17 Brachial Plexus Palsy and Outcomes. Did I read that
18 correctly?

19 A Yes, sir.

20 Q 18 months to 24 months, you guys worked on this?

21 A Affirmative.

22 Q Do you have an opinion whether or not this
23 constitutes junk science, sir?

24 A I say with respect anyone who thinks that hasn't
25 spent time either writing or gathering the data. Even to

1 this date, so let's say now it's seven years, I'm not
2 aware of any major publication which would have been the
3 thought process on brachial plexus. At that time, we
4 literally read everything written in English language we
5 and others have published, there's no major finding which
6 will change the conclusion of that. It may modify it or
7 add additional reference, it still stands alone as the
8 best work on that topic anywhere in the English language.

9 Q Thank you, sir. Explain to the jury some of your
10 current responsibilities, sir.

11 A Starting in September, I was promoted to be what we
12 call the director of maternal fetal medicine. So we
13 practice at eight hospitals in Houston. There are 18
14 maternal fetal medicine subspecialists. I manage all 18
15 of them. And in the eight hospitals, we deliver about
16 25,000 deliveries in a year approximately, in the ballpark
17 of 25,000. So my job is to make those eight labor and
18 delivery with 25,000 deliveries run smoothly, both in
19 terms of schedule, policies and anything that involves
20 having those deliveries being done.

21 Q Doctor, how many deliveries have you done?

22 A My estimate is north of about 10,000.

23 MR. DAVIS: Your Honor, I would offer Dr. Chauhan as
24 an expert in OBGYN and maternal fetal medicine.

25 THE COURT: Any objection, Mr. Graham?

1 MR. GRAHAM: I have no questions at this time, Your
2 Honor.

3 THE COURT: Ladies and gentlemen, as we've talked
4 about before, Dr. Chauhan is qualified as an expert in the
5 fields of obstetrics and gynecology and maternal fetal
6 medicine. Again, that does not mean you have to believe
7 his testimony. You should consider his testimony like
8 every other witness. It does permit him to give his
9 opinion, which witnesses are not normally allowed to do.

10 BY MR. DAVIS:

11 Q Dr. Chauhan, as we begin, can we have an agreement
12 that your opinions that you're going to give the jury
13 today when I ask about an opinion will be within a
14 reasonable degree of medical certainty unless you tell me
15 otherwise, sir?

16 A Yes, sir.

17 Q Thank you, sir. Are you familiar with any
18 publications or studies involving a neurosurgeon in
19 Michigan regarding brachial plexus palsy?

20 A Yes, sir.

21 Q Tell me about that.

22 A So we were at the meeting and I asked a question and
23 everyone dismissed me or I say laughed at my simple
24 question. Dr. Yang, who is a neurosurgeon, came up to me
25 during the break and she goes, you know, I'm Dr. Yang --

1 MR. GRAHAM: Objection, Your Honor.

2 THE COURT: I'm going to sustain the objection.

3 BY MR. DAVIS:

4 Q Doctor, you're not a lawyer. Technically, that's
5 hearsay. So just say as a result of your conversation
6 with Dr. Yang, is it?

7 A Dr. Yang.

8 Q What, if anything, did you do?

9 A So we have reviewed her chart of neurosurgery as well
10 as the OB chart and we have now, I think time I estimated,
11 I would say, at least, five or seven publications where we
12 have looked at neurosurgeon's note during surgery and even
13 OB notes and published on that.

14 Q How many publications have you been involved in in
15 the area of -- on the topic of brachial plexus injury or
16 brachial plexus palsy and/or shoulder dystocia, sir?

17 A Sometimes a paper can be both on shoulder dystocia
18 and brachial plexus, but if you put entity together, I
19 would say approximately north of, at least, 50 different
20 peer-reviewed publications over the last 20 years.

21 Q That's 5-0, 50?

22 A Yes, sir, 5-0.

23 Q Doctor, do you have an opinion whether or not one can
24 -- a baby can suffer a brachial plexus palsy without
25 shoulder dystocia?

1 A Yes, absolutely, it can.

2 Q What's the basis of that opinion, sir?

3 A In science, you need multiple line of reasoning to
4 come to similar conclusion, to come up with conclusion.
5 So one is, as we said previously, it can happen with a
6 C-section. So C-section is a cut above your bladder or
7 your bladder bone and you take the baby out through the
8 abdomen, so there's no way the shoulder got stuck. So
9 that's one line of reasoning. The second line of
10 reasoning is multiple authors, not only from America, but
11 from other country, including the very first report that
12 I'm aware of was in Libya, in Saudi Arabia, Netherlands,
13 England, everyone has said if they have ten cases of
14 brachial plexus, approximately four to five of them have
15 no documentations. So it's not just I say, but it's
16 different people in different countries coming to same
17 estimate four to five out of ten do not have shoulder
18 dystocia. The third one is what is consistent in
19 different countries is if you -- any hospital has 10,000
20 deliveries, there's about one or two brachial plexus
21 palsy, which is persistent.

22 Q And when you say persistent, we've heard the term in
23 this lawsuit permanent, does that mean the same thing?

24 A Yes, we use that interchangeably. It means that
25 beyond one year of life, there is an injury or inability

1 to move one of the arms.

2 Q Thank you, sir. Doctor, in this case, would you give
3 the jury sort of an overview of the materials, records,
4 depositions that you reviewed that helped to form the
5 basis of any opinions in this case concerning the care of
6 Dr. Miller in addition to your training, your experience,
7 your knowledge as an OBGYN and maternal fetal medicine
8 specialist, sir?

9 A So usually I start with the complaint and then I
10 chronologically just go from the OB's record from, let's
11 say, prenatal visit all the way to the actual delivery
12 process or being admitted into the hospital, the actual
13 delivery note, any major outcome noted in the nursery,
14 then fast forward five years, ten years. So the notes
15 from first visit with this pregnancy to as late as the
16 medical record I can get. Granted, my review of
17 (inaudible) record is summary than any understanding with
18 my focus being pregnancy and in this case, delivery. I
19 have also read the deposition of Dr. Miller. I've read
20 the deposition of the mother. I've read the deposition of
21 experts on our side as well as the experts on the other
22 side.

23 Q Thank you. Doctor, what are your opinions, sort of
24 in an overview fashion, and we'll drill down into the
25 bases of any opinions you render, but as an overview,

1 would you give the jury your opinions in this case as to
2 whether or not you have an opinion whether or not Dr.
3 Miller met or fell below the standard of care in his care
4 and treatment of Angela Patton, the mom, and the delivery
5 of the baby, Alexia, sir?

6 A I'm not trying to throw superlative, but I would
7 actually say exceeded the standard of care in the actual
8 delivery. So I'm just looking at the delivery, not the
9 outcome. One can have a bad outcome with bad management.
10 One can have a good outcome. This was managed, I would
11 say, exceedingly well overall in the decision not to do a
12 C-section, to proceed with vaginal delivery in the OR and
13 the actual management of shoulder dystocia.

14 Q Is there recognized -- in your experience, in your
15 writing, in your research literature among your
16 colleagues, is there such thing as a posterior shoulder
17 dystocia?

18 A Yes, though it happens infrequently. So posterior is
19 what is to the floor, in this case, left to the floor or
20 tailbone, the backbone, and anterior is towards the head
21 or what we call the bladder bone to keep it simple. So
22 bladder bone is anterior, the tailbone is the posterior.
23 Yes, that is a recognized, well-accepted, peer-reviewed
24 published entity.

25 Q I want to ask you about something called causation.

1 What word do you prefer to use, sir?

2 A Since being part of the monogram and I've taught
3 about it, I prefer the word association, meaning they
4 travel together, though, they may not be causing. Now, we
5 can split hair. In the monogram, it's clearly as you
6 stated, sir, there's a chapter called causation. I have
7 backed away from the word causation in our writing and
8 have consistently used the word association.

9 Q In your opinion, was this a difficult delivery?

10 A Yes.

11 Q What made it difficult in your opinion?

12 A So one way to describe a shoulder dystocia is how
13 many maneuvers did it take or how many steps did you take
14 to resolve the shoulder which was stuck, is one criteria.
15 The second one that affected was the posterior shoulder,
16 which is the uncommon one, are the two factors what makes
17 this a difficult shoulder dystocia.

18 Q Can you see this, sir? I've got it in evidence and
19 I'm happy to give you a smaller copy in your hand if you'd
20 like.

21 A No, sir, I can read it from here.

22 Q I would ask you to assume for the sake of my question
23 this is a transcript of the handwritten delivery note of
24 Dr. Miller. This has already been introduced into
25 evidence. For the record, it's Exhibit No. 3. We also

1 have the handwritten note -- you've read the handwritten
2 note?

3 A Yes, sir.

4 Q I will ask you to assume for the sake of my question
5 that this is a word-for-word transcription of his
6 handwritten note. And you've seen the handwritten note?

7 A Yes, sir.

8 Q Let me ask you about this, in your opinion, is the
9 information contained on this note an appropriate amount
10 of information to document a delivery, sir?

11 A Please forgive me, but I grade things. I would
12 consider that to be a B plus.

13 Q Not an A?

14 A With respect, no, sir.

15 Q Not an F?

16 A Oh, absolutely not. Far from it, sir.

17 Q Reading the second paragraph, if you would, I know
18 you read it before, just read it to yourself and let me
19 ask you a question about it just briefly. Let me do this.

20 A No, I can read it.

21 Q I know, but I'm --

22 A Thank you, sir. I've read the note, sir.

23 Q Have you also read the deposition testimony of Dr.
24 Miller in -- I think it was taken in 2011. You read that
25 whole deposition as well?

1 A Yes, sir.

2 Q Do you recall from his deposition testimony and --
3 well, just his deposition testimony under oath where he
4 described and explained what he meant by moderate effort,
5 sir?

6 A Yes, sir.

7 Q What did you understand him to mean either from his
8 deposition or just from reading the note?

9 A So moderate effort is a reasonable and a candid
10 admission of what you did. So that to me is not a red
11 herring. In my mind, I don't circle in red. The second
12 thing in the deposition, my recall is what he said was he
13 wasn't going to the extreme, that he needed additional
14 maneuvers and things than gentle traction to resolve the
15 shoulder dystocia. And I accept that to be within the
16 standard of care.

17 Q Doctor, when we see the word moderate effort in Dr.
18 Miller's sworn explanation of what he meant when he wrote
19 that note shortly after the birth on April 5, 2007, is it
20 fair for us to read traction, excessive traction?

21 A No, absolutely not. That's putting words in people's
22 mouth.

23 Q Explain to the jury what you understand from his
24 testimony that you reviewed, his sworn testimony back from
25 2011 and his notes, other records in the case, what you

1 understand happened in this delivery once the shoulder
2 dystocia was determined.

3 A So once the shoulder dystocia -- so with gentle
4 traction -- forgive my use of hand, with gentle traction
5 that came out and with gentle traction, the anterior
6 shoulder was not delivered. So he informed the other
7 clinicians, McRoberts is taking the knees of the mother to
8 the back, was done, which increases the distance to
9 relieve the anterior shoulder. A nurse pushed from the
10 top trying to get the shoulder to come below the pubic
11 bone. That did not work. Then an episiotomy extending
12 the distance -- I don't mean to be graphic -- from the end
13 of the perineum to the rectum, hoping to drop the
14 shoulder. He tried to take the posterior arm, which in
15 this case was the left, pull it out, that did not work.
16 Then the next maneuver is rotate the baby. He rotated the
17 baby and then what was stuck, the right arm became the --
18 the left arm went to the top, the right arm came down and
19 then he was able to deliver the baby after he rotated the
20 baby. So if I'm counting it correctly, that's, at least,
21 four maneuvers that he did to relieve the shoulder
22 dystocia.

23 Q In his note, he says when the head delivered, it
24 delivered LOP. Tell the jury what that means.

25 A So you're looking at the mother, so this is the

1 mother's left occiput posterior, so the head is kind of
2 looking this way. So the anterior shoulder is up, the
3 left shoulder of the fetus is towards the floor or the
4 backbone.

5 Q After his rotational maneuver, it says woodscrew
6 maneuver performed and rotation of 180 degrees occurred to
7 ROA. What's happening here? What's he saying?

8 A So now, it's the other way around. Now, it's on the
9 right side of the mother and the left, which was towards
10 the floor or the backbone, is now up.

11 Q When a woodscrew or modified Rubin's is performed, is
12 it appropriate to turn the baby 180 degrees?

13 A Oh, absolutely, if need be, yes.

14 Q That's not below the standard of care?

15 A No.

16 Q When the woodscrew maneuver is performed, Dr. Chauhan
17 -- have you ever done that?

18 A Yes.

19 Q As the baby is turned and rotated, how does the baby
20 get dislodged? What happens to the baby's body, head?
21 What's going on?

22 A So in this case, the right shoulder is stuck -- to
23 me, this is the bladder bone or symphysis. When you
24 rotate it, it just comes underneath it. So it's like when
25 you're moving furniture and you just tilt the furniture or

1 the table and it just passes through. That's the way I
2 envision it in my mind.

3 Q Were you able to prior to taking the stand today
4 review an animation that was prepared for trial purposes?

5 A Yes, sir.

6 Q We showed that to you?

7 A Yes, sir.

8 Q Tell me what you think about the animation. Was it
9 an accurate depiction of a woodscrew maneuver or a
10 modified Rubin's --

11 MR. GRAHAM: Objection, Your Honor. Could we get him
12 to clarify whether he's talking about the earlier
13 animation or the later animation.

14 MR. DAVIS: That's a great question. It was the
15 later one.

16 BY MR. DAVIS:

17 Q Do you know whether there was a first revision and
18 then a final revision?

19 A Yes, but the maneuvers itself were accurately
20 depicted.

21 Q On the very last one you saw?

22 A Yes, sir.

23 MR. DAVIS: Would it be permissible to show that to
24 him again?

25 THE COURT: Yes. Any objection, Mr. Graham?

1 MR. GRAHAM: No, sir.

2 THE COURT: Okay.

3 BY MR. DAVIS:

4 Q As we play this, Dr. Chauhan, if you need to pause to
5 make comments or if I have a question, I'll ask Drew to
6 pause it. Just let us know and we'll pause it, okay?

7 A Yes, sir.

8 (WHEREUPON, video animation is played.)

9 THE WITNESS: May I pause it, please?

10 MR. DAVIS: Pause it.

11 THE WITNESS: So there are two distinct, even though
12 it may seem different, one is -- it doesn't matter which
13 color one chooses. One is the actual contractions. So
14 the uterus muscle is literally pushing the baby down. The
15 other one is the mother is pushing. So it's two different
16 forces. So two different forces acting from all sides of
17 the womb -- or the uterus is pushing this baby, which
18 weighs over nine pounds by Mother Nature. So that's one
19 thing I wanted to share with you. Go ahead, please.

20 MR. GRAHAM: Your Honor, may we approach?

21 THE COURT: You may.

22 (WHEREUPON, a bench conference was held in the
23 presence of the jury, but outside the hearing of the
24 jury.)

25 THE COURT: Yes, sir, Mr. Davis.

1 MR. DAVIS: Thank you, Your Honor.

2 BY MR. DAVIS:

3 Q Dr. Chauhan, do you have an opinion about whether or
4 not there was a posterior shoulder injury in this case?

5 A Yes, I do.

6 Q Do you have an opinion as to whether or not a
7 posterior shoulder injury can cause a permanent brachial
8 plexus injury?

9 A Yes.

10 MR. DAVIS: I don't know what else I need to ask him.

11 THE COURT: Then it's going to stop there?

12 MR. DAVIS: I mean, I could go on. I'm happy to do
13 that.

14 THE COURT: Let me hear from Mr. Graham. Mr. Graham,
15 what is the objection?

16 MR. GRAHAM: He hasn't been qualified as a causation
17 expert.

18 THE COURT: Mr. Graham, I may be misunderstanding the
19 law. I don't think experts are qualified in causation. I
20 mean, his field of expertise is maternal fetal medicine
21 and obstetrics and gynecology, which would include the
22 birth process. So I think -- how would he not -- I mean,
23 I'm not sure I'm following.

24 MR. GRAHAM: I understand your ruling.

25 THE COURT: Is there anything else you want to say?

1 MR. GRAHAM: No, Your Honor. I just got it on the
2 record. Let's bring the jury back in.

3 (WHEREUPON, the jury enters the courtroom at
4 approximately 11:54 a.m.)

5 THE COURT: Mr. Davis, you can continue.

6 MR. DAVIS: Thank you very much, Your Honor.

7 BY MR. DAVIS::

8 Q Dr. Chauhan, we're going to pull up that video again
9 and kind of go through it. I think this is where we
10 stopped, where we took a little break?

11 A Yes, sir.

12 (WHEREUPON, video animation is played.)

13 THE WITNESS: So as the mother and the contractions
14 are pushing, this is a -- these yellow lines going from
15 the neck to the shoulders are the brachial plexus. In the
16 back is the sacral promontory, the backbone, or the
17 prominence or the low protrusion. And the shoulder, the
18 left shoulder has gotten stuck on that. If we can go to
19 the next one, please -- or keep going.

20 (WHEREUPON, video animation is continued.)

21 THE WITNESS: So the mother is pushing and the
22 contractions and the head is going to keep descending even
23 though the left or the shoulder towards the back is stuck
24 against the promontory. Keep going, please.

25 (WHEREUPON, video animation is continued.)

1 THE WITNESS: And that's where the posterior or the
2 left shoulder injury occurs. It's more from the
3 contractions. As you notice, the head is not even out.
4 No clinician has seen the head come out, therefore, by
5 definition, shoulder dystocia cannot be diagnosed and it
6 happens before the emergence of the head. Keep going,
7 please.

8 (WHEREUPON, video animation is continued.)

9 THE WITNESS: And then the right shoulder or the up
10 -- so this little white thing above the head is what I
11 call the bladder bone or symphysis, so the right shoulder
12 is stuck behind that bone. Please keep going.

13 (WHEREUPON, video animation is continued.)

14 THE WITNESS: So the doctor then comes and axial
15 traction is in almost a straight line. So the straight
16 line brings the head out hoping for the baby to come out.
17 And now, because the baby hasn't come out with straight
18 line and gentle traction, that's when at this moment, the
19 doctor for the first time recognizes that the shoulder is
20 stuck, not knowing that the left shoulder had already been
21 stuck at the backbone. So keep going, please.

22 (WHEREUPON, video animation is continued.)

23 THE WITNESS: Now, this is the first maneuver, so
24 shoulder dystocia was recognized, McRoberts. Here, we are
25 just showing the one leg, so this is the mother's left

1 leg. McRoberts is taking the knee and all that pushing
2 with the hope that the pubic bone moves up and gives room
3 for the anterior shoulder to drop and then deliver the
4 baby. So that's the McRoberts. Then a nurse or a
5 clinician -- so that's another second clinician, not the
6 doctor and nurse or another doctor in the room, pushes the
7 shoulder this way hoping to decrease the size and bring
8 the right shoulder under that bone or the bladder bone.

9 Q How often those two maneuvers initially in a shoulder
10 dystocia are they successful, the McRoberts and
11 suprapubic, in effecting a resolution of the shoulder
12 dystocia?

13 A I would say five to six out of ten. So if I have ten
14 children with dystocia, five to six, in that neighborhood,
15 just above 50 percent should relieve that. And that would
16 be two maneuver shoulder dystocia is how I describe it.

17 Q If those don't resolve the shoulder dystocia, what
18 does the standard of care dictate the doctor do?

19 A So we have, at least -- episiotomy is one, rotating
20 the baby is number two, extracting the posterior arm is
21 the third one, so that's a total of five maneuvers which
22 are the most commonly used in delivering the fetus if the
23 first two don't work. So those are the five things we do
24 most of the time.

25 Q Are all five of those things within the standard of

1 care to try to resolve a shoulder dystocia?

2 A Absolutely.

3 Q And before we go to the next frame, let me ask you
4 this, Dr. Chauhan, when the doctor first -- you, any
5 doctor first determines there is a shoulder dystocia, does
6 any doctor know how long it's going to take to deliver
7 that baby?

8 A I wish we did. We are not clairvoyant. We cannot --
9 no one, even mathematical modeling cannot tell based on
10 the facts known. Even after I put it into an equation or
11 something as to how long the shoulder dystocia would last.
12 It is absolutely unknown.

13 Q Thank you. Go ahead, please.

14 (WHEREUPON, video animation is continued.)

15 THE WITNESS: So this is episiotomy. And I know it
16 looks painful, so that's just extending the distance, was
17 cut by Dr. Miller. So among the remaining three he chose,
18 which is very reasonable, to reach inside and bring the
19 posterior or the left arm out, but he could not. And that
20 does happen. So you reach inside and try to bring the
21 left arm, and he could not. Now, this is the rotation --
22 they use names, I prefer just to describe it as rotation.
23 So you take part of the hand and then you rotate the baby,
24 so it's like, for lack of a better word, opening a cap on
25 the ketchup bottle, so you're rotating. And in this case,

1 he was able to do it almost 180 degrees. Now, the left
2 arm is at the top, the right arm is at the backbone or the
3 floor.

4 Q Dr. Chauhan, before we move to the next frame, have
5 you ever heard about, ever read about, ever seen in your
6 experience a 180-degree rotational maneuver taking the
7 posterior arm, making it anterior up and the rotational
8 maneuver causing the posterior now anterior to become
9 impacted, sir? Ever seen that, heard about it, read about
10 it?

11 A I've been doing it for, let's say, decades and I
12 don't -- forgive me if it sounds bragging, I think I've
13 read almost anything in English language on this topic.
14 I'm not aware of that. To me, that would be almost
15 unfathomable, that now the posterior -- so you have an
16 anterior shoulder, you rotate, now you get another
17 shoulder dystocia. It would be like somebody got hit by
18 lightening twice in a day, within a minute. I mean,
19 that's -- it has never been described in the English
20 language that I'm aware of.

21 Q Thank you, sir. Let's continue.

22 (WHEREUPON, video animation is continued.)

23 THE WITNESS: And once the shoulder is up, then the
24 hand just delivers the baby.

25 BY MR. DAVIS:

1 Q Thank you, sir. In your opinion, Dr. Chauhan, as a
2 delivering obstetrician, gynecologist, maternal fetal
3 medicine specialist with over 10,000 deliveries you've
4 been involved with, following a routine protocol to
5 resolve a shoulder dystocia, are you able to predict which
6 child will have a permanent brachial plexus injury?

7 A So we recently, within the last year or two, had two
8 of the largest series of over 1,000, in one case, 2,000
9 shoulder dystocia and an outcome on them. And with all
10 the math the statisticians have thrown every variable
11 known to us, including -- so this time, most publications
12 say what does the doctor know before the mother starts
13 pushing. I said let's forget that, what the doctor knows
14 within the five minute -- because we do five-minute
15 (inaudible), everything he/she knows if you put all those
16 variables in and put it in a mathematical complex model
17 would you know? And the simple answer is no. Even five
18 minutes after delivery, it is not feasible for any
19 variable that we can think of in the group using the
20 largest database from NIH under the study could we
21 determine which baby would have brachial plexus palsy, let
22 alone which baby would have brachial plexus palsy or
23 inability to move the arm a year later. It is not
24 possible as of today.

25 Q Dr. Chauhan, in your opinion, is shoulder dystocia

1 predictable or foreseeable?

2 A If I could predict it, I could literally go off into
3 the woods. I think my job would be done. It is
4 absolutely -- even when the mother is pushing and as
5 clairvoyant as one could be or as nerdy computer you want
6 to be, it is not possible to predict which mother would
7 have a delivery with shoulder dystocia, forget brachial
8 plexus palsy after birth and then a year later. It is
9 impossible to predict that.

10 Q In your opinion, does shoulder dystocia present
11 itself as an obstetrics emergency?

12 A To me, we call it obstetrics emergency. The other
13 word we have used is a sentinel event. When things are
14 going like this, certainly, I call it the floor drops off
15 and then you are in a free fall and you do the very best
16 to resolve the situation. Shoulder dystocia is absolutely
17 one of them.

18 Q Why?

19 A Because if not delivered, you have a real harm to the
20 child of having brachial plexus palsy is one of them,
21 brain damage and/or death, as in my case when I was a
22 resident, fracture of the neck and then death. Those are
23 real things that happen to clinicians in this country.

24 Q But, Doctor, don't babies have four or five minutes
25 before they suffer any anoxic injury, lack of oxygen to

1 the brain?

2 A First off, each baby is different. And you can't
3 assume this baby -- it would be like saying, you know,
4 this baby -- the house is burning, I'm going to leave the
5 baby for three or four minutes before I do anything. To
6 us, at the moment we think the shoulder is stuck, it's a
7 free fall and we do the best. We cannot assume that it
8 will be resolved. Old papers that said you had four to
9 five minutes are being revised. There are some reports
10 that it can happen sooner, but you cannot say well, I'll
11 wait for three and a half minutes before I do something.
12 So yes, in some older studies, three to four minutes
13 before brain damage, but that's not how you ought to
14 operate. That, to me, would be below the standard of
15 care.

16 Q Let me go back a moment. You read in the records --
17 do you still have his delivery note there, sir?

18 A Yes, sir.

19 Q I forgot my question. Hang on a second.

20 A Yes, sir.

21 Q How long did the medical records indicate it took Dr.
22 Miller to resolve this shoulder dystocia?

23 A So I read anywhere from 45 seconds, one minute or up
24 to two minutes is the range I have read.

25 Q In your opinion, was that an appropriate amount of

1 time to resolve a shoulder dystocia?

2 A Now, in retrospect, you can say two minutes is
3 nothing, but two minutes of shoulder dystocia from a
4 clinician's point of view is a fair amount of time. I
5 think considering the cord ph and everything else and the
6 number of maneuvers used to relieve the shoulder, I think
7 Dr. Miller did a very nice job of managing this shoulder
8 dystocia.

9 Q Before they went to the operating room, according to
10 his note in that first paragraph, the top paragraph, he
11 documents something about vacuum applied times one to help
12 facilitate delivery, however, would not hold effectively.
13 Let's talk about that a moment.

14 A Yes, sir.

15 Q What do you understand is happening here?

16 A You have to forgive me, imagine this is the head.
17 You can take a vacuum, for lack of better word, it's a
18 little cup and you can apply to the head and you create a
19 vacuum and you can pull the baby while the mother is
20 pushing down to help you because of the concern about
21 abnormal tracing. You're trying to shorten the duration
22 of pushing by bringing the head down or helping them move
23 along.

24 Q Doctor, do you have an opinion whether or not his
25 attempt to do the vacuum when he did prior to going to the

1 operating room was appropriate, inappropriate, within or
2 without the standard of care?

3 A To use vacuum because of bradycardia is a reasonable
4 thing, especially if you're experienced in the vacuum. We
5 call it abandon. You tried something hoping it would
6 work, abandoning vacuum or letting it go and not
7 persisting on it is also very reasonable and commendable.
8 So you tried something because of the concern about the
9 heart rate. There was no reason to think there would be a
10 shoulder dystocia, so it was a reasonable attempt -- so I
11 think it was a reasonable attempt, but what was definitely
12 admirable was abandoning it when it did not work after
13 first attempt.

14 Q He talks about it didn't attach. Does that happen
15 from time to time?

16 A Some days I go several times when it doesn't attach
17 or the vacuum doesn't work and I've had series where it
18 didn't and then it worked, so I would say in my personal
19 hand, and I've been doing vacuum/operative vaginal
20 delivery we call it since 1986. I mean, there are days
21 when -- or weeks and weeks when it goes beautifully and
22 then, like, hit a road bump and it doesn't three or four
23 times in a row. So, overall, I would estimate three out
24 of ten cases with me it does not work.

25 Q When he says he applied it one time to help

1 facilitate delivery one time, it would not hold
2 effectively, he testifies that he abandoned it, is that
3 appropriate?

4 A I think -- to know one's limitation is an admirable
5 quality in a clinician. So he attempted it because of
6 abnormal tracing, it did not work, he did not persist.
7 Sometimes we get focused and we make a decision and keep
8 repeating the same wrong thing. And he said no, I'm going
9 to the next thing and I think that shows his awareness,
10 situational awareness during this time when at that time,
11 there was abnormal tracing before. Vacuum had nothing to
12 do with the subsequent shoulder dystocia. The two are not
13 related. It had nothing to do with the brachial plexus
14 palsy. It was in response to abnormal heart rate.

15 Q Let's talk about that, abnormal heart rate. What are
16 you talking about?

17 A So during birth -- I call it baby's EKG. So we can
18 put an electrode either on the skin of the head or on the
19 mother's belly and it gives us an EKG, a continuous
20 monitoring. And we look for certain patterns. When the
21 heart rate drops below 110, we call it bradycardia. It's
22 like you would mean almost like in a movie, you know, the
23 heart rate stops and it's going down, down, down. And
24 that is a sign, a reasonable sign that the baby may not be
25 doing well with getting oxygenation. So at that time, we

1 make attempts to improve oxygenation and/or delivery if
2 she's pushing.

3 Q When the fetal monitor strips -- when the fetal
4 strips shows bradycardia or a low heart rate, is that a
5 direct or indirect way of measuring the oxygen level in
6 the brain of the baby?

7 A It's an indirect and the only way we know how to do
8 it during labor.

9 Q That's the only way that we know today?

10 A Even today, 2022.

11 Q When one encounters an extended bradycardia over
12 eight to ten minutes late in a labor, or at any time in a
13 labor, what, if anything, should the reasonably prudent
14 obstetric gynecologist do managing that delivery?

15 A So the national guidelines -- there's another
16 guideline on how to manage abnormal tracing. It says
17 expedite delivery based on your abilities, the situation,
18 what you know about the hospital and everything else. So
19 the word is expedite or move towards the delivery. It can
20 be by C-section, it can be by operative in this case,
21 vacuum or some other maneuver, but you move forward
22 expeditiously is the word to deliver the baby.

23 Q Dr. Chauhan, do you have an opinion whether or not it
24 would be appropriate for the physician managing the
25 delivery when he experiences an extended bradycardia that

1 raises some concern to him about the health, the safety
2 and welfare of that baby to encourage the mother to try to
3 push?

4 A Oh, absolutely. So once you're fully dilated and
5 head is coming down, the most expeditious or best way to
6 deliver is to deliver vaginally because to do a C-section
7 can take, even when you do it expeditiously, anywhere from
8 15, 20, 30 minutes. So vaginal delivery in someone who
9 has delivered before is probably the best way for the
10 mother and the baby.

11 Q And did you note from the records, Ms. Patton, the
12 last baby she delivered was nine pounds 11 ounces?

13 A That's my understanding and recall, sir.

14 Q And this baby turned out to be nine pounds six
15 ounces?

16 A Yes, sir.

17 Q All right, sir. When you say expeditious, does that
18 mean the doctor ought to be in a real hurry?

19 A No, you use clinical judgment and you do the best by
20 the mother and the fetus, but you move towards delivery in
21 the best judgment of your abilities, the patient, you have
22 to take the patient into con -- in this case, that she has
23 delivered before, I'm at this hospital, I've done vacuum,
24 C-section will take me additional minute. So you take all
25 that and use your clinical judgment to deliver as fast and

1 safety as possible.

2 Q Doctor, do you have an opinion whether or not it
3 would be appropriate for the obstetrician concerned about
4 an extended low heart rate of his delivering mom and that
5 baby to warn mom that she would need a C-section if the
6 effort to push did not improve, would that be appropriate?

7 A I think to say anything else would be inappropriate.
8 So if I've encountered, we call it the second stage when
9 you're pushing, a low rate, my plea to the patient would
10 be can we push harder to deliver the baby instead of doing
11 a C-section? That, to me, is the safest for both of them
12 majority of the time.

13 Q When the delivering physician makes a decision we
14 need to go do a C-section, what does the standard of care
15 require the reasonably prudent obstetrician do in the way
16 of informing his patient, the mom, about a C-section
17 before obtaining consent?

18 A So in situations like this, we have what we call
19 verbal consent. We need to do a C-section because the
20 heart rate is low. There are complications of C-sections,
21 but because the heart rate is low, we're going to proceed
22 with C-section. Complications include infection,
23 bleeding, damage to bladder, bowel and infrequently death
24 of the mother. So that would be what I would say and what
25 I have seen other clinicians say when you have a low heart

1 rate when the mother is pushing.

2 Q The note of Dr. Miller says, therefore, talking about
3 we need a C-section, still did not improve, therefore,
4 consent signed and patient taken to the operating room, is
5 that appropriate?

6 A I think it's more than appropriate. That's the way
7 it ought to have been done and it is done today.

8 Q Doctor, do you have an opinion whether or not it
9 would be appropriate for Dr. Miller himself to push his
10 patient in the bed that's she in the labor and delivery
11 room himself, push the bed or pull the bed to the
12 operating room?

13 A And I know this sounds like minutia, but often
14 clinicians say let's go and then they're doing other
15 things and not pushing. I think it's admirable that the
16 clinician himself or herself accompanies the patient from
17 the labor and delivery room to the operating room. It
18 shows to me a vested clinician or a caring clinician.

19 Q Would it be appropriate for the obstetrician to
20 notify neonatology to stand by?

21 A No, that's part of the things -- once you go down
22 that route, you have to call anesthesia, call the baby
23 doctor, call the OR tech and everyone has to congregate to
24 do the C-section.

25 Q Why a neonatologist?

1 A Because once the heart rate goes down, there's a
2 concern that the baby may be what we call depressed or not
3 get enough oxygen and may have difficulty and/or need
4 resuscitation to oxygenate the brain and other organs. So
5 that is just part of if this, then you do the following.
6 Anesthesia and neonatologist, OR tech, extra nurses, extra
7 assistance to help you assist with the surgery. That's
8 just part of what you do once you call an emergency
9 C-section.

10 Q We have the fetal monitor strips or a copy of them in
11 evidence. I'm happy to show them to you. Have you
12 reviewed those as well as part of your review in this
13 case?

14 A Yes, I have, sir.

15 Q When there are variable decelerations on the fetal
16 monitor strips, first of all, explain to the jury what
17 that is and what, in your opinion, can cause variable
18 decelerations?

19 A So I'm just going to imagine the heart rate is going
20 nicely at 120 and then it goes down like this, like a
21 U-shape, and then comes up or like a V-shaped variable and
22 then comes up. Those are called variable decels. The
23 thought process is let's say this is the sac where the
24 baby is, the cord which connects it when the contractions
25 or the pushing happens, this constricts the cord, what

1 supplies the blood. And it's the constriction of the
2 cord, presumably, with baby's response by decreasing. So
3 it's like someone uh, and your heart rate kind of goes
4 down is the way I look at it.

5 Q Did she have variable decelerations, sir, on her
6 strips?

7 A That's my recall.

8 Q Doctor, what is a head to body interval? What does
9 that mean?

10 A So I guess people have done it and we have published
11 on it. So once the head comes out, so not when you are
12 just seeing the top of the head, but let's say this much
13 of the head is out of the birth canal or vagina, that's
14 when time zero is. Once you see the feet, that's when you
15 stop the clock and that's head to body. Or the time
16 interval from the head emerging or when the doctor puts
17 the hand to the time when you see the feet coming out of
18 the mother's body, that's the head to body.

19 Q As best you could tell from the medical records in
20 this case, that head to body interval was anywhere from 45
21 seconds up to two minutes max?

22 A That's my understanding, yes, sir.

23 Q Doctor, is there any medical literature that you're
24 aware of that defines what excessive force is in the
25 delivery of an infant with shoulder dystocia?

1 A That's a very good question. So in the past or in
2 the laboratory setting -- when I say laboratory, either
3 with mannequins, people have come up with -- matter of
4 fact, the person who did it happened to work at the same
5 place where I am currently, so they put sensor gloves. So
6 they did that on mannequin and in limited number, they
7 have done it on actual human beings. So it's like, I call
8 it the NASA glove. But no one has ever done it outside
9 these two controlled settings. The reason I've been
10 working with Rice, one of the reasons is trying to come up
11 with a sensor, which I could put on top of my hand
12 underneath the glove and stand on this special platform,
13 which will detect the amount of force. I've done it now
14 for two and a half years before the COVID and it has not
15 taken off. We are having too many problems to measure
16 what is normal force where it can be objectively -- it's
17 like a weighing machine. Go back in time, we have not
18 come up with a weighing machine to measure how much it is
19 as of 2022. I'm not aware of anyone who has come up with
20 that, except the two exceptional cases which have been
21 reported upon, but no one has been able to duplicate that.
22 In science, one of the things, multiple group of people
23 should come to similar conclusion using the same thing.
24 That hasn't happened with that.

25 Q What about Dr. Gurewitsch? Are you familiar with her

1 research and publication, sir?

2 A Yes, I am with Dr. Gurewitsch, who now goes by name,
3 I think, Dr. Allen and her current husband, Dr. Allen. So
4 Dr. Allen, yes, I'm aware of those.

5 Q Do you have an opinion within a reasonable degree of
6 medical certainty whether or not Dr. Miller used 50 pounds
7 of traction on the head of this baby during any part of
8 this delivery, sir?

9 A I would say highly improbable. First of all, no one
10 has ever determined what is 50 pounds. That someone who
11 has been doing OB since 1993, all of a sudden, applies
12 excessive traction is just unfathomable to me. I mean, an
13 American-trained physician who is trained to deliver and
14 he has done, let's say, at least, 10,000 deliveries, all
15 of a sudden to apply excessive traction, to me, is
16 unimaginable.

17 Q How about lateral traction, inappropriate, more than
18 60 degrees of traction, did that happen in this case?

19 A No. There's no reason to think that it happened.

20 Q Why?

21 A I'll go back to the training in America, shoulder
22 dystocia is one of the emergencies, starting as if you're
23 a fourth-year medical student going into OB, that's just
24 something that is, and I mean it, drilled into us. This
25 is one of the emergencies you need to know. It's like

1 teaching someone how to do CPR. I'm sure everyone here
2 knows about chest compression and if we taught it to you,
3 you can do it. Now, imagine you're doing CPR everyday,
4 you've done it for 20 years. All of a sudden, you went
5 out of your way to push so hard, which you have never done
6 before. To me, managing shoulder dystocia is akin to
7 doing CPR for a person who has been trained and taught
8 about doing this on a daily basis. To me, it's just
9 unimaginable.

10 Q Dr. Chauhan, in your opinion, however one may want to
11 define excessive force, more than the appropriate amount
12 of force, if I might use that term, in your opinion, can
13 that always be determined by the nature or extent of the
14 injury, sir?

15 A No. And I say that with most deference to my
16 colleagues who believe in that. You cannot be omnipresent
17 and be everywhere and have the clairvoyant thinking that I
18 know this is the only way it can happen because I think
19 so. If you really believe in science, you have to connect
20 the dot and show me how it can be done or how it was done,
21 how did you assess it? If you what you say is true, then
22 I, independent of you, have done it now and being
23 literally involved on labor and delivery on a daily basis,
24 I should be able to replicate what your thought process in
25 my labor and delivery. None of them have come up with any

1 measurable thing. I've literally spent the last five
2 years measuring it objectively using sensors, doing it
3 subjectively, having two people watch the same phenomenon
4 and we cannot reproduce it. In science, one of the
5 fundamental things is a finding which is reproducible, not
6 only when I say it, when you take it and do it in your
7 labor and delivery, your labor and delivery and another
8 labor. The doubt that it's just an opinion of someone and
9 I respect that opinion, but it has no what we call
10 evidence base of what they're saying.

11 Q Thank you, sir. In Dr. Miller's note here, three
12 lines up from the bottom of the second paragraph, he talks
13 about -- and I'll read the whole sentence, Anterior left
14 shoulder delivered using McRoberts, suprapubic and
15 moderate effort -- I think I've already asked you about
16 that. Let me skip over that. I'm sorry.

17 A Yes, sir.

18 Q We talked about that, right?

19 A Yes, sir.

20 Q Thank you. What, if anything -- we talked about
21 bradycardia and extended bradycardia shown on the fetal
22 monitor strips. What, if anything, in your opinion did
23 that prior extended bradycardia have on the shoulder
24 dystocia?

25 A The two are not related, except I would say -- so you

1 already had the baby's heart rate drop, undeniably, it
2 recovered and it was doing fine. Now, you have another
3 free fall, i.e., shoulder dystocia. So you have to take
4 that into mind and you can't say well, I'll wait four
5 minutes and all that. So Dr. Miller did the prudent thing
6 using the right maneuver in the right sequence as in his
7 training. And I think as the shoulder dystocia is
8 progressing, I cannot fault him for any step he took.

9 Q What does instability mean to you in terms of a
10 shoulder dystocia or just a labor and delivery when you
11 have extended bradycardia --

12 MR. GRAHAM: Objection, Your Honor.

13 THE COURT: Counsel, approach the bench, please.

14 (WHEREUPON, a bench conference was held in the
15 presence of the jury, but outside the hearing of the
16 jury.)

17 BY MR. DAVIS:

18 Q Dr. Chauhan, what is instability in terms of delivery
19 when a mother -- excuse me, when the fetal heart rate has
20 an extended low heart rate as was in this case?

21 A In my writing, I don't use the word instability, but
22 speculating, to me, it's things are fine, now things are
23 unstable and we can't assume things would be in the normal
24 range is how I would translate that.

25 Q When a shoulder dystocia occurs, does that create any

1 instability for the health, welfare of the fetus?

2 A It is without doubt one of the OB emergency --
3 anything about this pregnancy or this delivery is off the
4 chart and you are literally free fall. You have X minutes
5 to resolve it. Anyone who thinks otherwise is being
6 clairvoyant is all I would say.

7 Q Do you have an opinion whether or not Alexia was in
8 any immediate danger of harm or serious bodily injury the
9 moment the shoulder dystocia was determined, sir?

10 A Yes, Alexia was in danger of possible damage to the
11 nerve and/or brain and/or even death.

12 Q Doctor, in your opinion, was there any point in time
13 during any of the care provided by Dr. Miller in the labor
14 and delivery, the resolution of the shoulder dystocia,
15 anything that he did that you're aware of from looking at
16 the records, reading his testimony that in your opinion he
17 did that was below the standard of care or in any way
18 failed to meet the standard of care of a reasonably
19 prudent obstetrician in the same or similar circumstances,
20 sir?

21 A I would say on the contrary, he did multiple things
22 which are above the standard of care. And I'm not trying
23 -- and we should remember if you just look at the timeline
24 to the moment of delivery.

25 MR. DAVIS: One moment, please, Your Honor.

1 (Pause.)

2 MR. DAVIS: Dr. Chauhan, thank you for being here
3 today, for answering my questions. Answer any questions
4 that either of these attorneys may have for you, sir.

5 THE WITNESS: Thank you, sir.

6 MR. GRAHAM: Your Honor, looking at the clock, it
7 appears it may be a good time for a lunch break.

8 THE COURT: All right. Ladies and gentlemen, it's
9 now 12:40. I'm going to ask you to be back at two
10 o'clock, please.

11 MR. GRAHAM: Your Honor, would you advise the witness
12 of --

13 THE COURT: Yes, sir -- well, I'm going to let the
14 jury go. Thank you, ladies and gentlemen. See you back
15 at two o'clock.

16 (WHEREUPON, the jury exits the courtroom at
17 approximately 12:40 p.m.)

18 THE COURT: Dr. Chauhan, you're still under oath, but
19 you can step down. You can go to lunch if you want. You
20 just can't discuss the testimony with your attorney.
21 Other than that -- I mean, Mr. Davis or Mr. Traylor.
22 You're welcome to go to lunch. Be back at 2:00 please.

23 MR. DAVIS: Thank you, Your Honor.

24 THE COURT: Anything we need to take up before we go
25 to lunch from the Plaintiff?

1 MR. GRAHAM: No, Your Honor.

2 THE COURT: From the Defense?

3 MR. DAVIS: No, sir.

4 THE COURT: All right. See everybody at two o'clock.

5 (WHEREUPON, a lunch break was taken.)

6 THE COURT: Gentlemen, I don't think we're going to
7 get to closing. Did y'all get a chance to look the draft
8 charge that my law clerk circulated?

9 MR. GRAHAM: Not completely, Your Honor. I got
10 interrupted halfway through.

11 THE COURT: Mr. Davis, have you had a chance to --

12 MR. DAVIS: No, sir, I've been a little busy.

13 THE COURT: I understand.

14 MR. DAVIS: I got it. Thank you.

15 MR. GRAHAM: I can read it quickly when we're done
16 with testimony.

17 MR. DAVIS: I can, too.

18 THE COURT: Sounds good. If we have to charge and
19 close tomorrow, I think that's doable. I would prefer at
20 all cost we not have witness testimony tomorrow. I just
21 think that's really -- we're risking running into a third
22 week then.

23 MR. DAVIS: I can compromise on my defense. I can
24 shorten my direct with Dr. Ernest.

25 THE COURT: Okay. Plaintiff ready to proceed?

1 MR. GRAHAM: Yes, Your Honor.

2 THE COURT: Mr. Davis, Defense ready?

3 MR. DAVIS: Yes, sir.

4 THE COURT: Let's bring them in.

5 (WHEREUPON, the jury enters the courtroom at
6 approximately 2:05 p.m.)

7 THE COURT: Dr. Chauhan, if you want to take the
8 stand, please. You're still under oath. Oh, I'm sorry,
9 the bailiffs are telling me we're missing one juror. Yes,
10 sir, go ahead and take the stand, please. Doctor, you're
11 still under oath. Mr. Graham, Mr. Jordan,
12 cross-examination.

13 CROSS-EXAMINATION

14 BY MR. GRAHAM:

15 Q Good afternoon, Dr. Chauhan.

16 A Good afternoon, sir.

17 Q Let me ask you, sir, if an obstetrician were to apply
18 a vacuum to a baby's head which is at zero station, would
19 you consider that an outlet, a low, a mid or a high
20 application?

21 A Excellent question. So zero is how far is the baby's
22 head -- if this is what we're looking at, how many
23 centimeters away. If it's at zero, which is where the
24 bones come in, then I would consider that to be mid.

25 Q Mid?

1 A Yes, sir.

2 Q Doctor, do you remember giving a deposition back on
3 May 31st of 2018?

4 A Vaguely, yes, sir.

5 Q Excuse me?

6 A Yes, I do remember, but somewhat vaguely, yes.

7 Q And this was done, I believe -- was it by telephone?

8 A It was virtual.

9 Q But it was being videotaped?

10 A Yes, sir.

11 Q And your attorney was participating? In whatever
12 format the deposition took, your lawyer was also
13 participating?

14 A I believe so, yes, sir.

15 MR. DAVIS: Your Honor, I don't represent Dr.
16 Chauhan. He keeps calling me his lawyer. I'm not his
17 lawyer.

18 THE COURT: Dr. Miller's lawyer.

19 MR. GRAHAM: Yes, sir.

20 BY MR. GRAHAM:

21 Q You are a witness on behalf of Mr. Davis's client,
22 Dr. Miller, right?

23 A That's my understanding, yes, sir.

24 Q Dr. Miller's attorney participated in the deposition?

25 A Yes, I believe so.

1 Q And you were sworn to tell the truth, correct?

2 A Yes, I was, sir.

3 Q Please follow along with me as we play the video,
4 starting at Page 22, Lines 7 through 12.

5 (WHEREUPON, video deposition is played.)

6 BY MR. GRAHAM:

7 Q Were those your words?

8 A Absolutely, sir.

9 Q Yes, sir. Now, when you're asked to review a case
10 involving an injured patient who believes they have a
11 claim against the doctor for being negligent and the
12 negligence causing severe injury, when you're called upon
13 to testify for the doctor, do you assume the doctor is
14 telling the truth?

15 A No. I take everything into account. So it's not
16 just what the doctor says, it's the notation, it's the
17 nurses, it's my experience for almost three decades, plus
18 the publication. It's the sum totality of everything that
19 I take into account.

20 Q Please follow along as we play 134, Line 23 through
21 135, 16.

22 MR. DAVIS: I'm sorry, would you it give it to me
23 just one more time, please?

24 MR. GRAHAM: Sure. 134, Line 23 through 135, Line
25 16.

1 MR. DAVIS: Thank you.

2 BY MR. GRAHAM:

3 Q Please follow along.

4 (WHEREUPON, video deposition is played.)

5 BY MR. GRAHAM::

6 Q Sir, do you believe everyone in the medical field
7 always tells the truth?

8 A Let me answer assumption. So the assumption is based
9 on multiple things. It's based on my training, that the
10 clinician is trained in America, the medical records of
11 doctor, nurses, my experience, plus literature. So when I
12 said assume, yes, I did assume knowing everything. You
13 can't isolate one factor. We call it situational
14 awareness when you walk in and you're aware of all those
15 facts. So regarding your second question, do I assume all
16 doctors to be honest --

17 Q Well, do you believe everyone in the medical field to
18 be truthful?

19 A In overwhelming majority of the case, yes, I do.
20 There can be exceptions and I'm not denying there are
21 exceptions, but in majority of the cases, physician,
22 especially clinicians under oath are truthful, yes, I do
23 believe that.

24 Q Please follow along at Page 53, Line 23 through Page
25 54, Line 11.

1 (WHEREUPON, video deposition is played.)

2 BY MR. GRAHAM:

3 Q In fact, if you assume things as an expert witness,
4 if you form opinions based on facts that you assume to be
5 true, then if the facts are not, in fact, that would make
6 your opinions unreliable, true?

7 A Not true, sir. So if the facts are not true, you
8 have to tell me what aspect of the fact. So there are no
9 one single fact in this case. There are multiple facts.
10 So there's what is called the peripheral facts, the
11 central, the underpinning and all that. Everything has to
12 come down for me to be inaccurate in my opinion.

13 Q Please turn to Page 137 and follow along, Lines 9
14 through 20.

15 (WHEREUPON, video deposition is played.)

16 BY MR. GRAHAM:

17 Q Do you ever miss the bulls eye, Doctor?

18 A Quite often in clinical judgment when I'm treating.
19 No one should think that they are perfect. Yes,
20 sometimes, I, human as I am, do make a mistake in clinical
21 judgment without a doubt.

22 Q Do you understand that I'm not asking you about your
23 clinical practice, sir, I'm asking as an expert witness,
24 when you rely on facts that are unreliable, your opinion
25 may be reliable if you get lucky and hit the bulls eye.

1 Do you sometimes miss that bulls eye?

2 A No, I would disagree. First of all, if you believe
3 the facts are not true, then the burden is on you or your
4 expert to show that these facts are not congruous with
5 what's known or what's practiced in America. I am still
6 waiting for that evidence of proof that quote, unquote,
7 the assumptions are inaccurate or not factual.

8 Q Sir, I'm talking about your career flying around the
9 country testifying in cases like this. If the facts you
10 assume to be reliable turn out to be unreliable, are you
11 willing to acknowledge that your opinion based on false
12 facts is an unreliable opinion?

13 A In theory, yes, but having done it for a few years,
14 I'm not aware of any instance where someone has said that
15 the facts as narrated in the medical records, under oath
16 by the clinicians and cross-examinations there was any key
17 evidence which was not factual, which would lead to a
18 chain reaction of me changing it. I'm not aware of any
19 case that has happened with me yet.

20 Q You're assuming the facts, you're assuming the person
21 who told you the facts is telling the truth and you base
22 your opinions on that?

23 A As I said --

24 Q If the facts you rely on are false, you still are
25 willing to testify under oath on behalf of the physician

1 that they did nothing wrong, correct?

2 A I have never just taken one fact. The facts come
3 from multiple sources. They come from the medical records
4 by the clinician, the nurses. They come from deposition
5 under oath, cross-examination and your own expert. When
6 you take all of them together, it's reasonable that I can
7 accept these to be facts. Otherwise, they would have been
8 brought up during any of the experts. When you take
9 everything together, yes, I do believe these facts to be
10 true and my opinion, which follows those assumptions, to
11 be reasonable.

12 Q All right. So sometimes you hit the bulls eye in
13 your opinion?

14 A Let me say, the bulls eye I'm talking about is in
15 clinical judgment because when I walk into a room, or
16 right now, at one time, can be managing 25 pregnant women
17 simultaneously. I can hit a bulls eye in clinical
18 judgment because I've done it. So I can diagnose things,
19 I think, sometimes fast. And that, to me, is a bulls eye.
20 That is bedside treatment I'm talking about. And I think
21 in the deposition I give the example, I diagnosed breast
22 cancer in my mother just based on two assumptions. Those
23 are clinical judgments. Medical, legal -- may I finish,
24 please, sir? Medical, legal, which last several months
25 allows me the luxury to examine every expert, including

1 your expert, the literature, which we are publishing while
2 we are doing that, using all of that, I am confident about
3 my facts till proven otherwise.

4 Q Let me ask you, we were talking about high, low or
5 high station for vacuum application, mid pelvic, low and
6 outlet, if a doctor believes that he should never under
7 any circumstances do a mid-pelvic delivery and he attempts
8 a mid-pelvic delivery at zero station, do you believe that
9 adds up right?

10 A No. To me, I would not have done it and I accept the
11 fact that it was applied -- attempted at zero. And as
12 soon as it was attempted, it was, as I said earlier in the
13 morning, abandoned or not persisted. Had Dr. Miller
14 persisted in that vacuum, I promise you I would not be on
15 this side, I would be on your side. So to attempt it
16 because of the heart rate dropping and his clinical
17 judgment and awareness of the OR and everything, I think
18 it was reasonable. Would I do it, I personally would not
19 have done it. But did he make an attempt which was
20 reasonable, I give him the leeway. The fact that he
21 abandoned is what I am focusing on and the fact that the
22 shoulder dystocia has nothing to do with the vacuum
23 attempt.

24 Q The doctor has already testified under oath that he
25 believed zero station was a low application and that the

1 only reason he was willing to attempt a vacuum extraction
2 at zero is because it was not mid pelvic, it was low, but,
3 in fact, it's high, correct?

4 A Yes, I accept that it is high, yes.

5 Q So do you call that -- when a doctor -- is that a
6 basic principle that first-year residents should know?

7 A I think I'm not the first one who has misspoken, but
8 the key thing I am focusing is it was at zero station,
9 what you call A, B, C, which he honestly candidly
10 acknowledged was at zero station. To me the label is not
11 that important. It's that he attempted it, he let go of
12 that attempt. The subsequent outcome has nothing to do
13 with that attempt and I accept all that.

14 Q Sir, the question is, do you first-year residents
15 learn stations and learn that zero is a high station?

16 A Most residents -- yes, I would accept that statement
17 to be true, sir.

18 Q Thank you. Dr. Miller thought it was a low station,
19 that's what he said in his deposition, true?

20 A I would accept that, sir.

21 Q Thank you. Do you believe that stations, high,
22 mid-pelvic, low and outlet are -- do you believe they
23 still have validity in modern obstetrics?

24 A Yes. I mean, I still teach them and I use them,
25 though I don't put a label. I just say zero, plus one,

1 plus two and the perineum.

2 Q Sir, do you believe it would be archaic in any sense
3 to discuss a baby's station in terms of positions and
4 outlet, low, mid and high?

5 A My preference and, in part, maybe my language is
6 challenged, is I just say zero station, plus one and I try
7 not to put the label. I would have just said zero, plus
8 one, plus two, perineum.

9 Q But first-year residents know that the numerical
10 explanation or the numerical designation of the baby's
11 station can be characterized as outlet, low, mid-pelvic
12 and high, true?

13 A I would accept that, sir, yes.

14 Q And you teach your own residents that?

15 A I teach them not to use those labels just for that
16 purpose.

17 Q But you know that other MFMs do teach their residents
18 those categories?

19 A Oh, absolutely, yes, sir.

20 Q You mentioned that you had -- that you were in favor
21 of pushing. Do you believe it's consistent with the
22 applicable standards of care for a doctor to order a
23 mother, a laboring mother to push after the diagnosis of
24 shoulder dystocia?

25 A That is debated in the literature. There are a group

1 of people who believe that it is acceptable and there are
2 other groups who believe it is not acceptable.

3 Personally, having done research on it, I don't think
4 there's enough evidence on either side to say one is more
5 right than the other. There are definitely two group of
6 people and I accept that.

7 Q You told us about some of the work you had done
8 publishing various articles, many of which relate to
9 shoulder dystocia, right?

10 A Yes, sir.

11 Q And you specifically mentioned the task force, right,
12 the -- you testified one of the articles that you had --
13 one of those articles, in fact, was the compendium that
14 you referred to that came out in 2014 or position paper,
15 whatever you want to call it?

16 A Monograph, yes, sir. I was part of it, yes, sir.

17 Q And you mentioned earlier that -- I think you
18 mentioned it, it might have been the prior witness, but
19 either you or Dr. Miller said that ACOG stands for
20 American College of Obstetrics and Gynecologists, right?

21 A That is one, yes, sir.

22 Q Exactly. It also stands for American Congress of
23 Obstetrics and Gynecology, true?

24 A That's my understanding, also, yes, sir.

25 Q So half of ACOG purports to educate and half of ACOG,

1 in fact, lobbies the government for changes in the law to
2 protect doctors, true?

3 A I'm not that part of it. As you know, my interest is
4 in research and publication, so I have stayed always at
5 the American College or educational materials related to
6 ACOG.

7 Q All right. So you stay away from the lobbying side?

8 A I haven't been invited. I don't have any interest in
9 it, so I don't get involved with it.

10 Q As part of that -- you referred to it as monograph.
11 As part of that monograph, did you agree or make the
12 representation that you had no financial interest in the
13 publication that would benefit you personally?

14 A No, that question was not asked during the monogram
15 or after it that I'm aware of or that I can recall.

16 MR. GRAHAM: Beg Your Honor's indulgence just a
17 moment.

18 THE COURT: Yes, sir.

19 (Pause.)

20 MR. GRAHAM: I apologize, Your Honor.

21 BY MR. GRAHAM:

22 Q Is this the executive summary?

23 A It appears to be, yes, sir.

24 Q And although you're listed, I believe, second on the
25 list of authors --

1 A That was mentioned this morning, yes, sir, but I
2 haven't checked personally.

3 Q And Dr. Gherman, who also testifies regularly in
4 defending doctors, he was the lead author?

5 MR. DAVIS: Objection, Your Honor.

6 THE COURT: Counsel, approach the bench, please.

7 (WHEREUPON, a bench conference was held in the
8 presence of the jury, but outside the hearing of the
9 jury.)

10 BY MR. GRAHAM:

11 Q Do you know Dr. Gherman, sir?

12 A Professionally, yes, I do.

13 Q And you know that's he a regular witness on behalf of
14 doctors who get sued in brachial plexus cases, correct?

15 A Two corrections on that. Yes, I know he does defense
16 work, but by the same token, I know he does plaintiff.
17 Matter of fact, I want to say four or maybe six years ago,
18 he was on the opposite side on a brachial plexus, so he
19 was on the plaintiff. So I know for a fact he does
20 plaintiff work for brachial plexus palsy.

21 Q For one lawyer in Atlanta, who was a friend of his,
22 correct?

23 A I don't know whether he's a friend. That, to me, is
24 not something I'm aware of, but I know on brachial plexus
25 palsy, we have had disagreement of opinion. Whether it's

1 regular or not, I do not know. But yes, I do know he does
2 defense work for brachial plexus. Yes, I know he has done
3 plaintiff work and we have opposed each other.

4 Q At any rate, you have benefited financially from the
5 publication of this article, true?

6 A Yes, I have made -- or there has been an income
7 related to that, but that's not the only topic. To me,
8 it's not about income per se.

9 Q How many times have you testified in the last --
10 well, let's say in 2021, how many times did you testify
11 either at depositions or at trial?

12 A I would say less than five in the last year.

13 Q Less than five?

14 A Last year, '21.

15 Q Yes, sir.

16 A I believe so, five, maybe seven.

17 Q You're saying that under oath?

18 A To my recollection. I've not tabulated it, but
19 during the COVID, there was very little movement.

20 Q All right. Let's take 2020, how many times did you
21 testify then for trial or deposition?

22 A On an average, I would say pre-covid, it's about ten,
23 maybe 15, in that ballpark range, per year.

24 Q That's your testimony under oath?

25 A To the best of my recollection. These are estimates

1 and I accept in the video you showed me, sometimes I can
2 be wrong. But that's an estimate, yes.

3 Q And are you willing to let your CPA provide 1099s to
4 show how many times you testified for defendant doctors in
5 cases like this back in 2020?

6 A No, sir.

7 Q Are you willing -- going back five years, how many
8 cases do you believe you've testified in?

9 A I honestly -- and I'm being very sincere, I can
10 barely remember what I did two years ago, let alone five
11 years ago.

12 Q And let me predict, sir, you have no idea what you're
13 making on this case?

14 A No, sir.

15 Q You probably haven't even charged yet; is that right?

16 A I think I've charged after the deposition, but not
17 lately, no, sir.

18 Q Well, as of the deposition, you had not charged
19 anything, correct?

20 A That is correct.

21 Q And you indicated that you usually don't charge until
22 after trial?

23 A That's the most likely scenario, yes, sir.

24 Q You weren't here, but Mr. Davis asked every
25 Plaintiff's expert witness how much money they made in

1 their work as an expert witness. Have you ever been
2 willing to tell a jury how much money you've made
3 testifying as an expert witness since the publication of
4 this article?

5 A I have said -- in last year or two during COVID, I
6 would say it's less than ten percent. Before COVID, I
7 would say about 25 percent was probably the highest.

8 Q I didn't ask you about percentage. Are you willing
9 to answer a question about how much money you made during
10 a typical year pre-covid testifying for defense doctors
11 after you wrote this article?

12 A I wouldn't say after I wrote it because with all
13 respect, I was doing medical legal work before this. I'm
14 not convinced it went up because of this. Having said
15 that, it's usually about 15 to \$25 for every hundred
16 dollar I make.

17 Q Well, the question was, are you willing to tell us
18 how much money you've made?

19 A No, sir.

20 Q And in the past, have you ever been an expert witness
21 against any of my other clients?

22 A I think we had a trial one other time that I'm aware
23 of.

24 Q You've given a bunch of depositions for doctors?

25 A Yes, I have.

1 Q And I was involved in how many, like, five or six in
2 the last few years?

3 A With me?

4 Q Yes, sir.

5 A I can remember one trial is the only one which sticks
6 out in my mind.

7 Q Depositions, you're not counting depositions?

8 A No, I'm not, sir.

9 Q In terms of depositions and trial experiences, in the
10 last three or four years, you've testified against my
11 client, at least, five or six times, haven't you, sir?

12 A I honestly don't remember testifying six times
13 against you in the last four years, honestly.

14 Q How many times have you testified against Pam
15 Pantages?

16 A Five times.

17 Q Five times?

18 A That I can recall.

19 Q All right. How many times have you testified against
20 -- in the last few years against Bob Tollascus (ph)
21 clients?

22 A I don't know that name. If I have -- I'm the first
23 one to admit I'm bad with names. If I have my two
24 daughters in front of me, I always mix up the names, so I
25 don't -- I remember Ms. Pantages. With all due respect, I

1 did not remember your name with other cases, except at
2 trial.

3 Q I'm not worthy to be compared with Pam Pantages, but
4 let me ask you, sir, what about Ken Levine, how many times
5 have you testified against his clients in the last few
6 years?

7 A I don't remember the Ken Levine. I apologize to
8 everyone. I am bad with names.

9 Q Yes, sir. How many different plaintiff lawyers
10 around the country have you testified against in the last
11 few years? I'm not asking for a total number of witness
12 experiences, but how many lawyers have clients that you've
13 testified against?

14 A I honestly don't -- right now, I have, at least, six
15 cases from the plaintiff that I have reviewed.

16 Q In 20 years, you have never testified on behalf of a
17 plaintiff in a brachial plexus case, have you?

18 A You're absolutely wrong, sir.

19 Q The vast majority of your testimony has been on
20 behalf of defendant lawyers, true?

21 A Because virtually no plaintiff lawyer has come to me
22 -- so there were two trials, one in North Carolina, one in
23 Georgia, which were on plaintiff's side related to
24 brachial plexus. Admittedly, they were, I would say, 15
25 plus years ago. Since then, no plaintiff lawyer has sent

1 me a case asking me to review on behalf of the plaintiff
2 in brachial plexus palsy. So to look at it the other way,
3 I have never said no. So tomorrow, you were to send me a
4 case, I would do the same due diligence as I would do on
5 this side.

6 Q Can you name a state in the country where you have
7 not testified?

8 A Yes, sir.

9 Q How many can you name?

10 A Being an immigrant, I'm not good with geography, but
11 I think I could do, at least, five, if not more, or ten.

12 Q Last time I asked you about how much money you
13 charge, you told me you don't know, you have no idea.
14 Does that ring true?

15 A Not for review or for trial, no, I don't believe I
16 would have said that. If I said that, I would have to
17 revisit the statement.

18 Q You don't deny that you said that, do you, Doctor?

19 A If the question was how much do you charge for travel
20 and while you're at the trial, that's different, but what
21 do I charge per hour to review, I don't think I have said
22 I don't know that.

23 Q I didn't ask about trial. I didn't ask about a
24 single case. I asked about total annual income, your
25 answer typically is I don't know, correct?

1 A Yes, it's 15 to 25 percent, yes.

2 Q To get a dollar figure, what would you have to do,
3 pick up the phone and call your accountant and ask him to
4 add up the 1099s on legal testifying cases?

5 A I presume that's one way to do it.

6 Q Other witnesses have not only done that, produced the
7 amount of money they earn, but they've also given a list
8 of how many cases they've testified, which lawyers and
9 which doctors, which courts. Have you ever testified in
10 federal court?

11 A Yes, sir.

12 Q So you had to produce such a list for federal court,
13 right?

14 A Yes, sir.

15 Q Did you bring it with you today?

16 A I wasn't ask to, but I can e-mail it.

17 Q Mr. Davis did not ask for that?

18 A I don't believe so.

19 Q And I understand your testimony that you have no
20 opinion about causation, what caused the child's injury?
21 You do have opinions about associations, but not about
22 causation, true?

23 A Yes, I have said that, sir.

24 Q There's been some discussion about Woods versus
25 Rubin, and I don't want to get into the technical aspects

1 of that. I doubt any of us care about those specifics.
2 But, traditionally, it was Woods that involved 180
3 degrees, not Rubin's, correct?

4 A That's an excellent question. I don't remember the
5 old articles as I sit here today.

6 Q But you've never rotated a baby 180 degrees, have
7 you?

8 A No, I've been fortunate enough not to have to rotate.

9 Q You've never rotated a baby even 90 degrees, have
10 you?

11 A No, I don't recall rotating 90 degrees nor measuring
12 whether it was 90.

13 Q The whole point of a rotational maneuver is to get
14 whichever shoulder is behind the pubic bone to rotate out
15 of the pubic bone and then with no blockage of that bone
16 to be delivered, correct?

17 A That is one of the aims, yes, sir.

18 Q So if your objective is to have the right shoulder
19 rotated to get away from the pubic bone, all you need is a
20 few degrees or a few inches, true?

21 A In theoretical sense, yes, it makes sense, but
22 clinically, you have to trust the judgment of the
23 clinician that in this case, when there was a difficulty
24 getting the posterior arm that the rotation may have to be
25 more than just -- there's no measurement that if you move

1 the shoulder by, let's say, I'm imagining the shoulder is
2 stuck by two degrees, it will come under and everything
3 will be resolved. It is a clinical judgment of how much
4 rotation one needs.

5 Q All right. Using your clinical judgment, you've not
6 even used more than 90 degrees?

7 A I've been fortunate, but I've had other bad outcome
8 related to shoulder dystocia, including a mother dying.
9 So yes, in that respect, I did not, but I have had adverse
10 outcome related to shoulder dystocia.

11 Q I'll ask you about that later. Right now, does it
12 make sense to you for a doctor to rotate a baby 180
13 degrees and have one shoulder stuck behind the pubic bone
14 replaced by another shoulder stuck behind the pubic bone?
15 Does that make sense to you?

16 A I'm not convinced once the left shoulder, which was
17 at the bottom, went to the top that there was a shoulder
18 dystocia.

19 Q Yes, sir. My question is does it make sense to you
20 that a doctor would turn a baby in a steering wheel
21 fashion rather than a screw-type fashion?

22 A To me, it's turning the baby, as illustrated in the
23 video, using, in this case, left arm with the shoulder to
24 the top. Now, whether it was this or this -- let's assume
25 for a second 180 degrees absolutely is red line, they

1 would have written about it. I would have read about.
2 ACOG would have come out as it says don't use fundal
3 pressure or don't do this, they would be someone who would
4 have said never do 180 because you could get a second
5 shoulder dystocia.

6 Q Do you believe Dr. Miller would have reported this
7 case?

8 A It would have happened in my -- I've done enough
9 deliveries. I've been part of large enough hospitals
10 where things happen. It would not be the first time where
11 the shoulder from the left, which was inferior, became
12 anterior and had a shoulder dystocia.

13 Q My question, sir, is if a doctor were to rotate a
14 baby in a steering wheel fashion instead of a screw
15 fashion, does that strike you as a very peculiar thing for
16 a doctor to do?

17 A To me -- and I'm being respectful. I don't
18 understand the different between the steering versus
19 screw. So what we do, as shown in the video, that is how
20 you do it. Whether you stop here, here and the baby
21 flipped all the way to 180 is not abnormal and I would not
22 find that to be below the standard of care.

23 Q You don't know what the steering wheel is?

24 A I do, but I don't use that in terms of the fetus.

25 Q Of course, you don't, but in trying to understand the

1 movement to go from a right shoulder stuck behind the
2 pubic bone 180 degrees to a left shoulder stuck behind the
3 pubic bone, that would require a steering wheel motion,
4 correct, and not a screw-out motion?

5 A I'm not convinced this is a screw-out because you
6 can't screw out a baby that is stuck, so that analogy is
7 not valid. I'm more than happy to walk you through the
8 video. That video clearly demonstrates the clinician
9 applying appropriate maneuver to change or rotate the
10 fetus. And I would accept that.

11 Q How many versions of the animation did you watch?

12 A I believe, at best, two.

13 Q You didn't watch the other one?

14 A I don't think so, no. I mean, to me, it was the
15 difference between right hand versus left hand, but
16 otherwise, the rotation -- the concept of moving the fetus
17 from the left arm in the back towards whether it was using
18 this hand or that hand is different, but it was the
19 rotation is what I watched.

20 Q Did you have any contact, direct contact between you
21 and the technical folks that did the animation?

22 A No.

23 Q Do you know of anybody that had direct contact with
24 the folks that made the animation other than Dr. Miller
25 and his lawyer?

1 A No.

2 Q How long does it take you to diagnose shoulder
3 dystocia, order the nurses to do McRoberts and suprapubic
4 pressure, have them carry out those orders, then gentle --
5 or traction again with your hands on the baby and then
6 attempt posterior arm delivery method three times and then
7 do 180-degree rotational maneuver and then apply
8 additional traction to deliver the baby? How long would
9 that take you?

10 A I have never done that, all that.

11 Q Can you -- just thinking through how long it takes
12 you to do each step, can you tell us how long it would
13 take?

14 A It could take me two minutes, three minutes. It
15 depends who the nurses are, who the patient is, how the
16 fetus is, how much it's impacted. I could see it easily
17 taking me 90 seconds, three minutes, even four minutes.

18 Q Doctor, I can't remember if it was you or a prior
19 witness for the defense, or maybe it was on the animation,
20 but somebody was talking about compression of the uterus
21 and maternal forces creating compression that could cause
22 injury to a baby's nerves. Was that you?

23 A I would have said contraction force, uterine, yes.
24 That, plus impaction, plus resolution, all of them put
25 together can lead to brachial plexus palsy.

1 Q Doctor, this monograph task force that you were a
2 member of, do you consider it to be a reliable authority?

3 A I would definitely say it's reliable. I don't
4 consider any publication to be authoritative because
5 things change in science rapidly, but I would consider it
6 reliable. I would consider it comprehensive. I'm still
7 not aware of any publication, which will either change or
8 modify any conclusion in a major way.

9 Q This task force that you say is the best thing that's
10 ever been written about shoulder dystocia is not a
11 reasonable authority?

12 A With all respect, maybe it's just the way I was
13 raised. In America, I don't believe in authority. I
14 believe people have opinions and it's respected. To me,
15 authority is more, let's say, other governments. I just
16 don't use the word authority.

17 Q I appreciate that. These are opinions, right?

18 A These are opinions based on the best science at that
19 time and even valid today.

20 Q But you say they're valid, you say they're the best
21 based on science, but you're not willing to say that
22 they're even reasonably authoritative?

23 A They're very reasonable, yes. Science and authority
24 or just opposing thing. In science, there is no
25 authority, it's evidence-based. There is no you know I

1 say so because I'm the authority on it. By mere
2 definition, science is looking at things, looking at all
3 the evidence and coming up with evidence-based assessment.
4 It is the best evidence-based assessment on the topic.

5 Q All right. I want to ask you about some of this
6 science that it's based on. Do you recall how many --
7 well, do you believe the footnotes are based on science?

8 A You have to take the footnotes -- so I'm going to
9 assume, just to keep it simple, there are 100 pages and
10 I'm going to make some 100,000 sentences. You can take a
11 footnote, distort and make it say what you want to, but
12 when you look at the comprehensive 100 pages, I would say
13 more likely than not overwhelmingly, all the sentences in
14 congruent with the rest of it true.

15 Q I'm not sure what that meant. Are you saying that
16 there are some footnotes in here that are not reliable?

17 A It depends. First of all, you can take a footnote,
18 you can take any sentence -- like, for example, and I'll
19 make it simple and please forgive my analogy. Like, I
20 love you, I love you not. If you freeze the sentence I
21 love you not, it doesn't mean I don't love my wife, just
22 that you froze that little silly saying I love you, I love
23 you not. So it depends on where you freeze it, but if you
24 look at the entirety of the conversation, or in this case,
25 monogram, I think everything is reliable.

1 Q All right. Are you telling us that the task force
2 members cited footnotes that do not really support the
3 proposition in the article that they're cited as though
4 they do support?

5 A Sir, I'm happy to read it. I'm happy to give you my
6 opinion. It was several years ago when I read it several
7 times.

8 Q Are you familiar with that portion of Chapter 3 that
9 talks about compression might matter?

10 A I would accept that statement to be true.

11 Q Do you recall that the only two footnotes listed as
12 support for that proposition are by lead author O'Choa
13 (ph)?

14 A That author's name does not ring a bell right now as
15 I sit here today.

16 Q Does the magazine Nature ring a bell?

17 A Yes.

18 Q All right. Does an article in Nature written by
19 O'Choa address what happens to baboons legs if you tie
20 them tight enough to squeeze the blood flow and let it
21 stay like that for a number of weeks?

22 A I don't --

23 Q That's what it says, right, Doctor?

24 A No, I don't remember that. And maybe the reason, I
25 do not manage or treat or opine on baboons, so I have

1 nothing to say about baboons and tying off the leg of a
2 baboon.

3 MR. GRAHAM: Beg the Court's indulgence, Your Honor.

4 (Pause.)

5 BY MR. GRAHAM:

6 Q I'll go on to another matter while my colleagues look
7 for that.

8 A Yes, sir.

9 Q Let me ask you, sir, how serious do you believe
10 Alexia's Lumpkin's injury is?

11 A I believe it's very serious.

12 Q Is it a pan flexus injury?

13 A I would have to defer to the expert who treat Alexia,
14 but I accept it is severe injury.

15 Q And do you accept that it's a three nerve root
16 avulsion with two ruptures?

17 A Sir, I'm not a doctor for children or, in this case,
18 a teenager. I respect the specialist who have managed and
19 treated her and what they say holds true as far as I'm
20 concerned.

21 Q So are you saying that you're not really one with
22 knowledge about neurosurgery --

23 A No, I'm not.

24 Q I'm confused because, earlier, weren't you talking
25 about learning from a doctor who was a neurosurgeon?

1 A Sir, it would be, let's say, arrogant of me to say
2 that because I did papers with a neurosurgeon that I know
3 about neurosurgery.

4 Q Of course.

5 A All I did -- and it's in the publications what was my
6 role, what has the neurosurgeon's role and we were the
7 first one to combine the chart is what I said. Do I claim
8 to know anything about neurosurgery, what she or any
9 neurosurgeon do, absolutely not.

10 Q You led off your testimony today by talking about
11 this person up in Michigan who did neurosurgery and you
12 were impressed and got together and did articles together?

13 A Yes, I stand by those statements, yes.

14 Q But you don't have the ability to evaluate whether
15 what she said is reliable or not, do you?

16 A I think I can trust a neurosurgeon who is a co-author
17 on a publication who has opened the chart and opined. I
18 accept her statement and what she says that case number
19 one has this, I accept that to be true, yes.

20 Q The lifecare planner in this case, as well as -- oh,
21 do you know Dr. Armenta, he's from Houston as well?

22 A No, I don't believe I've met him. I'm bad with
23 names, but I don't believe so.

24 Q There used to be a guy in Houston named Dr. Nath
25 (ph), did you know him?

1 A I know of that name, but I don't believe I've met him
2 personally.

3 Q But he's left or been encouraged to leave the
4 brachial plexus center in Houston, true?

5 A I did not know that, sir.

6 Q So you don't know that Dr. Armenta took his place in
7 Texas, brachial plexus?

8 A I know you think Houston is one little thing, but
9 Houston -- one of the things we brag about is it's the
10 largest medical center globally. There are, at least,
11 four, if not six different hospitals. I am 100 percent
12 sure neither of them are in my department or in my
13 division.

14 Q Sure. There's hospital after hospital after hospital
15 all together, right?

16 A Let's say in X mile radius, yes, that is true, sir.

17 Q Do you know enough about brachial plexus
18 reconstruction surgery to know how many highly regarded
19 brachial plexus surgery centers there are in the country
20 that focus just on those instead of general surgery of all
21 kinds?

22 A No, sir, I do not.

23 Q Do you recognize Texas as one?

24 A I wouldn't know that, sir. I have no way of knowing
25 that.

1 Q Do you know if Cincinnati is one?

2 A I don't know.

3 Q Or Miami?

4 A Sir, I try to stay in my lane and my lane is
5 pregnancy and delivery. After that, I would defer to my
6 colleagues.

7 Q Don't really pay attention to what happens to the
8 children who get life-changing permanent nerves ripped out
9 of their spinal cord?

10 A Sir, I think you're being somewhat unfair. I didn't
11 say I don't respect -- my professional opinion here has to
12 do with OB and I respect my colleagues and I accept this
13 is a severe injury. My older daughter has a severe injury
14 and I respect family member who are raising children with
15 neurological injury.

16 Q Yes, sir.

17 A But I keep myself within what I know and the rest as
18 a human being and as a citizen, I accept and respect other
19 people.

20 Q I appreciate that. I'm sorry about your daughter and
21 I wish her well. With respect to this case, do you
22 believe that there's any reason why this child, Alexia,
23 why you or anyone else would have a legitimate basis to
24 contend that she's not entitled to have surgery at a
25 brachial plexus center to improve her arm, her elbow and

1 her wrist and hand?

2 A I accept that when a clinician or a brachial plexus
3 surgeon says Alexia needs surgery that she needs it and I
4 would absolutely encourage her to have the surgery if
5 recommended.

6 Q I don't mean to get personal about your family
7 situation, but if a family member of yours had a pan
8 flexus injury, brachial plexus injury with nerves to their
9 spinal cord ripped out, would you want that family member
10 to have first class medical care?

11 A Since you brought it up and I appreciate your
12 bringing -- my older has seizures since birth. She's 34
13 years old and she still has the seizure. And I do my best
14 to raise her. She's a little bit defiant and, you know,
15 (inaudible) in my book. And whenever she needs the
16 treatment, I take her to the best doctor in the area. I
17 think Alexia deserves the same thing as my daughter at the
18 age of 34 does, yes.

19 Q So you would not deny first class medical care to
20 Alexia?

21 A I would defer to the clinicians and yes, she does
22 deserve treatment, yes.

23 Q Does she deserve excellent treatment?

24 A I think most clinicians provide excellent treatment,
25 yes.

1 Q Does she deserve first class treatment?

2 A I know you keep saying first class, the epilepsy that
3 my daughter has, I don't know what is a first class
4 treatment. Is Norfolk, Virginia not first class? I would
5 argue Norfolk, Virginia is very good and my daughter and I
6 have never had any problem with that. Is it first class?
7 I don't know. I've never looked into it. When people
8 come to me, am I the first class doctor? I'm not aware of
9 an OB that's quote, unquote first class. So this concept
10 there's a first class of doctors in brachial plexus, if
11 they say so, then yes.

12 Q So you would defer to those who actually treat these
13 injuries?

14 A Oh, absolutely, sir. I would stay in my lane.

15 MR. GRAHAM: Your Honor, may we approach?

16 THE COURT: You may.

17 (WHEREUPON, a bench conference was held in the
18 presence of the jury, but outside the hearing of the
19 jury.)

20 THE COURT: Ladies and gentlemen, I'm going to give
21 y'all a ten-minute recess.

22 (WHEREUPON, the jury exits the courtroom at
23 approximately 3:09 p.m.)

24 (WHEREUPON, a short break was taken.)

25 THE COURT: All right. Ready to proceed?

1 MR. GRAHAM: Yes, sir.

2 THE COURT: Mr. Davis, ready to proceed?

3 MR. DAVIS: Yes, sir.

4 THE COURT: Dr. Chauhan, if you don't mind, take the
5 witness stand again. Doctor, am I pronouncing your name
6 correctly?

7 THE WITNESS: Yes, sir.

8 THE COURT: Let's bring them in.

9 (WHEREUPON, the jury enters the courtroom at
10 approximately 3:22 p.m.)

11 THE COURT: Mr. Graham, you can resume your
12 cross-examination.

13 MR. GRAHAM: Thank you.

14 BY MR. GRAHAM:

15 Q Sir, we were talking earlier --

16 THE COURT: Mr. Graham, I'm not sure the mic is
17 picking you up where you are.

18 MR. GRAHAM: May it please the Court?

19 THE COURT: Yes, sir.

20 MR. GRAHAM: Thank you for that recess.

21 BY MR. GRAHAM:

22 Q Doctor, in the monograph that Dr. Miller's lawyer
23 asked you about earlier, there was one reference about
24 compression --

25 MR. DAVIS: May it please the Court, Your Honor, if

1 he intends to cross-examine this expert on an article,
2 doesn't he have to first lay the proper foundation and
3 have the witness testify that this article is a reliable
4 authority, like Dr. Duboe did? This expert has never said
5 that. He's never been asked.

6 THE COURT: I think it's different, though, in this
7 case where this expert was the co-author of a paper that
8 allegedly cites this article.

9 MR. GRAHAM: In addition, I'm not presenting it for
10 the truth, just what is said in the article.

11 THE COURT: Right.

12 MR. DAVIS: Note my objection.

13 THE COURT: Yes, sir.

14 MR. DAVIS: Thank you.

15 BY MR. GRAHAM:

16 Q (Inaudible) sentence about compression.

17 A Just give me a minute, please. Thank you, sir.

18 MR. DAVIS: Your Honor, while he's reviewing it, can
19 I get for the record a citation of whatever it is that he
20 just handed him? Because I've never seen -- I don't know
21 what he's doing. Hasn't been disclosed to me.

22 MR. GRAHAM: It's the monograph that you disclosed to
23 me.

24 MR. DAVIS: There's a hundred pages here, which page?

25 THE COURT: What page are we on, Mr. Graham?

1 BY MR. GRAHAM:

2 Q Doctor, could you identify the page number?

3 A Give me a second, please. It's page 35 where the
4 highlight is and the reference highlight is Page 39.

5 Q So how many sentences are there that talk about
6 compression?

7 A So one sentence that you have highlighted is the only
8 one I have read.

9 Q Well, do you need more time to search for another?

10 A If you wanted me, I would need my computer because
11 I'm more adapt at reading from the computer than this.
12 But one thing you are not mentioning is this sentence
13 which you have highlighted so kindly and the two
14 references you have highlighted, just so it's clear, it's
15 your highlight on the references, they're reference number
16 44 and 45, they were published in 1971 and 1972. So if my
17 math is correct, that's half a century ago. I would
18 respectfully not recalling those two would say that they
19 have minimal relevance. They are not on humans. Those
20 references, just by the nature of it, I will -- I am quite
21 certain have nothing to do with a fetus. So to me, the
22 relevance on brachial plexus palsy at the time of shoulder
23 dystocia is not relevant with what you have cited and/or
24 what you are referencing.

25 Q Thank you so much, Doctor.

1 A You're welcome. Thank you, sir.

2 Q The name of this chapter, of course, pathophysiology
3 and causation with reference to the brachial plexus nerve
4 damage, correct?

5 A That sentence you have highlighted have to do with
6 animal studies. I am not here to opine on animal. I'm
7 not even convinced animals have shoulder dystocia. So it
8 is a concept out there and they have mentioned it. They
9 are not linking it to brachial plexus palsy during
10 shoulder dystocia.

11 Q The subtitle of this section is biomechanics of nerve
12 injury, correct?

13 A In medicine, so when you start out, you quote,
14 unquote, start out with a 30,000 feet view. So the 30,000
15 view of nerve injury in humans, animal is this, that's not
16 what we are here for. The question to me of relevant is
17 from a clinician's point of view during the delivery of a
18 human, the clinician and the management. That sentence is
19 totally irrelevant to why we are all here today.

20 Q It's your task force monograph, correct?

21 A Well, I'm a part of it, yes, sir.

22 Q And under biomechanics of nerve injury, there's one
23 sentence on compression 50 years ago. It doesn't talk
24 about babies, it doesn't talk about humans. It talks
25 about the hind leg of a baboon, correct?

1 A I have not read those two articles and I'll accept
2 that to be true.

3 Q So they figured if you inflate a cuff to 1,000
4 millimeters of mercury on the hind limb of a baboon for
5 one to three hours, it started to show some kind of signs
6 of being asleep or slightly worse than that, correct?

7 A Sir, I say with respect, first of all, this is not a
8 leg injury. We're talking about a human being. We're
9 talking about shoulder dystocia. No one compressed to
10 1,000 millimeter mercury.

11 Q So if anybody got in front of this court and talked
12 about compression of the uterus and the mother's pushing
13 as a cause of brachial plexus nerve damage, they would
14 have no basis for that, would they?

15 A Definitely not based on baboon study, no, I would not
16 accept that. I agree with that part. The two are not
17 related. They are two different aspect. It's like
18 comparing apples with a car.

19 Q Sir, how many deliveries have you performed in your
20 career?

21 A It's an estimate. I would say 10,000.

22 MR. GRAHAM: Could you please fill in with 10,000
23 under Dr. Chauhan?

24 Q And approximately how many shoulder dystocias have
25 you encountered?

1 A I'm going to estimate because I haven't kept a count
2 of it that it's national rate is one to two percent. Me
3 doing high risk pregnancy, maybe two or maybe three. So
4 around two percent would be a reasonable estimate.

5 Q So that would be how many, 200?

6 A I would let someone with a calculator do that, but I
7 will assume you to be right as I have assumed other
8 things, sir.

9 Q Let's assume Eugene to be right.

10 A I will assume Eugene is right, sir.

11 Q Now, how many of those shoulder dystocias throughout
12 your career, those 200, how many of those have resulted in
13 severe injury, either brachial plexus birth injury or
14 maternal death or breaking the baby's spinal cord?

15 A Two, sir.

16 Q And do you believe that the one involving -- well,
17 only one of these involve the spinal cord; is that right,
18 or both?

19 A No, the other one was the maternal death.

20 Q It did not involve the baby?

21 A You asked me about including maternal death.

22 Q So let's change this to severe birth injuries to
23 babies?

24 A One, sir.

25 Q Do you believe that one brachial plexus or spinal

1 cord injury to a baby was caused by gentle traction or by
2 excessive traction?

3 A In retrospect, I would say it was excessive traction.

4 Q Thank you.

5 MR. GRAHAM: Thank you. No further questions.

6 THE COURT: Mr. Davis, redirect?

7 MR. DAVIS: Briefly, Your Honor.

8 REDIRECT EXAMINATION

9 BY MR. DAVIS:

10 Q Dr. Chauhan, has anything in the last two or three
11 hours changed your opinion on whether or not my client,
12 Dr. Miller, met or fell below the standard of care when he
13 delivered this child on April 5, 2007, sir?

14 A No, sir. And I wish you would give me third choice.
15 Did he exceed, do things better than most and I would say
16 yes. He did not -- Dr. Miller on April 5th did not even
17 come close to being below the standard of care without any
18 doubt.

19 MR. DAVIS: Nothing further. Thank you.

20 THE WITNESS: Thank you, sir.

21 THE COURT: Any recross?

22 MR. GRAHAM: No, Your Honor.

23 THE COURT: Any objection to excusing Dr. Chauhan?

24 MR. GRAHAM: No, Your Honor.

25 MR. DAVIS: Thank you, Your Honor.

1 THE COURT: Doctor, thank you. You're excused.

2 THE WITNESS: Thank you.

3 THE COURT: Mr. Davis, we just took a break, so I
4 guess go ahead and call your next witness.

5 MR. DAVIS: He, of course, has been sequestered, so
6 it will take just a minute to get him.

7 THE COURT: Absolutely. Doctor, you can go ahead and
8 approach the clerk's table, please. Mr. Davis, you can
9 call your next witness.

10 MR. DAVIS: Your Honor, we would like to call Dr.
11 Mack Ernest.

12 THE COURT: Madam Clerk.

13 THE CLERK: Place your left hand on the Bible and
14 raise your right.

15 Dr. Joseph Ernest, being
16 first duly sworn, testified as follows:

17 THE CLERK: Thank you. Please be seated.

18 DIRECT EXAMINATION

19 BY MR. DAVIS:

20 Q Sir, may I ask you to remove your mask while you
21 testify?

22 A Thank you.

23 Q Thank you, Doctor. Dr. Ernest, would you please
24 introduce yourself to the jury?

25 A Yeah, my name is Joseph McDonald Ernest, III. I go

1 by Mack. And I have been practicing in North Carolina
2 since the 70s when I started residency in Charlotte.

3 Q I'm going to ask you just some questions about your
4 background. I've got your curriculum vitae, can we call
5 that just a CV. I've got an old one, but let me ask you
6 just about some of the things about your background. When
7 it's listed chair of the department of obstetrics and
8 gynecology at the Carolina Medical Center, what was that
9 about?

10 A In 2008, I left Wake Forest where I had been
11 practicing for 26 years to go back to Charlotte where I
12 did my residency and became the chairman of the
13 department. That's the system now called Atrium. The
14 hospital is downtown. And that was the department where
15 we had a lot of specialists. My speciality of maternal
16 fetal medicine practice is there. Oncology (inaudible).
17 We also have a residency training program and we have
18 medical students -- had medical students that came from
19 Carolina. They just joined with Wake Forest and will have
20 a new medical school there. But it was the large hospital
21 there and I was the chairman. So I was directing the
22 research, the patient care and education going on in the
23 department from 2008 to 2014, when I retired.

24 Q It's just my old ears, but can you pull that
25 microphone a little closer to you, sir? I know that chair

1 doesn't move. I'm sorry.

2 A How's that?

3 Q It's much better. Thank you.

4 A Okay.

5 Q Dr. Ernest, at some point, did you retire from the
6 active practice of medicine?

7 A Yes, I retired in 2014.

8 Q And this case happened in 2007, the delivery?

9 A Yes.

10 Q Doctor, tell the jury just a little bit about your
11 educational background coming up through college and the
12 different medical school and post-graduate training, that
13 sort of thing.

14 A I went to high school and college in Mississippi.
15 After college, I taught high school for a year, taught
16 chemistry and physics and general science. In 1974, I
17 went to medical school at the University of Mississippi in
18 Jackson, graduated in 1978. From '78 to '82, I was in
19 Charlotte doing residency training. From '82 to '84, I
20 then went to Wake Forest and did a fellowship in high risk
21 obstetrics. I stayed on the faculty from '84 to 2008 and
22 then, as we mentioned earlier, went to Charlotte. I
23 worked for six years and that's when I retired from
24 obstetrics.

25 Q Several places you have been listed as (inaudible),

1 who are your students?

2 A The students at Wake Forest were students that were
3 at the medical school there, but we had students from
4 other medical schools come in as well from all over the
5 country. We had residents that trained that were
6 post-medical school that were preparing to do obstetrics
7 and gynecology. My students were also private
8 practitioners. I did a lot of lecturing and was involved
9 in national organizations that developed educational
10 material for medical students across the country.

11 Q How does one write a book chapter? Is that something
12 you just decide I'm going to write a book chapter in a
13 medical book or is that by invitation? How does that
14 work?

15 A You can come up with an idea or, in my case, you can
16 get invited by an editor of a book, who is either writing
17 a new book and you write a new chapter, or, also, I've
18 been invited to revise chapters that someone else has
19 written and update and give new information to an old
20 chapter. And I've done both of those.

21 Q This CV, I think, is from back in, it might have been
22 2018 or earlier. I counted six, I may have miscounted,
23 six book chapters, does that sound right?

24 A Yes.

25 Q What's a journal article?

1 A In medicine, magazines are called journals, so it
2 would be some article, case, medical study that's been
3 published.

4 Q Are those what we call peer-reviewed journal
5 articles?

6 A There are peer-reviewed and there are
7 non-peer-reviewed. I think I only listed on my CV the
8 peer-reviewed ones. There were others that I didn't list
9 because they're not -- in an academic world, you get more
10 credit for a peer-reviewed journal, so you get promoted by
11 the peer-reviewed ones. So those are the ones you tend to
12 list. They tend to carry more weight.

13 Q Some of the journals that you've published and
14 peer-review, the Journal of Obstetrics and Gynecology, the
15 Journal of Perinatology, the American Journal of
16 Obstetrics and Gynecology, would those include all those?

17 A Yes.

18 Q I've got a list of 52 of those, New England Journal
19 of Medicine?

20 A Yes.

21 Q And you've given presentations, I didn't have time to
22 count them, there's multiple pages, 30, 40, 50
23 presentations, I don't know how many?

24 A More than that, but those are just the ones I listed.

25 Q And what's a presentation?

1 A Well, on my CV, it would be a medial talk that was
2 given to an audience of -- generally, they are
3 practitioners or educators around the country, I've done
4 both of those, and some in other countries.

5 Q Doctor, what are boards in OBGYN and how does one
6 become board certified, sir?

7 A The OBGYN boards are done at the end of the four-year
8 residency program. A resident who's graduated from
9 medical school chooses a speciality. In OBGYN, it's four
10 years of training. They then go to Dallas now and have a
11 three-hour sit-down session with examiners who quiz them
12 on their knowledge of obstetrics and gynecology. And if
13 they have an adequate knowledge, they pass that part. And
14 if they have gathered enough cases and they pass that
15 exam, they become board certified.

16 Q Doctor, you have listed in here 1996 until I'm not
17 sure when that you were an examiner for the American Board
18 of Obstetrics and Gynecology. You were one of those oral
19 board examiners, sir?

20 A Right. There were about 300 around the country that
21 go to Dallas and spend a week. So I would go Sunday night
22 and review case list with other examiners of the
23 candidates who were coming to get board certified. Then
24 two people at a time would interview the candidate. We
25 would ask them questions about their cases, ask them

1 prepared questions about medical topics related to OBGYN.
2 Then we would determine if they passed or failed. So I
3 did that for 10 or 15 -- around 15 years, I think.

4 Q Does everybody pass?

5 A No.

6 Q If they don't pass, what do they have to do?

7 A In order to pass?

8 Q If they don't pass?

9 A Oh, if they don't pass. Well, if they don't pass
10 that examine, they have to take it again. Usually, they
11 have to wait a year or so because they have to reapply and
12 get everything order. But they have to pass that examine
13 in order to get board certification.

14 Q Are you board certified?

15 A Yes.

16 Q You weren't the oral board examiner for yourself,
17 were you?

18 A No.

19 Q You pass them on the first time?

20 A Yes.

21 Q Have you had to be recertified through your career?

22 A I voluntarily did. I was in the last group in 1987
23 that did not require mandatory recertification. In other
24 words, I could have stopped at that point and not had any
25 more testing, but I chose and I actually was encouraged to

1 do this because I was a board examiner to take those exams
2 every year to get recertified. So I voluntarily did that
3 and I continue to do that. So I am still board certified
4 and maintain my certification even though it's a voluntary
5 thing.

6 Q Thank you, sir.

7 MR. DAVIS: Your Honor, I would offer Dr. Ernest as
8 an expert in OBGYN and maternal fetal medicine.

9 THE COURT: Any objection?

10 MR. GRAHAM: We'll reserve our questions. Thank you.

11 THE COURT: Okay. Any objection to his qualification
12 as an expert?

13 MR. GRAHAM: No, sir.

14 THE COURT: Ladies and gentlemen, as I've said
15 before, this witness is now qualified as an expert in
16 obstetrics and gynecology and maternal fetal medicine.
17 That allows him to offer his opinion, which regular
18 witnesses cannot, but it does not mean you have to believe
19 the testimony. You should evaluate his testimony like
20 that of any other witness.

21 MR. DAVIS: Thank you, Your Honor.

22 THE COURT: Yes, sir.

23 BY MR. DAVIS:

24 Q Dr. Ernest, have you had the occasion to review prior
25 medical malpractice cases, been asked to do in medical

1 malpractice cases, sir?

2 A Yes.

3 Q This isn't the only case you have ever reviewed?

4 A This is not the only case I have ever reviewed.

5 Q Have you given depositions other than the deposition
6 you gave in this case?

7 A I have given other ones.

8 Q Have you testified at trial other than this case in
9 medical malpractice cases as an expert?

10 A Yes.

11 Q Have you reviewed other cases for me at my request
12 other than this case?

13 A I know of one other one. There may be a third, but I
14 know of two counting this one.

15 Q Doctor, have you ever reviewed a case, a medical
16 malpractice case for a plaintiff lawyer?

17 A Yes.

18 Q How many times?

19 A Several dozen.

20 Q Doctor, what are the fees that you're charging to
21 review deposition that was given some time ago and then
22 the trial today? What sort of fees do you charge for the
23 time that you spend, sir?

24 A I charge \$400 an hour.

25 Q Straight across the board?

1 A Yes.

2 Q Doctor, explain to the jury what information you were
3 able to review in this particular case that helped you to
4 form any opinion you intend to render in addition to your
5 education, your training and experience in your specialty,
6 sir?

7 A I reviewed the medical records of the pregnancy of
8 Ms. Patton. I reviewed the delivery records of Alexia. I
9 reviewed the post-partum course of Ms. Patton. I reviewed
10 some of the followup records, including the surgeries of
11 Alexia. I reviewed the labs, of course, the fetal heart
12 rate tracing during that labor. And I reviewed a number
13 of depositions that were given by the medical care
14 providers as well as the experts from both sides.

15 Q Did you also have occasion to review any medical
16 literature?

17 A Yes, I did.

18 Q Doctor, to the extent I ask you any of your opinions
19 today, can we have an agreement that your opinions will be
20 within a reasonable degree of medical certainty unless you
21 tell me otherwise?

22 A Yes.

23 Q Thank you, sir. What are your opinions, Doctor, in
24 this case regarding the care provided by Dr. Miller in the
25 delivery of Alexia? If you'll just give me a summary of

1 what you understand happened and whether or not you think
2 he met the standard of care, whether or not you think he
3 fell below the standard of care.

4 A Well, he clearly met the standard of care. He
5 evaluated Ms. Patton during the labor process. He
6 recognized the fetal heart rate abnormality and promptly
7 took her to the delivery room. He recognized the need for
8 cesarean section, which prompted the move to the delivery
9 room, was no longer present because the heart rate had
10 recovered and was looking normal. He evaluated her at
11 that time and recognized her pushing was going to allow
12 her to deliver vaginally. At the time of delivery, he
13 appropriately and quickly recognized that there was a
14 shoulder dystocia present where the shoulder was not
15 moving through the birth canal at the proper rate. He
16 performed the appropriate maneuvers in the proper sequence
17 when he recognized that shoulder dystocia and delivered
18 the baby with those maneuvers. He also treated a second
19 problem she had, which was a post-partum hemorrhage that
20 happened after the delivery appropriately with the proper
21 medicines to minimize the blood loss that she was having.

22 Q Do you have an opinion as to whether at any point in
23 time Dr. Miller fell below the standard of care in his
24 care and treatment of both of his patients, the baby and
25 mom, on April 5, 2007 in this case in spite of the very

1 serious and permanent injury suffered by this child?

2 A Yes, my opinion is that he very clearly met the
3 standard of care in all those situations.

4 Q Doctor, in your deposition some time ago, Mr. Graham
5 took your deposition, I think it was 2018. I'm not sure
6 of the date, but you've probably got that?

7 A Yes, sir.

8 Q You seemed to indicate -- and he was asking you the
9 question about a second shoulder dystocia following a
10 rotational maneuver. You seemed to indicate that may have
11 happened or that happened or something. Would you explain
12 that?

13 A The delivery note described a rotational maneuver,
14 which is appropriate for the sequence in a shoulder
15 dystocia, as moving the baby 180 degrees. My initial
16 thought was that the one shoulder, which was the right
17 shoulder, had moved from behind the pubic bone to 180
18 degrees and that the left shoulder became located behind
19 the pubic bone. That was my initial impression when I
20 read that note.

21 Q Did you read the deposition testimony of Dr. Miller?

22 A Yes.

23 Q In its entirety?

24 A Yes.

25 Q Anywhere in that deposition did Mr. Graham ever ask

1 Dr. Miller about some second shoulder dystocia, sir?

2 A He did not.

3 Q You were not here when Dr. Miller testified in this
4 case because even if you had been in town, you would not
5 have been permitted to do so because there's a rule of
6 sequestration, which means all witnesses need to be
7 outside the courtroom when other witnesses are testifying,
8 except, obviously, the parties. I want you to assume for
9 the sake of my question, sir, that Dr. Miller testified
10 before this jury in this trial under oath that there was
11 never any second shoulder dystocia when he did his
12 rotational maneuver, but that the left shoulder, when it
13 went from posterior to anterior, the baby unscrewed, came
14 toward him and that left shoulder never got stuck behind
15 the pubic bone and came, indeed, under the pubic bone. I
16 want you to assume that that's true and assume that's what
17 he said to this jury under oath. Does that information in
18 any way alter or change your opinion about the second
19 shoulder dystocia?

20 A Well, it does because of several things. It makes
21 more sense. When I read that, my initial interpretation
22 was that one shoulder was displaced with another shoulder
23 behind the pubic bone and that's really unusual. I've not
24 seen that in my experience or heard about it. So that was
25 unusual for me. Having a baby rotate 180 degrees, but not

1 get behind the shoulder makes a whole lot more sense and
2 is a whole lot more common and it also helps me to
3 understand more about what happened to the baby.

4 Q I want to go back to this hypothetical. I want you
5 to assume for the sake of my question that there was a
6 second shoulder dystocia after 180-degree rotational
7 maneuver, just assume that. Does that constitute a
8 deviation from the standard of care?

9 A No.

10 Q Why not?

11 A Well, because the rotation was done properly. It was
12 done in the right sequence. And if that happens, it
13 happens. It means you have to do some additional -- take
14 some additional time to deliver that shoulder, but it
15 doesn't mean there was a deviation from the standard of
16 care. It just means the shoulder went a little further or
17 in a direction or in a position that you weren't
18 expecting.

19 Q Doctor, do you have an opinion whether or not all
20 babies have the same tolerance with regards to this type
21 of brachial plexus injury that Alexia suffered in this
22 case?

23 A I do, and they do not have the same tolerance.

24 Q What's the basis of that opinion?

25 A Well, there are different factors of labor and there

1 are different factors of the baby's wellbeing or health
2 that can impact how much pressure it can withstand on its
3 brachial plexus. The easiest example in this situation
4 would be the fact that Alexia was born and had low tone.
5 The medical term is hypotonia. When a baby is born with
6 hypotonia, it's not able to protect its shoulder as well
7 given the same amount of pushing or pulling, traction or
8 pressure. And that is a clearly recognized risk for a
9 nerve injury. That's pretty intuitive because if you are
10 anesthetized, for example, your arm on an operating table
11 might be more likely to be injured because you're not
12 protecting it. So because she was hypotonic, that's a
13 very good example of a situation where a brachial plexus,
14 everything else being equal is going to be more
15 susceptible to being injured.

16 Q Doctor, do you have an opinion whether or not an
17 extended period of bradycardia for six to eight minutes,
18 heart rate in the 60s to 90s for eight to ten minutes
19 creates any concern or should create any concern for the
20 delivering position?

21 A It should and it did here. And it was preceded by a
22 series of heart rate decelerations called variable
23 decelerations that usually mean cord compression. The
24 umbilical cord was being compressed. So if we see a
25 preceding episode of dips which we think are caused by

1 cord compression when the uterus contracts and then we see
2 a heart rate that drops down, we have to be concerned that
3 the cord is being compressed. And so that can be -- that
4 can interfere with the oxygen flow to the baby and it does
5 concern us.

6 Q What's the big deal about the oxygen going to the
7 baby, if the umbilical cord gets compressed, what harm or
8 danger or risk does that pose?

9 A Well, it can pose no risk if it's minimized, meaning
10 if it doesn't last too long or the cord is not completely
11 blocked or occluded or it can lead to death in most severe
12 cases if there is no oxygen exchange for a period of time.

13 Q Is that the way the baby survives through the
14 umbilical cord?

15 A Yes.

16 Q That's how the baby, if I can say it, breathes?

17 A That's how the baby gets oxygen and that's how the
18 baby gets rid of carbon dioxide when we exhale. The
19 carbon dioxide is pushed back through the umbilical cord
20 to the mother who then breathes it out. So it's the way
21 the baby's energy supplies are generated and how the baby
22 survives.

23 Q Would it be appropriate for the delivering physician
24 in light of an extended bradycardia to want to try to
25 encourage mom, assuming she's now complete, to push,

1 encourage her vigorously to push to try to get the vaginal
2 delivery effected?

3 A Yes. Because we are concerned that if that heart
4 rate or the deceleration persist, it can cause harm to the
5 baby. And in a woman who's having her fourth baby,
6 generally, it does not take as long for the baby to exit
7 the birth canal. So we know that if we can speed up that
8 process, if the mother and us together can speed the
9 process up, then it can reduce the amount of time the
10 baby's oxygen levels might be low and minimize the risk to
11 the baby's brain.

12 Q Dr. Ernest, what is a posterior shoulder dystocia?

13 A Well, a shoulder dystocia is an impediment to the
14 progress of the shoulder during delivery. Babies tend to
15 be delivered sideways with one shoulder down and one
16 shoulder up. The posterior shoulder, the one down is --
17 there are parts of the bony pelvis in the mother, the
18 maternal pelvis that the baby has to pass in order to get
19 out. The back shoulder, the posterior shoulder has to
20 pass the lower part of the spine, the junction of the
21 lumbar segment is called L5 and then the sacral
22 promontory, which is where the sacrum sort of sticks out,
23 there's a little bump or a notch there. It's a bump, it's
24 not really a notch, it's a bump or protrusion and the
25 shoulder has to pass that. In some situations, as the

1 baby is moving down the birth canal, that back lower
2 posterior shoulder gets hung up on that protrusion or that
3 bump and it's well before you can see the head. It's well
4 before the doctor can touch the baby. But as the uterine
5 contractions continue, it can cause injury to that
6 posterior brachial plexus because it can be stretched. So
7 that is the ultimate concern of a posterior shoulder
8 dystocia and that is that the brachial plexus on the
9 posterior shoulder will be injured before we are able to
10 do anything about it or even know about it.

11 Q Doctor, in reviewing this case and some of the
12 medical literature, the articles that you have reviewed I
13 think you were asked about by Mr. Graham at your
14 deposition, all 12 or 14 of them, whatever they were, were
15 there any articles that you found or that you're aware of
16 that addressed or spoke to the, I'll call it the
17 permissible or allowable pull or force within the standard
18 of care?

19 A The recommendation is to apply as little traction as
20 possible to deliver the baby. People have tried to come
21 up with numbers, but each delivery is different. In some
22 deliveries I've had, I've had to apply no traction and the
23 baby came out very quickly without me doing anything,
24 really, other than just holding my hands and catching the
25 baby, basically. With other deliveries, I've had to apply

1 a significant amount of traction. People have tried to
2 quantitate how much is too much and it varies from
3 situation to situation. For example, in a baby with
4 hypotonia, less traction would be likely to cause an
5 injury than a baby that had normal tone. In a baby that's
6 big, you may be required to apply more traction because
7 the fit is tighter than a smaller baby. So there are no
8 really good numbers. There are people that have generated
9 computer models, that have generated physical models, that
10 have developed gloves with sensors in the fingers or
11 sensors in the arm to measure the EMG impulses in the
12 muscles to try to estimate how much doctors pull. And we
13 have those numbers, but there's not really a number that
14 is permissible because you want to use the least amount
15 possible for the situation.

16 Q What are uterine contraction forces, sir?

17 A Well, a force is an impulse or it's a -- impulse is
18 probably a -- influence, it's an influence that makes
19 something start or stop. That's a way to think about
20 force. And there are forces inside the uterus on the baby
21 to move the baby down the birth canal. Those forces --
22 there are three that I commonly think about. One of them
23 is the force of the uterus contracting. And that alone
24 can push some baby's out. I've had patients that were
25 totally anesthetized and their uterine contractions alone

1 pushed the baby out without the mother pushing or doing
2 anything else. The second force on the baby before it's
3 born is the mother is pushing. The medical term for that
4 is Valsalva where the mother takes a deep breath and bears
5 down. And that generates a force or a pushing on the baby
6 inside the uterus. And the third force can be generated
7 when the mother is put in a position called McRoberts.
8 And McRoberts is where the mother's legs are brought back
9 toward her abdomen and the movement of the legs back
10 actually increases the force or the pushing ability of the
11 uterus. So those three forces, the contractions, the
12 mother's pushing, which is additive to that, and then the
13 McRoberts, which is additive to that are all forces inside
14 the uterus on the baby. And that grouping is called
15 endogenous forces. And that's as compared to the
16 exogenous, which is what the doctor would be applying.

17 Q How many deliveries have you performed, sir?

18 A I have performed or assisted 5, 6, 7,000.

19 Q Thank you. If a physician is using the least amount
20 necessary to effect delivery, to help resolve a shoulder
21 dystocia, are there any -- are these forces that you've
22 mentioned, are they additive, you know, the maternal
23 contraction, pushing, McRoberts, do those add one to
24 another?

25 A They do. It's a little bit like if your car gets

1 stuck in the snow, you can try to tow it out by pulling it
2 out. And that would be the traction force that the doctor
3 would be applying. You could try to get some of your
4 friends to push from behind. That would be the endogenous
5 uterine forces. Or you could do the combination. And if
6 you can't get enough friends to push, then you get the tow
7 truck and together those two additive forces get the car
8 out. So that's the same thing when a baby is delivered.
9 There are internal or endogenous forces pushing the baby
10 out and that may be all the baby needs in some situations.
11 In other situations, you have to add to that force the
12 external or the exogenous forces of the doctor, midwife,
13 the nurse who's applying traction. But those are additive
14 to get the baby out.

15 Q Are you familiar with any medical literature, Dr.
16 Ernest, that you reviewed that addresses the amount of
17 force used by a physician in a live actual delivery?

18 A There are a number of articles published about this.
19 This is a very important topic for us because we want to
20 apply the least amount of traction or force possible to
21 minimize the problems. So if you look at the literature,
22 probably, the best literature I think is actual human
23 deliveries where, as I said, doctors wore gloves that had
24 sensors in the fingers or sensors in the arm. One doctor
25 developed a platform and he stood on the platform and he

1 delivered babies on the platform. The principle is the
2 same as if you were on a scale and want to make it look
3 like you weigh less, you pull yourself up a little bit.
4 That's another way to measure how much pulling is involved
5 in a delivery. So there are also computer models, but I
6 think the human models to me are probably the most
7 accurate as far as what doctors have actually really,
8 really pulled in real human deliveries.

9 Q Any of the studies or anything you've looked at,
10 medical literature, come up with, I'll call it pounds of
11 pull or pounds of pressure or force?

12 A Right.

13 Q Any numbers that you recall?

14 A Yeah, the numbers of traction and I -- again, I think
15 if you think about some deliveries that don't need any
16 traction, if you look at a range of what it takes to
17 deliver a baby from the external, exogenous doctor
18 standpoint, it's from zero to about 45 pounds. 45 is
19 probably the highest number I've seen of an actual
20 delivery of a baby with some type of pressure monitor,
21 that was the EMG monitor, that actually delivered a live
22 baby. So zero to 45 pounds is probably the range that I
23 think is most -- today, the research, that's the best we
24 have.

25 Q In the 45-pound measurement, was there any injury to

1 the baby?

2 A No, not in that case.

3 Q Do you have any opinion about how much force is
4 necessary to break a nerve in the brachial plexus in a
5 neonate during a delivery?

6 A There have been fewer studies in humans for obvious
7 reasons. You can't test a baby's neuro that's alive to
8 see how much it takes to break it, so studies have been
9 done with cadavers, human cadavers. Studies have been
10 done with animals. Studies have been done with computer
11 models. Studies have been done with physical models. The
12 numbers that I've seen that I think are most reliable from
13 a breaking standpoint are probably in the 30 to 45-pound
14 range. Human studies have -- with cadavers, newborn
15 cadavers from a study in the 70s showed that you could
16 break a brachial plexus nerve with about 40 to 45 pounds
17 of pulling. Computer models and other physical models put
18 that number at 30 to 35. So probably 30 to 45 pounds
19 would be a good range to use for a breaking point. It
20 varies from baby to baby, but that's the range that I've
21 seen that probably is the best we know today.

22 Q Dr. Ernest, in this case, you're familiar with the
23 level of injury that's documented in the medical records,
24 you've reviewed those?

25 A Yes.

1 Q Was there a more serious injury at C5-C6 than lower
2 down?

3 A C5 and C6 had a rupture, which is a tearing of the
4 nerve, and it was completely torn through, so there's no
5 transmission of the electrical impulse. C7 and C8 had
6 what's called an evulsion, which is a pulling apart of the
7 nerve at the spinal cord. That tends to be a little bit
8 more severe. If you look at the gradation of nerve
9 injuries, stretching is the least serious, that usually
10 gets better without any treatment. Those are the
11 temporary type. And then there are different degrees of
12 tearing of the nerve at different portions of the nerve
13 until it's torn all the way through. And then there's the
14 evulsion. So it tends to be the most severe.

15 Q Does the nature of the injury in this case indicate
16 or prove to you that Dr. Miller used excessive downward or
17 lateral traction?

18 A No, it does not.

19 Q Why not?

20 A Well, because these injuries that Alexia has can be
21 generated by internal forces. I just mentioned that
22 nerves can be torn at 30 to 45 pounds and internal forces
23 have been measured or calculated up to 50. So there
24 clearly is enough internal or endogenous force to cause
25 permanent injury. So just because a child has an injury

1 to any degree, it does not mean that there was too much
2 external force applied.

3 Q I'm trying to go through my questions. I'm going to
4 skip down a little bit. Bear with me. Do you have an
5 opinion as to the percentage of stretch that is required
6 to cause a permanent brachial plexus injury?

7 A Newborn nerves tend to be less susceptible to injury,
8 which is good. And the number that I've seen is about 50
9 percent. That varies. If a nerve is stretched quicker,
10 it tends to break at lower traction. That's the principle
11 behind if you're fishing and get your fishing line caught
12 in the tree, if you reel it slowly, it will stretch,
13 stretch, stretch, stretch, stretch before it breaks.
14 Whereas, if you pull it real hard, it will pop. That's
15 the same principle. Nerves tend to be more susceptible to
16 breaking if the stretching is quick compared to if the
17 stretching is slow. 50 percent is sort of the number that
18 people start with and then they look at how quickly does
19 the nerve stretch and how big is the nerve and other
20 indicators, but about 50 percent is a good number to use.

21 Q Thank you. Do you have an opinion about any range of
22 force during labor and delivery that can cause a stretch
23 of a brachial plexus even without shoulder dystocia
24 occurring?

25 A Well, people have never been able to measure

1 individual baby stretch, but people have done calculations
2 and --

3 MR. GRAHAM: Excuse me, Your Honor. We object on
4 hearsay as to this. Or if they want to do learned
5 treatise the correct way, I would withdraw the objection.

6 THE COURT: Mr. Davis, if you can just lay a
7 foundation for what he's basing -- the source of that
8 information.

9 BY MR. DAVIS:

10 Q What's the source of that information, Doctor?

11 A There are medical articles that have calculated the
12 stretch inside the uterus during contractions and with
13 models.

14 Q What articles are you referring to?

15 A There are articles by folks like Robert Allen,
16 articles by folks like Michelle Grimm that have calculated
17 the force inside the uterus that would cause a nerve to
18 stretch.

19 Q Do you have an opinion based on your research --

20 THE COURT: Hold on. Excuse me, Mr. Davis.

21 MR. GRAHAM: We object on the grounds that this is
22 not a proper use of the learned treatise exception to
23 hearsay. We still don't have the identification of the
24 article. And the Rule limits him to reading portions, not
25 having the witness paraphrase.

1 THE COURT: Counsel, can y'all approach the bench?

2 (WHEREUPON, a bench conference was held in the
3 presence of the jury, but outside the hearing of the
4 jury.)

5 BY MR. DAVIS:

6 Q Doctor, do you have an opinion about a range of force
7 during labor and delivery that can cause a stretch of a
8 brachial plexus even without shoulder dystocia occurring?

9 A Yes.

10 Q What is that?

11 A The range could be anywhere from 20 pounds and up,
12 depending on the speed of the force.

13 Q Thank you. We've talked about posterior arm
14 dystocia. How often does that typically occur? Do you
15 have an opinion about the incidents of a posterior arm
16 dystocia?

17 A I don't know the incidents if you take a thousand
18 deliveries, but shoulder dystocia, it's a pretty
19 significant percentage. If you have a shoulder dystocia,
20 maybe a third or more of the dystocias are of the
21 posterior shoulder.

22 Q Do you have an opinion in this case whether or not
23 that happened?

24 A Yes.

25 Q What's your opinion?

1 A My opinion is that did happen in this case.

2 Q In preparation for your testimony today, did we send
3 you an animation that was prepared to help the jury
4 understand or, at least, visualize, at least, what Dr.
5 Miller contends occurred in this case? Did we send that
6 to you?

7 A Yes.

8 Q Have you had a chance to review it?

9 A Yes.

10 Q And you reviewed it again, I think, last night?

11 A Yes.

12 MR. DAVIS: Your Honor, we'd like to play that at
13 this time.

14 THE COURT: Ladies and gentlemen, just a reminder,
15 this video is not evidence. It's an illustration of what
16 one side believes happened. Yes, sir.

17 MR. DAVIS: Thank you, Your Honor.

18 BY MR. DAVIS:

19 Q If you need to pause or want to pause it at any time,
20 just let us know and Drew will be glad to pause that if
21 you want to make comments.

22 A Okay.

23 (WHEREUPON, video animation is played.)

24 A One of the things that I think is important is the
25 baby's head, the back part of the head, the occiput is

1 down. Normally, that part right there should -- not
2 should be, but it normally is up at the top. So the baby
3 is coming down the birth canal in a way that takes more
4 room. The posterior occiput takes more room to get
5 through the birth canal than the anterior position.

6 Q That's not mom's fault, is it?

7 A No, no, no, it's just -- it happens. We see occiput
8 posteriors commonly, but it takes more room. Sometimes,
9 we have to actually rotate the head, not the shoulder,
10 just the head. That didn't happen in this case, but
11 sometimes, to make room for the head and for the mother to
12 push the baby out, we actually turn the head from looking
13 straight up to looking straight down. That allows -- that
14 takes less room in the birth canal and then the baby can
15 deliver.

16 Q No evidence that happened in this case?

17 A No, but the baby is -- the baby's head is -- the
18 occiput is down, which is a less common way for a baby to
19 deliver.

20 Q Okay. Thank you.

21 A The other thing we can notice is we talked about the
22 sacral promontory -- stop that right there.

23 (WHEREUPON, video animation is paused.)

24 A The sacral promontory is right there where those blue
25 stripes, right there --

1 THE COURT: Hold on one second, Doctor.

2 THE WITNESS: Yes, sir.

3 MR. GRAHAM: Would you kindly note my objection to
4 this witness' use of the animation.

5 THE COURT: The objection is noted. Yes, sir.

6 BY MR. DAVIS:

7 Q Go ahead, sir.

8 A The blue stripes -- that last blue stripe right there
9 where you're circling, that little bump there is the
10 sacral promontory. The sacrum is the bone that -- it's
11 just to the right of that. That is one of the two bones
12 that the baby has to pass to get out of the birth canal.
13 The other one is the one in the front of up there just
14 above the baby's head. Right there, yeah, that's the
15 pubic bone.

16 Q All right, sir.

17 (WHEREUPON, video animation is continued.)

18 A This part is just showing that the baby's shoulder
19 has been obstructed or has slowed down the downward
20 progress. And the red on those nerves there indicates
21 that they're being stretched, which is when I think --
22 this is the time of the delivery process when I think it's
23 more likely than not that the baby's nerves were injured.

24 Q At that point -- we have these arrows, green, yellow,
25 green, yellow. If we can assume just for the sake of my

1 question that the green arrows, for example, are the
2 uterine contractions and the yellow arrows are mom's
3 pushing, would that be a fair way to depict that
4 phenomenon we earlier spoke of?

5 A Yeah, I think that an even better way would think
6 that all those arrows are additives. So there's one
7 direction, those are called vectors, and each of those
8 adds up so that there's one main driving force or
9 direction that those arrows all end up generating or
10 influencing the baby's movement. And so even though the
11 one at the top, the yellow one is pushing down, that is --
12 and there's a green one down at the bottom that's pushing
13 sort of to the northeast there, they all end up being one
14 force or one vector, which ends up pushing the baby out
15 through the birth canal.

16 Q So maybe a better way to have illustrated this,
17 perhaps, according to what you're telling us, would it
18 have been to have just one big arrow kind of from the top
19 of the uterus heading down toward the head in a straight
20 line?

21 A That's the result of all these smaller arrows.

22 Q Okay.

23 A And there's one other force that we talked about
24 earlier that I want to remind people, is that -- maybe
25 it's going to get to that, but she's not in McRoberts yet.

1 Q Getting there.

2 A The legs are still down. Okay. So we'll hold that
3 thought for a minute.

4 Q All right, sir. Thank you.

5 (WHEREUPON, video animation is continued.)

6 A This shows that the right shoulder is behind the
7 pubic bone. The baby's back is on the mother's left side.
8 And that shoulder is preventing the delivery with the
9 gentle traction that is being applied. That's how you
10 recognize shoulder dystocia is when your normal traction
11 does not move the baby down through the birth canal.

12 Q You said the McRoberts adds some force?

13 A Right. I would have put an arrow -- I would have put
14 a third color arrow on this because people that have
15 measured this find that the -- just the McRoberts maneuver
16 adds some internal force. So now you've got a contraction
17 force, you've got the mother's pushing down force and you
18 also have the force of the McRoberts maneuver, all working
19 to push baby out of the birth canal, but because baby's
20 shoulder is not moving, the maneuvers are required to help
21 get the baby in a position that can deliver with less
22 force on the baby. So suprapubic pressure is being
23 applied and that pushes the shoulder under the pubic bone
24 to try to get that shoulder under so the baby can deliver.
25 The episiotomy is being cut and it helps with the ability

1 of the doctor to get his or her hand into the uterus,
2 which is what's going to happen next, to try to deliver
3 the posterior arm. The posterior arm when it is delivered
4 reduces the width of the shoulders so that the baby can
5 get delivered more easily. One other thing I would add at
6 this point is, the reason every baby does not have a
7 shoulder dystocia is not because some babies are smaller
8 necessarily because great big babies sometimes don't have
9 them and smaller babies do have them. It's the position
10 that the baby has as it comes down. So most babies, as
11 they come through the birth canal don't come down exactly
12 straight up and down, they come down sideways a bit. So
13 that avoids the sacral promontory and that avoids the
14 pubic bone. But when a baby comes down straight up and
15 down -- or sideways, rather, like this baby is doing, then
16 one or both of the shoulders can be impacted or can be
17 slowed down during the birth process. So, again, it's
18 more common, even for big babies, to not have shoulder
19 dystocia because they tend to come out just a little bit
20 to the side, angled just a little bit one way or the other
21 and then they don't get caught behind the pubic bone or
22 they don't get caught on that sacral promontory. The
23 maneuver done here is a maneuver that reduces the width of
24 the shoulders. There's two ways to do it. You can push
25 this way or you can push this way. If you push the way

1 this shows, it collapses the shoulders. And one of the
2 problems with these type of deliveries, with shoulder
3 dystocias is that the shoulders are very broad and they
4 need to either be compressed or rotated. So if you push
5 on the back on the shoulder as this shows right there, it
6 reduces the width of the shoulders, which means it takes
7 less room for the baby to come out. At the same time, the
8 baby is unscrewing out of the birth canal, which takes
9 less force for the baby, both from the uterus and from the
10 doctor that's delivering. So you get two benefits from
11 that posterior pressure. One is it collapses the
12 shoulders and one is it works to unscrew the baby.

13 Q You reviewed Dr. Miller's handwritten note and the
14 transcribed note?

15 A Yes.

16 Q Exhibit 30 is the transcribed note. Dr. Ernest, is
17 there anywhere on his note, particularly in the middle
18 paragraph when he starts off in the operating room, things
19 going on there, anywhere where Dr. Miller uses the word
20 traction, sir?

21 A No, there is not.

22 Q In his deposition, Dr. Miller mentioned what he meant
23 by moderate effort, do you recall that?

24 A Yes.

25 Q What do you understand he meant by his sworn

1 explanation under oath when he was deposed in 2011 in this
2 case as to what he meant by the note that he wrote?

3 A Yes.

4 Q What do you remember him -- how do you remember him
5 explaining it?

6 A He said that this had nothing to do with traction, it
7 was the total sum of the maneuvers, that it was not a --
8 it was not a straightforward easy delivery. It required
9 moderate effort and the sum total of the process to get
10 the baby delivered, but it did not have anything to do
11 with the traction applied.

12 Q Dr. Ernest, I just want to ask very briefly about
13 vacuum because it's come up some in this trial. He
14 documents that he before they went to the operating room
15 attempted a vacuum times one to help facilitate delivery,
16 however, would not hold effectively. He did that after
17 the eight to ten minute bradycardia down to 60 to 90. Do
18 you have an opinion whether or not his attempt at that
19 point was within the standard of care?

20 A It was.

21 Q Why?

22 A Well, he had a situation with a woman having her
23 fourth baby. It generally happens very quickly, the
24 delivery process. And even a baby at zero station
25 generally delivers very quickly in a woman having her

1 fourth baby. And it is very reasonable to expect that if
2 you can get a vacuum on a baby at that point you can
3 deliver the baby more quickly and as safely, if not safer
4 than going to do a C-section, which would take some time
5 to get the operating room set up and so forth. So it's
6 appropriate in that situation to try to get the baby to
7 deliver vaginally because of the heart rate changes that
8 were potentially going to harm the baby.

9 Q Thank you, sir. He notes in his note that we have in
10 front of us it would not hold effectively. It never
11 attached. Did that, in your opinion, cause any harm or
12 injury to this baby or to Ms. Patton?

13 A No, it was an irrelevant part of the delivery. It
14 was an appropriate thing to do, but it had no bearing on
15 the delivery process.

16 Q Dr. Ernest, as a former oral board examiner for
17 OBGYN'S, in your opinion, what is most important to the
18 reasonably prudent obstetric -- obste -- OBGYN? It's late
19 in the day, sorry. His fund of knowledge or what he does
20 in the delivery room?

21 A Well, it depends on -- from an examiner, if I was
22 examining a person in Dallas, I don't know what he's going
23 to do in the operating room but I would check his fund of
24 knowledge. If I'm in the operating room, especially if
25 I'm a patient, the fund of knowledge is not really

1 critical to me. It's what the doctor does to take care of
2 me. So I think from a patient perspective and I think
3 from a general care perspective, it's what the doctor does
4 with the knowledge he has. It's much more critical than
5 the facts that he does or doesn't know.

6 Q Did you find anything in this record, in his
7 deposition, in the medical records, in his note that
8 indicated to you in any way that Dr. Miller, what he did
9 violated the standard of care or was in any way below the
10 standard of care?

11 A No, he met and exceeded -- he did exactly what he
12 should have done at the right time and clearly met the
13 standard of care.

14 Q Bear with me, please, sir.

15 (Pause.)

16 Q Are you aware of any time where a baby has some
17 posterior injury to the brachial plexus without any
18 physician traction being used? Is that known?

19 A It's known that babies have been delivered without
20 any excessive traction in normal deliveries. There's been
21 plenty of routine deliveries with no reason to think that
22 there was excessive traction applied. And those have been
23 reported for many, many years, so it's clear that
24 posterior shoulders can be injured permanently without the
25 doctor causing the injury. And if it's a posterior

1 injury, the doctor could not have applied the traction to
2 cause the injury because the posterior shoulder is damaged
3 before the doctor can get to the baby.

4 Q Bear with me, please, sir.

5 (Pause.)

6 Q Doctor, in your opinion, did Dr. Miller's note give
7 you adequate information to determine whether or not he
8 met the standard of care?

9 A Yes.

10 Q In your opinion, Dr. Ernest, who would be in the best
11 position to determine the actual amount of traction used
12 by the delivering physician?

13 A That would be the delivering physician, Dr. Miller,
14 in this case.

15 Q Do you have an opinion whether or not a shoulder
16 dystocia as occurred in this case constitutes in your
17 professional opinion an obstetrical emergency?

18 A Yes, it does.

19 Q Why?

20 A Well, when a shoulder dystocia occurs, the oxygen
21 supply to the baby is reduced or completely cut off and
22 that causes a change in the baby's heart rate. It causes
23 a change in the oxygen level in the blood and it can lead
24 to damage to the baby. So it is an obstetrical emergency.

25 Q Doctor, do you have an opinion whether or not

1 shoulder dystocia is a reasonably foreseeable or
2 reasonably predictable event in any delivery?

3 A There are some that potentially could be reasonably
4 foreseeable, but not in this delivery. This was a
5 delivery where the most likely weight was almost a pound
6 below the previous baby's weight that had no problems, so
7 there was really no reason to suspect that there would be
8 a shoulder dystocia in this case.

9 Q Doctor, was there any point in reviewing the medical
10 records that Alexia was medically unstable?

11 A Yes.

12 Q When and what's the basis of that opinion, sir?

13 A Well, the information that we know now after the baby
14 delivered was that her one-minute APGAR score was four.
15 That score is usually higher than that. And a four means
16 that a baby needs to be resuscitated. So that is an
17 indicated that there was some instability of the baby.
18 That was a subjective number that's given by the
19 pediatrician there. An objective way to tell that there
20 was some instability is the cord blood gas that was drawn.
21 And there are two numbers on that gas that are pertinent.
22 The ph was 7.2, which is right at the lower limit of
23 normal. It was normal, but it was at a lower limit of
24 normal. And the base assess, which was just below normal,
25 so it was abnormal. That base assess of minus 13 puts the

1 baby at an increased risk of death. So that base assess
2 is very objective information and evidence to me that
3 there was instability going on prior to the delivery and
4 that there was an emergency here. Another factor that is
5 important is the baby's tone. The fact that the baby's
6 tone was low indicates that there was some instability as
7 well and that all is part of this process of the oxygen
8 levels being effected, the baby heading toward acidosis
9 and --

10 Q What's acidosis?

11 A Acidosis is a situation where -- it can be caused by
12 many different things, but in deliveries, it can be caused
13 by oxygen flow to the baby being reduced or cut off and
14 the baby changes the way it generates energy and that
15 change in energy generates acid, so the acid builds up in
16 the baby's blood. And we can see that with the base
17 assess. That's a very good way to tell that over a period
18 of time, this baby -- Alexia had been generating some
19 acids in her blood and was right at the level where there
20 was a potential for harm.

21 Q What kind of harm, sir?

22 A Well, the 13 puts her in a category of increased risk
23 of death. It probably puts her at an increased risk of
24 brain damage. That one is a little bit less firm in the
25 literature. I've seen both, yes, it does, no, it doesn't.

1 But it clearly puts the baby at an increased risk of death
2 because of the acid level that had built up.

3 MR. DAVIS: Your Honor, I'd like to show Mr. Graham
4 what I would like to mark as Defendant's Exhibit No. 34,
5 which is a arterial blood gas of Alexia Lumpkin taken
6 shortly after her birth from the note that's in her lab
7 report.

8 MR. GRAHAM: Is that already in evidence?

9 MR. DAVIS: I honestly don't know.

10 THE COURT: Any objection, Mr. Graham?

11 MR. GRAHAM: No, sir.

12 THE COURT: Defendant's Exhibit No. 34 is in evidence
13 without objection.

14 (WHEREUPON, Defendant's Exhibit No. 34 was admitted
15 into evidence.)

16 BY MR. DAVIS:

17 Q Is this what you were referring to, Doctor?

18 A Yes.

19 Q What does that show for the ph?

20 A The ph was 7.21.

21 Q And the base assess?

22 A The base assess was minus 13.

23 Q Those are the -- that's the record you were referring
24 to just a little while ago, the numbers you talked about?

25 A Yes. Anything below 7.2 is considered acidosis, so

1 this was right at the border. Anything 12 and above is
2 considered in the normal range. 13 and below is
3 considered abnormal, so the 13 puts the baby in a category
4 of an increased risk of death. Not a lot, but it clearly
5 is an increased risk.

6 Q I'll ask you to assume for the sake of this question
7 because, obviously, you weren't here with Dr. Miller
8 testified under oath in trial, but I want you to assume
9 for the sake of my question that he testified that in his
10 opinion, the way he reflected on the records and, of
11 course, he was there that this shoulder dystocia lasted
12 about 45 seconds. If it lasted 45 seconds, even up to two
13 minutes, do you have an opinion whether or not that was a
14 prompt resolution of this shoulder dystocia for this
15 child, particularly given her tone and the ph and the base
16 assess that we find out after she's born?

17 A Right. I think that it was very appropriate timing
18 because these numbers indicate that the baby clearly had
19 already had some events that was causing it to have some
20 low oxygen levels and building up acid in its blood. And
21 these numbers didn't just happen in 45 seconds to two
22 minutes. They probably happened during the heart rate
23 changes that dropped before going to the operating room.
24 It got a little bit better, but it didn't completely
25 clear, which we wouldn't expect it to clear that quickly.

1 So I think this is evidence that the time was very
2 important to get the baby out when he did because a longer
3 timing would have meant that the acidosis would have
4 worsened.

5 MR. DAVIS: One moment, please, Your Honor.

6 (Pause.)

7 MR. DAVIS: Dr. Ernest, thank you for your patience
8 with me today. Please answer any questions that either of
9 these attorneys may have for you, sir.

10 THE COURT: Counsel, do y'all want to approach the
11 bench?

12 (WHEREUPON, a bench conference was held in the
13 presence of the jury, but outside the hearing of the
14 jury.)

15 THE COURT: Ladies and gentlemen, Dr. Ernest is the
16 last witness in the case. My preference would be to
17 finish Dr. Ernest testimony today and just have my charge
18 on the law and argument tomorrow, then it would be time to
19 deliberate. Is there anyone -- if we go past five o'clock
20 today, is there anyone that's going to be a hardship on
21 and can't do it?

22 (No response.)

23 THE COURT: Ladies and gentlemen, thank you very
24 much. Mr. Graham.

25 MR. GRAHAM: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. GRAHAM:

Q So Dr. Ernest, good afternoon.

A Hello.

Q We've done this a few times before. Have you changed some of your approach to these cases? Do you remember saying in the past that no one can really assign a cause to brachial plexus birth injury, it's more of a multi-factorial process?

A It can be in some cases.

Q In fact, you've said that consistently, haven't you, sir?

A I don't know about that. I would agree that in an individual case, because we don't measure the stress on the nerves, we have to say what's more likely than not in a case and that's what I'm doing here and that's what I've done in the past.

Q You weren't there when it happened, obviously?

A I was not, but even if I had been there, I would still have to say what's more likely than not because we don't have the advantage of knowing exactly what's happened to this baby, especially if there's a posterior injury. Even if I were there, I would not be able to tell that.

Q Tell us this, in coming up with your opinions on this

1 case, have you assumed that Dr. Miller was telling the
2 truth?

3 A Yes.

4 Q Is that typically what you do when you come into
5 court to support a doctor, you assume they're telling the
6 truth?

7 A I have to do that.

8 Q Of course, you do. How much do you get paid for of
9 course, you do?

10 A I get paid \$400 an hour to testify and review.

11 Q Let me get you, sir, to -- Doctor, could I get you to
12 step down here and draw me a baby? It doesn't have to be
13 a beautiful artistic representation, but could you draw
14 just a curvature of a baby in the birth canal showing the
15 stations?

16 A (Witness complies.)

17 Q Thank you. What does it mean for a baby to be at
18 zero station?

19 A That means the baby's head is even with a couple of
20 little bony prominences called (inaudible) and their on
21 either side of the birth canal.

22 Q (Inaudible).

23 A And that means the baby --

24 THE COURT: Hold on, Doctor, the jury can't hear you.

25 THE WITNESS: It means the baby has entered the

1 pelvis --

2 THE COURT: Mr. Graham, the mic is still not picking
3 him up.

4 THE WITNESS: Zero station means that the baby has
5 entered the pelvis and the lowest part of the baby's head
6 is at the level of those little bony prominences that we
7 can feel.

8 BY MR. GRAHAM:

9 Q So you're showing a plus three system. Is that what
10 you use?

11 A Yes.

12 Q What does Dr. Miller use?

13 A I think he said he uses plus five.

14 Q Okay. In a plus five system, would the plus five be
15 at the same level as a plus three?

16 A Yes.

17 Q Okay. If a vacuum were applied to a baby's head at
18 zero station, would that represent an outlet, low, mid or
19 high application?

20 A Mid.

21 Q So Dr. Chauhan said it would be a high, but you
22 disagree with that?

23 A If it's exactly a zero, it would a mid.

24 Q If it's a micronewton above a zero, would you call it
25 a high?

1 A Anything above zero is a high because that means the
2 head is not engaged. This means the head is engaged.

3 Q So can you tell me -- either on a plus three or a
4 plus five, can you tell me where a low --

5 THE COURT: Counsel, the jurors are still indicating
6 to me they're having trouble hearing.

7 MR. GRAHAM: We might need a different mic.

8 BY MR. GRAHAM:

9 Q Doctor, tell us numerically what would represent a
10 low application of an instrument?

11 A Low would be at two or higher -- or two or lower,
12 rather, in this graph.

13 Q Lower meaning toward the birth canal -- I mean,
14 toward the outlet?

15 A Correct.

16 Q Toward the place where the baby comes out?

17 A Correct.

18 Q And on a plus five system, it would be what?

19 A I've never really seen where a plus five would be.
20 It would probably be somewhere around there. I've just
21 seen the numbers for the one to three.

22 Q So on your system, a low application would be the very
23 outlet plus, what, a centimeter?

24 A It would be right about in the middle. I think if
25 you think about it in thirds, this is a mid, this would be

1 a low, this would be an outlet. So just think of it in
2 thirds.

3 Q Well, how much is there between the positive numbers
4 on a plus three system?

5 A About three centimeters, a little more than an inch.

6 Q Okay. Between each number?

7 A Each of these is about a centimeter.

8 Q So from zero to the head coming out, crowning or
9 outlet would be how much distance?

10 A It would be a little more than three centimeters.

11 Q Which is how many inches?

12 A An inch is 2.54 centimeters, so it would be around
13 inch and a -- well, let's see, three centimeters would be
14 about an inch and a half, so couple inches.

15 Q Would you just please draw a line from there to there
16 and label it as the number of inches you just said?

17 A That's three centimeters. That's about 1 point --
18 let's say one and a half inches.

19 Q And from this point up -- I mean, the baby's not
20 stretched out from head to toe, correct?

21 A Correct.

22 Q But even if we assume the longest possible length of
23 the baby, the baby's length above zero station would be
24 the length of the baby, correct?

25 A Well, the baby is sort of --

1 Q Right, so it would be less than that?

2 A It would be less than the baby's total length
3 stretched out.

4 Q So do you remember the height of this baby?

5 A I do not.

6 Q Would you check please and see if it's 21 and a half?
7 Would your notes help?

8 A I don't know that I have it in my notes. I would
9 have to look at the chart.

10 Q Okay. The chart, sir, is up here, I believe. These
11 are the Piedmont records. Just look through those. I'll
12 see if I can find one more quickly.

13 (Pause.)

14 Q Excuse me, Dr. Ernest, Laura just handed me a summary
15 that shows it was 21 and a half?

16 A Yes, the baby was 21.5 inches, correct.

17 Q Could you kindly draw 21 inches from here upward or
18 if you want to give it a lower length for being in a fetal
19 position, that's fine, but the maximum length would be 21
20 and a half?

21 A Well, I don't know what the length would be because
22 the uterus has contracted the baby down, so it's somewhat
23 less than 21.5.

24 Q Sure. But why don't we show 21 and a half, which is
25 the maximum, right, without any --

1 A It's not that long. It's not stretched out.

2 Q How long do you believe it is?

3 A I don't know because it depends on whether there's a
4 contraction, it depends on how much the baby is being
5 pushed, so it's somewhere less than -- I can put less than
6 21.5.

7 Q That's fine. Thank you.

8 A Okay.

9 Q So we've got 21.5 inches --

10 A Less than.

11 Q Okay, less than 21.5. 1.5 approximately would be,
12 what, less than 23 inches?

13 A Yes.

14 Q Would you just show that total down there?

15 A I'm not sure what total I need to put.

16 Q Well, if you add -- if we're going from the highest
17 point of the baby through the outlet, that would be 1.5
18 inches plus less than 21.5 inches, correct? So the sum of
19 these would be less than 23 inches, correct?

20 A Okay, that sounds right.

21 Q Can you tell us what time the baby's head -- is this
22 called engagement when you get to zero station?

23 A Yes.

24 Q So what time did the baby's head go to zero station?

25 A My recollection is between 7:00 and 8:00. I'd have

1 to look at the chart to see exactly what time.

2 Q Does that have the information?

3 A No, I need the nurse's notes or my notes. I do have
4 that in my notes.

5 Q Are these your notes?

6 A Yes. My notes indicate the baby was at a zero
7 station at 8:12 p.m.

8 Q Okay. Would you kindly label it as such?

9 A I'll use military time since that's what the chart
10 uses.

11 Q That's fine. Thank you. And what time was the baby
12 completely delivered?

13 A At 2051.

14 Q Could you kindly label that?

15 A (Witness complies.)

16 Q So given the baby's head here, given the baby's
17 position one and a half inches from here to here and then
18 considering less than 21 and a half inches, the baby would
19 have traveled less than 23 inches between 2012 and 2051,
20 correct?

21 A I haven't really thought about it this way because
22 that's not the way I tend to think about deliveries, so
23 let me think about this. Between 2012, the baby went from
24 here all the way out. Is that what you're asking.

25 Q Yes.

1 A That's correct. So that would be from this time to
2 this time, the baby was completely out.

3 Q All right. So we're talking -- just doing some math
4 in my head, we're talking 51 minus 12, like 39 minutes?

5 A Yes, 39 minutes.

6 Q Would you label that down there 39 minutes and less
7 than 23 inches?

8 A (Witness complies.)

9 Q Thank you, sir. Now, we've heard you say today that
10 only one shoulder was ever stuck and it was stuck on the
11 sacral promontory, that little bump?

12 A That's what I recognized after seeing the video and
13 hearing what Dr. Miller has said, which clarifies what I
14 read in the chart.

15 Q The animation was convincing, right?

16 A It makes a whole lot more sense than what I initially
17 thought, yes.

18 Q The animation convinced you?

19 A Well, it convinced me along with the fact that that's
20 what I would have expected to have happened and it's more
21 likely to have happened and I've never seen two shoulder
22 dystocias in the same delivery. So it makes a whole lot
23 more sense to me that that's what happened.

24 Q So based on seeing the animation, you changed your
25 testimony from the deposition to trial, correct?

1 A Based on the animation and what I know normally
2 happens and based on the fact that that makes much more
3 sense, yes, I believe that that's more likely what
4 happened.

5 Q So, Doctor, how long did you say at your deposition
6 that it took for a baby's -- in a shoulder dystocia
7 situation for a baby to be at the point in terms of
8 oxygenation where the doctor should start thinking about
9 delivery even if more traction is required? Four to six
10 minutes, does that ring a bell?

11 A I don't think I can answer the question the way you
12 asked that. It has too many parts to it.

13 Q Do you have your deposition up there?

14 A No, I don't.

15 Q Let me hand it to you.

16 A Thank you.

17 Q Please turn to Page 130, Line 25 and I'll start
18 reading from there. I'm going to read the question and
19 answer and you tell me if I've read it correctly, okay,
20 sir? In prior testimony, you've made reference to one or
21 two articles that suggest brain damage can occur within
22 two minutes of a certain event. Do you know what I'm
23 talking about? Answer: Well, you can have brain damage
24 that occurs rapidly within an amniotic fluid embolism. I
25 think there have been reported cases of brain damage that

1 have occurred that quickly with shoulder dystocia,
2 although we tend to not expect or, at least, not think
3 that the risk of brain damage is significantly increased
4 until four or five minutes into the shoulder dystocia
5 process. Did I read that correctly?

6 A Yes.

7 Q This child didn't have any sort of amniotic fluid
8 embolism, correct?

9 A No.

10 Q And the two minutes that you referenced in those
11 articles included babies that were in a terrible state of
12 health prior to the shoulder dystocia, correct?

13 A I don't know what articles we had discussed or I was
14 referring to, but I will tell you that this baby clearly
15 had a level of stress measured by its blood gases that was
16 in need of delivery.

17 Q You said the ph was what, 1.2?

18 A 7.2.

19 Q I'm sorry, 7.2?

20 A Yeah.

21 Q And you said that was the low end of normal?

22 A Correct.

23 Q So it's normal, it's just the low end of normal?

24 A That is one component of acidosis. A better measure
25 of acidosis is the base assess and it was abnormal.

1 Q Well, that has to do with metabolic --

2 A That's the worst --

3 Q In terms of ph, we're talking about respiratory
4 acidosis, lack of oxygen, correct?

5 A No, ph can be respiratory or metabolic. This was a
6 metabolic acidosis, which is the worst type. And it tells
7 me that this baby is delivered at exactly the right time
8 because it was right on the border of becoming -- it was
9 in -- just got in a range that increased the risk of baby
10 dying. It just got to that range.

11 Q You're basing that on the proposition you made
12 earlier that the baby was doing so terribly earlier with,
13 I think you called it excessive -- or maybe it was Mr.
14 Davis, excessive bradycardia?

15 A No, I didn't say the baby was doing terribly, I said
16 the baby had been affected by the variable decelerations,
17 which were probably from the cord occlusion that was
18 intermittent, that lowers the baby's oxygen level.

19 Q Sure.

20 A It got down to a certain level.

21 Q Sure.

22 A It got better temporarily when Dr. Miller took her to
23 the back, but it didn't completely clear and the base
24 assess tells me that this baby was in an acidotic, higher
25 risk range for death and needed to be delivered.

1 Q So you're saying that should have been a C-section?

2 A No, I'm saying he delivered the baby at exactly the
3 right time when you would not expect to have a problem,
4 but had it gone on, there was greater and greater risk of
5 a problem.

6 Q Well, Doctor, you can't have it both ways. Either
7 this baby is in bad enough health to be delivered by
8 C-section or there's no -- there's no reason for this
9 doctor to not take the time to do the job right, is there?
10 Is it ever right for a doctor to not take the time to do
11 the job right?

12 A He took exactly the right time and that's exactly
13 what these numbers show. He delivered the baby more
14 quickly than he could have delivered it by a C-section
15 once he decided that the vaginal delivery route was the
16 appropriate route. He had done a C-section, it would have
17 probably taken longer.

18 Q Another example of -- that was based on some of the
19 animation stuff as well as the records --

20 A I'm sorry, what was based on?

21 Q That last testimony was based on the animation you
22 were provided as well as the records?

23 A I don't understand, I'm sorry. I don't understand
24 what you're referring to.

25 Q Please follow along with me if you would, Doctor,

1 starting at Page 104, Line 4 -- well, starting at Line 1.

2 Question: Have you ever used a Woods maneuver so that the
3 impacted anterior shoulder goes to a 180 degree turn come
4 the posterior shoulder and the posterior shoulder becomes
5 the anterior shoulder and becomes the impacted shoulder?

6 Answer: I may have, but I don't recall that specific
7 rotational maneuver has happened to me. So you're not
8 sure if that's happened to you or not, correct?

9 A I don't recall that that has ever happened to me,
10 that's correct.

11 Q And then drop down to Line 20. Question: So based
12 on that, do you believe we actually had two shoulder
13 dystocias in this case? Initially, one on the anterior
14 shoulder and the second one on the shoulder that had been
15 posterior, but became anterior with the rotation? Answer:
16 My understanding is that the right shoulder was impacted
17 initially and could not be delivered. So the rotation
18 transferred the shoulder -- the left shoulder from
19 posterior to anterior and then that was the shoulder that
20 was delivered with the first two maneuvers that tend to
21 work, the McRoberts and the suprapubic. So, yes, it
22 sounds as if rather than the baby unscrewing, the baby
23 simply rotated, but did not descend in the birth canal,
24 which just simply replaced one shoulder for the other.
25 Question: So is it your understanding that no internal

1 maneuvers were used by Dr. Miller for the second shoulder
2 dystocia? Answer: That was my understanding. Did I read
3 that correctly?

4 A Yes, but the correct pronunciation was my
5 understanding.

6 Q Okay. If I --

7 A No, you read it exactly and that was what I thought
8 when I read that report based on the information I had at
9 that time.

10 Q You've read all the maneuvers that Dr. Miller said he
11 did?

12 A I read all the maneuvers he reported, yes. I know
13 what he did.

14 Q So if you were to do -- you're supposed to be calm
15 when you manage a shoulder dystocia, correct?

16 A Yes.

17 Q If you were calm in performing the maneuvers he did,
18 what would it take, two minutes, three minutes, less than
19 two minutes?

20 A It would depend. It would depend on how big the baby
21 is, how much force you generated. It would depend on a
22 lot of things, the cooperation of the patient, how strong
23 you are, whether you're right or left-handed, which way
24 the baby's head is directed. There are a lot of things
25 that determine that time.

1 Q Sure. Dr. Chauhan testified that he thought it would
2 be roughly two to three minutes. Do you disagree with
3 him?

4 MR. DAVIS: Your Honor, it's pitting a witness
5 against another. He's been sequestered.

6 THE COURT: I'm going to sustain the objection.

7 MR. DAVIS: Thank you.

8 BY MR. GRAHAM:

9 Q You have talked about shoulder dystocia being an
10 emergency. When do you believe shoulder dystocia was
11 first labeled by obstetricians as an emergency? How many
12 years ago or decades or centuries?

13 A Two to three centuries.

14 Q Centuries, all right. I know you weren't alive then,
15 but do you remember what size computers were back in those
16 days?

17 A I think they took a little ball and went from one
18 side to the other and you could count that way.

19 Q And do you remember what kind of safety features they
20 had on automobiles and airplanes?

21 A Two or three centuries ago?

22 Q Yes, sir.

23 A There were no automobiles or airplanes at that time.

24 Q Doctor, are you saying that over the last few
25 centuries while there have been advancements in every

1 other field, obstetricians have not learned how to refrain
2 applying excessive traction to a baby's head?

3 A No, sir, that's not what I said.

4 Q Well, you know the articles that focus on training by
5 avoiding traction have eliminated permanent brachial
6 plexus injuries?

7 A That's not true.

8 Q Dr. Crofts --

9 A No, that is not -- they have not shown that.

10 Q Well, we've gone over Dr. Crofts' article earlier, so
11 I won't belabor the point, but isn't it your understanding
12 that over 12 years, tens of thousands of deliveries, there
13 were no permanent brachial plexus injuries after training
14 that emphasized don't pull on the baby's head, don't pull
15 -- don't bend the baby's neck?

16 A That's not what that article showed.

17 Q We'll come back to that in a minute, sir.

18 A I can save you some time if you'd like me to explain
19 what I mean by that so you can save looking up the
20 article.

21 Q Thank you for the offer, sir, but I'm going to do it
22 with the article.

23 A Okay.

24 Q All right, sir. I refer to an article published on
25 February 17 of 2015, lead author J. F. Crofts, Prevention

1 of Brachial Plexus Injury, Twelve Years of Shoulder
2 Dystocia Training, an interrupted time series study. Are
3 you familiar with enough of this article that -- well, let
4 me hand you a copy. All right, sir. It's already been
5 referenced by Dr. Duboe, but in this article, it
6 demonstrates, does it not, that -- if you turn to Page 4
7 under the discussion section, main findings, and drop down
8 to about the last sentence, Twelve years after the
9 introduction of training for all maternity staff,
10 compliance with (inaudible) was sustained and the fetal
11 morbidity rate associated with shoulder dystocia was
12 extremely low with no cases of permanent brachial plexus
13 injury in the last four years of the followup involving
14 more than 17,000 vaginal births. Did I read that
15 accurately?

16 A Yes.

17 Q Do you believe that that is a flawed article in
18 reaching that conclusion?

19 A This article is reporting on shoulder dystocias and
20 brachial plexus, not the total incidents of brachial
21 plexus, is my recollection. So there were cases of
22 brachial plexus injury, just not in these. So you had
23 asked me if they reduced the permanent rate of brachial
24 plexus injury and I said no, because they didn't show
25 that. They showed that they reduced in cases of shoulder

1 dystocia. There were still cases of brachial plexus
2 injury, just not in the shoulder dystocia cases.

3 Q Well, if you take shoulder dystocia and if you take
4 other causes of the injury, you still get to zero, right?

5 A I don't think that's what they said in this article.
6 And there are other articles that Dr. Crofts has written
7 that explains that better.

8 Q Let me ask you, sir, you indicated that -- well, how
9 do you define bradycardia?

10 A Bradycardia is a heart rate that is below 110 for an
11 extended period of time.

12 Q At least, ten minutes?

13 A Yes.

14 Q For, at least, ten minutes?

15 A Correct, that's the technical definition, yes.

16 Q For the last few days, we've been hearing from Dr.
17 Miller and Dr. Chauhan and Mr. Davis and you that six to
18 eight minutes is extensive bradycardia, but, in fact, it
19 doesn't even meet the definition of bradycardia, does it?

20 A I'm not sure I used the word extensive, but I think
21 there was bradycardia here. The heart rate was clearly at
22 a level that was in that bradycardia range and it was
23 about ten minutes, maybe more, maybe less, but it was a
24 bradycardic episode that needed to be attended to.

25 Q The definition is ten, six to eight counts as ten?

1 A I don't know that it was six to eight. I'll be glad
2 to look at the chart if you would like and we can count
3 them.

4 Q Well, I mean, we've heard that from the Defendant,
5 Dr. Miller. We've heard it from Dr. Chauhan, do you have
6 any reason to doubt --

7 MR. DAVIS: Your Honor, again, he's pitting witnesses
8 that he hasn't heard --

9 THE COURT: I'm going to sustain the objection.

10 THE WITNESS: I'll be happy to look at the chart and
11 we can count it if you'd like.

12 BY MR. GRAHAM:

13 Q Let me ask you about this, you were talking about
14 three forces, three endogenous forces. One was
15 contractions, right?

16 A Correct.

17 Q This mother's uterus didn't contract on its own, did
18 it? It had Cytotec to get it going and Pitocin to make it
19 go faster and quicker, true?

20 A It had those two medications to start labor, correct.

21 Q Not just to start, but it augmented labor, too,
22 correct?

23 A Well, it started it and it augmented it, yes.

24 Q And we've heard that this was just a regular amount
25 of Pitocin, but, in fact, this was -- there are two types

1 of protocols for Pitocin, right, low dose and high dose,
2 right?

3 A They're both appropriate and within the standard of
4 care and this was an appropriate amount of Pitocin, 26
5 milli-units, yes.

6 Q This was high dose?

7 A No, sir, it was a normal dose of Pitocin.

8 Q Normal dose of a high dose protocol?

9 A No, you can use that in any protocol. It's an amount
10 of Pitocin that's normal and accepted and clearly was the
11 right amount of Pitocin because she did not have excessive
12 uterine activity and did not have excessive, more frequent
13 contractions, so it was a perfect dose of Pitocin.

14 Q So anyway, you said there were three forces involved.
15 Are you saying these impacted on the uterus and the baby?

16 A Contractions impact on the baby, yes.

17 Q All right.

18 A And normal contractions impacted on the baby, yes.

19 Q Well, the contractions that impacted on the baby were
20 augmented, made stronger and faster by the drugs that were
21 given, true?

22 A The drugs made the uterus normal and made normal
23 contractions, which impacted the baby and the way we would
24 expect it to impact a baby.

25 Q And the baby was moving slowing down the birth canal.

1 Dr. Miller said she was pushing ineffectively. In fact,
2 what that really means is you've got a tight fit. The
3 baby is not coming down quickly because the baby's got a
4 tight fit, right?

5 A No, sir, that's not what that means.

6 Q At any rate, the doctor had everybody encouraging the
7 mom to push, push harder, push harder, true?

8 A I think they wanted her to push more effectively,
9 which may mean more frequently, it may mean harder, it may
10 be better, but she was not pushing effectively enough to
11 move the baby down the birth canal. We know she could
12 because she did in just a few minutes. So I think they're
13 encouragement was a good thing.

14 Q And you say McRoberts also impacted forces against
15 the baby?

16 A It does.

17 Q All right. Do you acknowledge that McRoberts was
18 only put in place because of the doctor's orders?

19 A I don't remember why it was put in place. It tends
20 to be something we commonly do when there's a difficult
21 delivery and sometimes we use it for shoulder dystocia.
22 But I don't remember specifically if it was a nurse or
23 doctor order, it doesn't really matter.

24 Q Well, three forces that you said are endogenous all
25 relate to the medical care Dr. Miller provided, right?

1 She had drugs, she was encouraged to push, she was put in
2 McRoberts?

3 A Those are the things that we have to have in order to
4 deliver a baby. And if the doctor encourages them, I
5 think that's a good idea.

6 Q We've got damages in this case. Do you know just how
7 severely this child was injured?

8 A Yes.

9 Q Tell us about that.

10 A Well, I read the operative note. I haven't seen
11 notes recently, but I do know that she has had injuries to
12 C5 through C8, possibly T1.

13 Q With two complete ruptures and three complete
14 avulsions?

15 A Two or three avulsions, correct.

16 Q That's a severe brachial plexus injury?

17 A That is in a level of severe, right.

18 Q And plexus, every single part of the brachial plexus
19 was injured?

20 A Not every single part, but every single one of those
21 nerve roots was injured.

22 Q That's as severe as it gets, true?

23 A No, you can have a phrenic nerve injury and you can
24 have other injuries. So there are more severe injuries,
25 but that is a severe injury. I'm not downplaying the

1 severity of the injury, but there are worse conditions.

2 Q Tell us what a phrenic nerve injury is.

3 A Phrenic nerve is an injury where the hemidiaphragm is
4 affected.

5 Q Where the what?

6 A Half of the diaphragm is affected, where the
7 diaphragm doesn't move up and down.

8 Q And there's also something called a Horner's
9 Syndrome, correct?

10 A Uh-huh, yes.

11 Q All right. (Inaudible)?

12 A Yes, that's correct.

13 Q Horner's only comes from the most extensive type of
14 injury, correct?

15 A I'm not sure that's correct.

16 Q Are you familiar with Dr. Stephen Clark's study on
17 behalf of Hospital Corporation of America concerning
18 reducing the cost of shoulder dystocia?

19 A Probably, but I haven't reviewed it for this case.

20 Q In that case, do you recall that Hospital Corporation
21 of America -- the country's largest hospital corporation,
22 right?

23 A I do not know that for sure, but I'll take your word
24 on it.

25 Q All right. And Dr. Stephen Clark is a

1 well-recognized professional in your field who's published
2 lots of articles on these issues, correct?

3 A Yes.

4 Q And Hospital Corporation of America hired him to
5 figure out why they're spending so much money on brachial
6 plexus injuries, right?

7 A I don't remember the details of that study.

8 Q All right. Do you remember that the ultimate
9 conclusion was --

10 MR. DAVIS: Objection, Your Honor. Now, he's citing
11 from an article that Dr. Ernest has just testified that
12 he's not familiar with. If he wants to lay the proper
13 foundation, I think that's okay, but I object to the
14 hearsay.

15 THE COURT: Counsel, approach the bench, please.

16 (WHEREUPON, a bench conference was held in the
17 presence of the jury, but outside the hearing of the
18 jury.)

19 MR. GRAHAM: Doctor, would you mind stepping down?

20 MR. DAVIS: Your Honor, I need to take up something
21 with the Court.

22 THE COURT: Yes, sir.

23 (WHEREUPON, a bench conference was held in the
24 presence of the jury, but outside the hearing of the
25 jury.)

1 BY MR. GRAHAM:

2 Q Dr. Ernest, approximately how many deliveries have
3 you had?

4 A We can put 6,000, that's an estimate.

5 Q How many shoulder dystocias?

6 A I'd say a hundred.

7 Q Of those hundred, does that include the one when you
8 were a resident?

9 A Yeah, that's an estimate. It's probably more than
10 that, but just for a round number, we use a hundred.

11 Q That's fine. Counting your time as a resident, how
12 many severe permanent brachial plexus birth injuries have
13 you had?

14 A Well, I know of two severe initial injuries, one as a
15 resident, one as an attending. One of them, I followed
16 longer than the other. I didn't follow them long enough
17 to technically say either was permanent, but I know one
18 lasted several months. So maybe one, maybe two minimum.

19 Q Do you remember you testified by video on one of your
20 prior cases that there was one --

21 MR. DAVIS: Your Honor, if he wants to go ahead and
22 lay a foundation and impeach him on prior sworn testimony,
23 this isn't the way to do it. I object.

24 THE COURT: Go ahead and ask the question.

25 BY MR. GRAHAM::

1 Q Dr. Ernest, do you recall when we were trying a case
2 in Greenville, South Carolina?

3 A Yes.

4 Q Do you recall that you testified just like you did
5 now that there were two severe permanent brachial plexus
6 injuries? So far you remember it?

7 A I remember that two was the number we talked about
8 and then you found a deposition from a previous time that
9 said probably one, maybe not even one. So there were two
10 severe ones. I thought they were both permanent when you
11 asked me that in Greenville, but a closer time point to
12 the deliveries was probably a better recollection. So I
13 have zero to two would be the best way I could answer that
14 question.

15 Q We played the video in court and it showed that you
16 had testified to one after the one you were saying was
17 number two. In other words, you only had zero to one
18 severe permanent?

19 A I've had zero to two.

20 Q Well, you don't know -- you only know of one
21 permanent one, true?

22 A I know of one that lasted several months because I
23 was able to follow that patient. She was a private
24 patient of ours. The other patient, I was not able to
25 follow, but because of the severity of it, initially, I

1 think it was probably permanent.

2 Q But you didn't follow --

3 A I was not able to follow that one.

4 Q -- for two to see if it was permanent?

5 A Right, I could not see that baby for two years,
6 right. So zero to two is the number to put there.

7 Q I'm asking you, sir, not for your reasoning out what
8 might have happened, you know of one, correct?

9 A I know of one that last several months, yes.

10 Q So let's put one under severe brachial plexus birth
11 injuries. We put permanent, but --

12 A I think that's reasonable.

13 Q And how many of those -- how many of that one severe
14 brachial plexus birth injury do you attribute to extreme
15 negligence?

16 A Zero. I don't think I was negligent in that
17 delivery.

18 Q The one as a resident?

19 A Which one are we talking about now? I thought you
20 were talking about the one that I knew about. I think as
21 a resident, I pulled too hard -- actually, I didn't pull
22 too hard, the junior resident pulled too hard and I was
23 supervising her.

24 Q Right.

25 A As an attending, it happened and I was not pulling

1 too hard.

2 Q I'm asking about the one that you followed for three
3 months.

4 A Okay.

5 Q The one where you were supervising and pulled too
6 hard?

7 A No, no, no, we're -- let me -- when I was a resident,
8 I was supervising a junior resident. She put on some
9 forceps, she pulled too hard under my supervision and we
10 had a shoulder dystocia. I do not know the outcome of
11 that baby, but it was a very severe initial injury. I
12 assumed it was permanent, but I could not follow that baby
13 for two years. Years later, 20 years later, I was
14 delivering one of our private patients and had a shoulder
15 dystocia. I was the only delivering person in the room.
16 It was totally me and I delivered the baby. I was
17 appropriately managing her and there was another shoulder
18 dystocia that lasted several months. That's the one that
19 I thought we were talking about. That one may have been
20 permanent, but I was not able to follow her for the full
21 year or year and a half to meet the definition of
22 permanent. But it was a several-month shoulder dystocia.

23 Q Doctor, do you remember testifying in the past that
24 the one as a resident was, in fact, the one that was
25 severe and permanent? Did you actually report that case?

1 A To whom?

2 Q You saw the excessive traction as the supervisor, did
3 you report that to anyone else?

4 A I was the supervisor. I was the one that needed to
5 know about it so I could explain to her that was too hard.
6 So we did take care of it.

7 Q The accountability stopped there, telling her she
8 messed up?

9 A No, we have other accountability with grand rounds
10 and we have accountability with M&M and things. So that
11 was in 1979, so I don't remember the details, but I
12 remember the event quite well because it was very
13 dramatic.

14 Q You personally watched this delivery with extreme or
15 excessive traction, bending of the neck and as a
16 supervisor, you didn't pass on the complaint, but she's a
17 board certified OBGYN today?

18 A I don't know. I don't know what happened to her. I
19 can give you more detail about that delivery if you would
20 like because I remember the details of the delivery.

21 Q What I'd like to know is did she write down a
22 confession that she had used more than gentle traction on
23 that child?

24 A I don't remember what she wrote down. This was 1979.

25 MR. GRAHAM: No further questions.

1 THE COURT: Mr. Davis.

2 MR. DAVIS: No redirect, Your Honor.

3 THE COURT: Any objection to excusing this witness?

4 MR. GRAHAM: No, Your Honor.

5 THE COURT: Thank you, Doctor. You're excused.

6 Ladies and gentlemen, thank you very, very much for your
7 patience today and your willingness to stay after. So
8 we'll see you back at 9:30 tomorrow.

9 (WHEREUPON, the jury exits the courtroom at
10 approximately 5:40 p.m.)

11 THE COURT: Mr. Graham, anything from your
12 perspective we need to take up before we break for the
13 day?

14 MR. GRAHAM: No, Your Honor. As I mentioned, we need
15 to think through the process of whether to call a rebuttal
16 witness.

17 THE COURT: Mr. Davis, anything from the defense?

18 MR. DAVIS: No, sir.

19 THE COURT: All right.

20 MR. DAVIS: Well, I guess I need to rest my case.

21 THE COURT: We can do that tomorrow morning.

22 MR. DAVIS: Okay.

23 THE COURT: Because I think you need to do that
24 officially in front of the jury.

25 MR. DAVIS: Okay. Thank you very much. I appreciate

1 that. I will do that, sir.

2 THE COURT: Counsel, I was actually planning on doing
3 charge discussion right now, but I'll be honest, I'm
4 mentally fairly exhausted and I would prefer to do that
5 tomorrow. Is that okay?

6 MR. DAVIS: I join you in that mental exhaustion,
7 Your Honor, and with great sympathy and agreement, I
8 consent.

9 THE COURT: I know it looks like I'm just sitting up
10 here doing nothing.

11 MR. GRAHAM: We're all working hard.

12 THE COURT: Well, then, that makes it unanimous.
13 Everybody back here at 9:30 tomorrow. We'll discuss
14 charges tomorrow as well.

15 MR. DAVIS: Thank you, Your Honor. And thank you,
16 too, for sending the charges. I will look at them
17 tonight.

18 THE COURT: Yes, sir. Thank you.

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20 THE COURT: Counsel, so that brings us up to, I will
21 let Mr. Davis say on the record he is resting once the
22 jury comes in. But we will be ready for the charge and
23 then closing argument. Mr. Graham, Mr. Jordan, have y'all
24 had a chance to look at my proposed charge?

25 MR. JORDAN: Yes, Your Honor.

1 THE COURT: And any objections or request for
2 additions?

3 MR. JORDAN: Yes, Your Honor. We do have some
4 requests for additions. And I apologize, Your Honor,
5 these are out of order with the numbering. May I
6 approach, Your Honor?

7 THE COURT: Yes, sir.

8 MR. JORDAN: And there was one, Your Honor, we are
9 asking for a charge with regard to proximate cause, that
10 cause need only be a substantial factor. I know there are
11 several South Carolina cases on point with regard to that
12 as well.

13 THE COURT: You want me to charge proximate cause
14 must only be a substantial factor?

15 MR. JORDAN: Let me see if I can find the language,
16 Your Honor, I apologize.

17 THE COURT: Let me read my proximate case charge.

18 MR. JORDAN: The language, I believe, was a
19 substantial factor in producing the injury.

20 MR. GRAHAM: And right along that same line, make it
21 clear that all it has to be is a cause, not the cause.

22 THE COURT: That is already in the charge.

23 MR. GRAHAM: Thank you.

24 THE COURT: This is the current language I have.
25 Proximate cause does not mean the only cause. Where

1 several causes have combined to produce injury, a
2 Defendant is not relieved from reliability because it is
3 responsible for only one of them. That pretty much covers
4 it, doesn't it?

5 MR. JORDAN: We are reviewing yours.

6 THE COURT: Okay.

7 MR. JORDAN: Just one moment.

8 THE COURT: Mr. Graham, Mr. Jordan, your request to
9 charge number two wants me to discuss insurance in my jury
10 charge?

11 MR. GRAHAM: Your Honor, there was a team effort in
12 pulling some charges from something else. We agree with
13 you on that.

14 MR. JORDAN: I apologize, Your Honor, we missed that
15 one.

16 THE COURT: That is okay.

17 MR. GRAHAM: Your Honor, may I simplify our request?

18 THE COURT: Yes, sir.

19 MR. GRAHAM: There is one in there about respondeat
20 superior and I like the way that you have done yours, the
21 verdict form in terms of focusing on the Defendant, I
22 assume Dr. Miller.

23 THE COURT: Yes, sir.

24 MR. GRAHAM: Because I think we can all agree that
25 the corporations liability rises or falls --

1 THE COURT: I have not heard any testimony that there
2 would not be respondeat, is that an issue.

3 MR. GRAHAM: I don't believe so.

4 MR. DAVIS: No sir, I don't think so.

5 THE COURT: Okay.

6 MR. GRAHAM: I don't think there is any reason for
7 the jury to be heard on whether the corporation has
8 liability.

9 THE COURT: Okay.

10 MR. GRAHAM: Whether they do, rises on falls on Dr.
11 Miller's liability. So we withdraw the respondeat
12 superior.

13 THE COURT: Yes, sir. I am just working my way
14 through, request to charge number six I looked at. And my
15 Law Clerk, that is one about the specialist and as my Law
16 Clerk just pointed out to me, we have already got, under
17 the standard of care in my proposed charge, a Doctor who
18 holds himself out as a specialist is required to use a
19 degree of learning and skill ordinarily possessed by
20 specialist of good standing in that field.

21 MR. GRAHAM: We don't need ours.

22 THE COURT: Okay. Mr. Graham, I have read through
23 all of your proposed additions and I, although I think, I
24 am sure the correct statements of the law, I think my
25 charge covers all of those situations. So I would be

1 inclined not to use any of them. But if, are there any
2 particular ones you want to fight for, be heard on or any
3 language that you really are passionate about?

4 MR. GRAHAM: Request number one. We can provide
5 additional authority about that.

6 THE COURT: What is justice. Is the intent of that
7 charge, I am telling the jury, not let one juror kind of
8 overwhelm the other ones. Where are we going with that
9 charge?

10 MR. GRAHAM: No, sir. We have a number of cases in
11 this State that say, one of the purposes of tort law is
12 to, is to protect the community. And it is just not a
13 matter of compensation, it is a matter of protecting the
14 community. In other words, they are not speaking on their
15 individual viewpoint. They are here as representatives of
16 the community and part of their job is to express the
17 conscious of the community in an effort to further the
18 interest, for purposes of tort law which are not just to
19 compensate. But also to protect the community from
20 dangerous acts and omissions. We have other case law if
21 Your Honor would like to see it.

22 THE COURT: I am not disagreeing with what you are
23 saying, I just never heard a charge before. Do you have
24 cases where a Judge actually charged that to a jury?

25 MR. GRAHAM: Not at my fingertips, no.

1 THE COURT: I mean, we don't, I mean certainly the
2 law has purposes and case law discusses that in statutory
3 interpretation and things like that. But I, we don't
4 normally charge the jury on the purpose of the law, why we
5 have, I will think about that. Anything else?

6 MR. GRAHAM: I beg the Court's indulgence.

7 THE COURT: Yes, sir.

8 MR. GRAHAM: Number three. While similar to your
9 charge it does add a little tweak that we feel passionate
10 about.

11 THE COURT: Okay. I have already told them if there
12 is any juror that is not following my instructions they
13 need to tell me. Is it the part of not making up your own
14 standard of care.

15 MR. GRAHAM: And burden of proof. In talking to
16 jurors after some trials we, we realize that many times
17 they make up their own burden of proof.

18 THE COURT: Mr. Davis, you want to be heard on that
19 one?

20 MR. DAVIS: Your Honor, I think your charge covers
21 all of that more than adequately and I would respectfully
22 object to that charge being given to this jury.

23 THE COURT: I will pull that one out and I will think
24 about that. Any other ones, Mr. Graham?

25 MR. GRAHAM: Number seven.

1 THE COURT: Okay. I will be honest, this doesn't
2 seem to fit the facts to me. The allegation is that Dr.
3 Miller wasn't paying attention, was it, didn't check on
4 the patient. To me when you say, lack of diligence, that
5 typically means the Doctor was paged, didn't respond or
6 didn't, I mean --

7 MR. GRAHAM: I understand, Your Honor.

8 THE COURT: Okay. Anything else?

9 MR. GRAHAM: If you will give us just a minute.

10 THE COURT: Yes, sir.

11 MR. GRAHAM: Out number 14, about future damages. We
12 have strong feelings that the future damages language is a
13 more accurate statement of the law and a more balanced
14 statement of the law than prospective damages. It seems
15 to me some people interpret the connotation of that as
16 being, as commenting on a lack of certainty or something
17 to that extent.

18 THE COURT: Let me find future damages. One second.
19 You would ask me to substitute, in my current charge the,
20 word, future, in place of perspective?

21 MR. GRAHAM: Yes, sir.

22 THE COURT: Mr. Davis?

23 MR. DAVIS: Your Honor, I don't have any problem in
24 your charge substituting the word, future for perspective.
25 Because that is really, I think that brings some clarity

1 to the jury.

2 THE COURT: I agree and I always think when you can
3 use layman's language it is better. So we will do that.

4 MR. GRAHAM: We are fine with it.

5 THE COURT: And, Mr. Davis, give me a second and let
6 me read through yours.

7 MR. DAVIS: Yes, sir.

8 THE COURT: Mr. Davis, on the others, it is the same
9 position as with the Plaintiffs. There is nothing wrong
10 with what you presented to me but I think my current
11 charge covers those issues pretty well. Are there any
12 particular ones you want to fight for or particular
13 language you think I should include.

14 MR. DAVIS: Your Honor, number seven, on the burden
15 of proof. You have got an appropriate charge on the
16 burden of proof, I just like mine better.

17 THE COURT: I understand.

18 MR. DAVIS: That is the way it is. It is up to the
19 Court, obviously.

20 THE COURT: I think I am going to stick with mine.

21 MR. DAVIS: Also, with regards to, number eight as
22 well.

23 THE COURT: I have got you covered on that one, Mr.
24 Davis, I am looking at the bottom of page six of my
25 proposed charge. It says, you may not award damages for

1 any injury or condition from which the Plaintiff may have
2 suffered or may now be suffering unless it has been
3 established by the greater weight of the evidence,
4 proximately caused by the actions in question.

5 MR. DAVIS: Thank you, Your Honor. I respectfully
6 submit my request and your ruling. Obviously we will
7 withdraw number nine. Number 11, opinions regarding
8 treatment. We would request that that be charged.

9 THE COURT: That one I am not going to charge. That
10 one to me, I think, runs the risk of them thinking, if
11 there is a conflict in expert testimony we have to rule,
12 vote for the Defense.

13 MR. DAVIS: And, Your Honor, thank you very much for
14 that explanation. And I do want to acknowledge you do
15 have that different expert or at least experts, how to
16 judge their credibility and credentials and all of that.
17 So I think that is a good charge that you have, I
18 appreciate that. Number 15, I very much like that one.
19 And that may be covered in your charge.

20 THE COURT: I think it is covered pretty well.

21 MR. DAVIS: And that is it, and we have already
22 talked about number 18. Your Honor, I have reviewed and
23 thank you for sending me the proposed verdict form. I have
24 emailed your law clerk this morning. I like simple
25 verdict forms and I appreciate that yours is very simple.

1 But the problem I have with it is it doesn't break down
2 standard of care and proximate cause. And I think that is
3 a better way for the jury to have walk through with their
4 deliberations and make a decision first, was there a
5 breach of the standard of care. If so, yes. Then go to
6 the next question and do you find that the breach of the
7 standard of care proximately caused the injuries alleged.
8 And I think they do that, they do that, then they have got
9 to go to damages obviously and I think that damages need
10 to be broken down between economic and non-economic
11 damages because of statutory cap has been plead in this
12 case. And it would apply if there is a verdict for the
13 Plaintiff. There is no way for me to ask the Court, at
14 the conclusion of an adverse verdict, to apply a cap to
15 just one number. I think that needs to be distinguished.

16 THE COURT: I am not inclined to do that in regard to
17 question one. I think in this case simplicity is better.
18 And it does, it does remind the jury that they do have to
19 prove proximate cause and injury. So you can refer to
20 that. What about the second question. What about
21 breaking out economic and non-economic damages. Mr.
22 Graham, Mr. Jordan?

23 MR. GRAHAM: We have no objection.

24 THE COURT: We will do that. Mr. Graham and Mr.
25 Jordan, have you seen what Mr. Davis proposed for that

1 question, is what he calls question three on his proposal.
2 Does that look okay to y'all? Just say, my question two
3 would be, what amount of economic damages resulted. And I
4 would now have a question three on my verdict form that
5 would say, what amount of non-economic damages resulted.
6 Let me just write out what it would say. Y'all want to
7 approach and see what I changed the verdict form to.

8 MR. GRAHAM: That is fine.

9 MR. DAVIS: Yes, sir.

10 THE COURT: All right.

11 MR. GRAHAM: Your Honor, with question one, as you
12 have decided to do, if they answer where they have a block
13 yes or no.

14 THE COURT: Yes, sir.

15 MR. DAVIS: So if it says yes, what do they then do?

16 THE COURT: I am not sure I follow you.

17 MR. DAVIS: I am just trying to anticipate the jury,
18 if they check yes, what do they then do, go to two and
19 three. Shouldn't there be some direction if they check
20 yes or if they check no, what should they do.

21 THE COURT: Where it says yes or no, an instruction
22 that says, if the answer is yes proceed to questions two
23 and three. If the answer is no, stop now.

24 MR. DAVIS: Yes. I would appreciate that. It makes
25 it clearer.

1 THE COURT: Any objection, Mr. Graham?

2 MR. GRAHAM: No, Your Honor. I did have one matter.
3 Some days ago, last week I guess, an issue had come up,
4 probably at the end of our case about gross negligence and
5 so forth. Your Honor, you had tentatively ruled but you
6 invited briefs. I note that Mr. Davis has presented a
7 proposed charge number nine.

8 THE COURT: He withdrew that one.

9 MR. GRAHAM: I am just wondering, depending on Your
10 Honor's ruling, whether we should add to the verdict form
11 a question about recklessness.

12 THE COURT: No, sir. I granted a directed verdict on
13 the punitive and on the gross negligence. That was my
14 recollection.

15 MR. GRAHAM: I thought you said you had tentatively
16 done that but invited briefs.

17 THE COURT: What I meant to say and if I didn't say
18 this I apologize. I said I was granting the motion but I
19 would be happy to reconsider it if the Plaintiffs wanted
20 to put briefing in. Let me clarify for the record, that
21 is what I intended to say, that I granted the Defendant's
22 motion for a directed verdict on the issue of punitive and
23 gross negligence. But I am open to reconsidering that
24 ruling.

25 MR. GRAHAM: We would like to submit a very short --

1 THE COURT: All right, thank you. Mr. Graham, I
2 don't, I try to listen pretty carefully. I don't recall
3 any expert testimony from any of the Plaintiffs experts
4 that there was gross negligence or recklessness involved
5 in this case. Did I miss any?

6 MR. GRAHAM: Well, Your Honor, here is what is out
7 there for you to decide. Dr. Miller testified, he
8 testified, of course, he used gentle proper traction. He
9 also testified that he used the amount of traction that he
10 chose to use or he intended to use, not that he intended
11 to cause harm but he intended to use the amount of
12 traction force he used and that he was aware of the risk
13 of using the amount of traction that we contend he did, in
14 fact, use. So I am not addressing gross negligence.
15 Recklessness, he had a conscious awareness of the danger
16 and he was indifferent, in viewing the case it the light
17 most favorable to us, he was aware of the danger, he
18 consciously applied as much traction as he intended and
19 that was a devastating amount of traction that caused a
20 life changing injury to Alexia.

21 THE COURT: Doesn't that sort of swallow all of the
22 negligence. I mean, as I understand your argument, you
23 are saying that Dr. Miller understood the risk of
24 excessive traction and he, it wasn't an accident, he
25 didn't slip; he intended to do what he did therefore that

1 makes it intentional?

2 MR. GRAHAM: No, sir. It makes it, it makes it
3 conscious disregard for the rights of Alexia.

4 THE COURT: I mean, if you apply that to a wreck
5 case, isn't that the same thing as saying, well, the
6 Defendant, did you intend to press the gas pedal. Yes, I
7 intended to press the gas pedal. Then you intended to
8 cause, isn't that the same argument?

9 MR. GRAHAM: I don't believe so, Your Honor, because
10 pressing the gas pedal does not foreseeable cause an
11 injury. Running a red light intentionally, I believe
12 would be a better analogy.

13 THE COURT: If the question is, did you, you saw the
14 light, you stepped on the gas. I don't want to spend time
15 on hypothetical. I think, let me hear from Mr. Davis.

16 MR. DAVIS: Your Honor, I think the burden of proof
17 on the Plaintiff is to prove excessive force. That has
18 been the whole allegation, the whole case. This whole
19 entire case comes down to, according to Dr. Duboe's
20 testimony, and Dr. Gurewitsch's testimony, two or three
21 seconds or less after the rotational maneuver was
22 performed, when they allege that at that point he placed
23 his hands on the baby's head and they allege that he then
24 used excessive force. I mean, that is, the whole case
25 comes down to those few seconds. It is their burden to

1 prove that, they are trying to, as I heard Mr. Graham's
2 argument, he seemed to be saying, well, because Dr. Miller
3 intended to use what he characterized under oath as
4 minimal downward traction at that point where they allege
5 excessive force, that because he intended to use minimal
6 force, which he clearly testified to, that that
7 constitutes intent to use excessive force. I don't know
8 how they get there from his testimony.

9 THE COURT: I think, as I understand Mr. Graham's
10 argument is, Dr. Miller said he intended to use the amount
11 of force that he used therefore, their theory that is
12 excessive force. I just don't think that is enough. My
13 understanding of the law is, in almost every case expert
14 testimony is required to establish, to send gross
15 negligence to a jury in a medical malpractice case. And I
16 think, there are exceptions but I don't think this is one
17 of them.

18 MR. GRAHAM: And frankly, I am not a fan of gross
19 negligence as a target for me to try to prove because of
20 how it is defined. But recklessness is a different matter
21 and Ashby's argument is really, if you construe the facts
22 in our favor, then the motion should be denied. But his
23 motion should be granted but obviously the facts have to
24 be construed in our favor, in the light most favorable to
25 us.

1 THE COURT: You are talking about conscious disregard
2 of a known risk. Again, I just don't think, I mean how
3 does that not cover every medical malpractice claim. I
4 mean, Doctor, when you evaluated this spot on the
5 patient's skin, didn't you know there was a risk of
6 cancer. Then you disregard that.

7 MR. GRAHAM: I understand.

8 THE COURT: I understand your argument. I think
9 conscious disregard has to be more than he has medical
10 training and he knows the risk of making an error in the
11 procedure.

12 MR. GRAHAM: I understand and I would just make one
13 more important. As far as expert witness is concerned,
14 Dr. Gurewitsch did talk about an extreme amount of force,
15 way more than would be typical.

16 THE COURT: Was she asked at deposition, did that
17 constitute gross negligence.

18 MR. GRAHAM: No sir, we did not use the word, gross
19 negligence. I frankly, unless that statute has been plead
20 and I have to deal with gross negligence, my preference is
21 to deal with recklessness. To me it is easier to prove.

22 THE COURT: Did you ask her if he was reckless?

23 MR. GRAHAM: No sir, I don't recall doing that. I am
24 certain I did not do that. But she did talk, she did talk
25 about just how extreme this man's action was. It was 60

1 degrees of neck bending, extraordinary amount of neck
2 bending and 50 pounds of pulling force which is, I mean
3 she said a normal amount of pulling force is 10 to 12
4 pounds. So four or five times of that is what he pulled,
5 she did say she is not going to support a Plaintiff's case
6 if the pulling is up to 25 pounds. But even then, he
7 pulled twice that hard according to her testimony in
8 addition to the 60 degrees of neck bending. And she
9 mentioned the twisting as well but she did not use the
10 word, recklessness.

11 THE COURT: In the Court's opinion for me to send it
12 to the jury based on Dr. Gurewitsch testimony is a
13 punitive case or possible punitive case. I think she has
14 to say, either in her opinion it was reckless or exercised
15 slight care or disregard of a known risk or something to
16 that effect.

17 MR. GRAHAM: I understand. Thank you, Your Honor.

18 THE COURT: Anything else. I will be happy to give
19 you time to put anything on the record on that issue.

20 MR. GRAHAM: No, sir. But I do have another request.
21 After you finish your charge can we have a technology
22 break.

23 THE COURT: Yes, sir. Let's take a break to 10:30.
24 Tell the jury I am finishing up some legal matters with
25 the attorneys and we will bring them in at 10:30.

1 (Whereupon, a short break was taken.)

2 THE COURT: We are on the record. Mr. Davis, when
3 the jury comes in I will give you a chance to call your
4 next witness and then you can rest.

5 MR. DAVIS: Thank you, Your Honor.

6 THE COURT: Anything we need to take up from the
7 Plaintiff before we bring the jury in?

8 MR. GRAHAM: No, Your Honor.

9 THE COURT: From the Defense?

10 MR. DAVIS: No, sir.

11 THE COURT: Bring them in.

12 (Whereupon, the jury came into open court at
13 approximately 10:34 a.m.)

14 THE COURT: Ladies and gentlemen, welcome back.
15 Thank you for your patience. We worked through some legal
16 issues. Was everyone able to follow the instructions I
17 have been giving you. Thank you very much, I appreciate
18 that. Mr. Davis, you can call your next witness.

19 MR. DAVIS: Your Honor, the Defense rest.

20 THE COURT: All right. Thank you, sir. Ladies and
21 gentlemen, as I told you yesterday, we believed that would
22 be the final witness yesterday. So you have now heard all
23 of the evidence in the case. What is going to happen now
24 is I am going to give you what is called the Judge's
25 charge or explanation of the law. And then the final,

1 then you will hear from the attorneys in their closing
2 arguments. Ladies and gentlemen, if a member of the jury
3 is not following my instructions please let me know
4 because it is often fixable if I find out about it. If I
5 find out about it after the trial is complete it may have
6 to be redone all over again.

7 Mr. Foreperson and members of the jury, you have now
8 heard the evidence and will hear the arguments of both
9 sides. I will now explain to you the rules of law you
10 must follow and apply in deciding this case. When I have
11 finished you will hear the closing arguments of the
12 parties before you go to the jury room and begin your
13 discussions, sometimes called deliberations. Your
14 decision must be based only on the evidence presented
15 here. You must not be influenced in any way by either
16 sympathy for or prejudice against anyone. I will give
17 these instructions in a written form for you to have with
18 you in the jury room, you will have a copy, my copy here.
19 During your deliberations you may refer to my instructions
20 to guide your decision making. You must follow the law as
21 I explain it, even if you do not agree with it. You must
22 consider my instructions as a whole and not follow some
23 parts and ignore others.

24 Duties of the jury and trial Judge. I remind you
25 that during the trial you and I have certain duties to

1 perform. As the trial Judge it is my responsibility to
2 preside over the trial of the case and also I have the
3 duty to rule on the admissibility of evidence. You should
4 consider only the evidence before you. If I order any
5 testimony stricken from the record you must disregard that
6 testimony. You are to consider only the testimony that
7 has been presented from the witness stand and any exhibits
8 which have been made part of the record and any
9 stipulations or agreements of the attorneys. In addition,
10 I have the duty to charge you on the law applicable to
11 this case, which I am doing now. As the presiding Judge,
12 I am the sole Judge of the law of this case and it is your
13 duties as jurors to apply, to accept and apply the law as
14 I now state it to you. If you already have an idea as to
15 what the law is or what the law ought to be and it does
16 not agree with what I am now telling you, you must abandon
17 your idea because you are sworn to accept the law and
18 apply it exactly as I state it to you. In every case
19 tried in this court before a jury you, as the jury, are
20 the sole and exclusive judge of the facts of the case. As
21 a trial Judge I cannot intimate, or state or comment on or
22 make any statement to a jury about the facts in the case.
23 Since you, the jury, are the sole Judge of the facts you
24 should not infer from what I have said during the trial or
25 any rulings on issues of law other otherwise or anything I

1 am saying now that I have an opinion about the facts of
2 this case. The law does not permit me to have an opinion
3 about the facts of this case. This is solely a matter for
4 you, the jury, to determine. As jurors it is your duty to
5 determine the effect, the value, the weight and the truth
6 of the evidence that was presented during the trial.

7 Burden of proof. In this case the Plaintiff has the
8 responsibility to prove every essential part of his, I am
9 sorry, of her claims by a preponderance of the evidence.
10 This is sometimes called the burden of proof or burden of
11 persuasion. The preponderance of the evidence simply
12 means an amount of evidence which is enough to persuade
13 you that a claim or contention is more likely true than
14 not true such as by the greater weight of the evidence.
15 In deciding whether any particular fact has been proved by
16 preponderance of the evidence you should consider the
17 witness testimony regardless of who may have called that
18 witness and all of the exhibits in evidence regardless of
19 who produced them. If the proof fails to establish any
20 essential part of a claim or contention by a preponderance
21 of the evidence you should find against the party making
22 the claim or contention.

23 Evidence. As I said before, you must consider only
24 the evidence I have admitted in this case. Evidence
25 includes witness testimony and exhibits. Remember that

1 what the lawyers say is not evidence and is not binding on
2 you. As I said earlier, again, you should not assume from
3 anything that I have said that I have any opinion about
4 any factual issue in the case. In fact, except for my
5 instructions on the law to you right now, you should
6 disregard anything I may have said during the trial when
7 you are arriving at your own decision about the facts.
8 Your own recollection and interpretation of the evidence
9 is what matters. In considering the evidence you should
10 use your reasoning and common sense to make deductions and
11 reach conclusions.

12 Direct and circumstantial evidence. There are two
13 types of evidence which are generally presented during a
14 trial. Direct evidence and circumstantial evidence.

15 Direct evidence is the testimony of a person who says they
16 have actual knowledge of a fact, like an eyewitness. It
17 is evidence which immediately establishes the main fact to
18 be proved. Circumstantial evidence is a proof of a chain
19 of facts or circumstances indicating the existence of
20 another fact. It is evidence which immediately
21 establishes collateral or side facts from which the main
22 fact can be inferred. Circumstantial evidence is based on
23 inference and not on personal knowledge or observation.
24 The law makes no distinction between the weight or value
25 to be given to either direct or circumstantial evidence,

1 nor is a greater degree of certainty required of
2 circumstantial evidence than of direct evidence. You
3 should weigh all the evidence in the case.

4 Redactions. Ladies and gentlemen, during the
5 presentation of the case you may have noticed that certain
6 parts of the audio or video or documents that were
7 presented were redacted or edited out. This is due to the
8 rules of court and was a decision made by me. Please do
9 not speculate as to what may or may not be contained in
10 these portions and do not hold these portions against
11 either party.

12 Expert witnesses. The rules of evidence normally do
13 not allow a witness to testify to their opinion or
14 conclusion. Normally a witness can only testify about
15 what they saw or heard themselves. An exception to this
16 rule exist for what we call expert witnesses. A witness
17 who by education and experience has become an expert in an
18 art or science or profession or calling may give their
19 opinion on relevant and material matters in which they are
20 an expert and they may also give the reasons for their
21 opinion. You should consider expert opinion received in
22 this case and, like any other evidence, give it the weight
23 you think that it deserves. If you decide the opinion of
24 an expert is not based on sufficient education and
25 experience or if you conclude the reasons given in support

1 of the opinion are not sound, or if you conclude the
2 expert is outweighed by other evidence you may disregard
3 the expert's opinion entirely. An expert witness'
4 testimony should not be given greater weight than that of
5 other witnesses simply because they are an expert.
6 Further, you are not required to accept an expert's
7 opinion even if it is not contradicted.

8 Conflict in expert testimony. In this case there has
9 been a conflict in the testimony of expert witnesses. You
10 must weigh one expert's opinion against that of the other
11 and you must consider the reasons given by one expert as
12 compared with the other expert. You should consider the
13 relative credibility and the knowledge of the experts and
14 you should decide in favor of the expert testimony which,
15 in your opinion, is entitled to the greater weight.

16 Credibility and believability of witnesses. When I
17 say that you must consider all of the evidence I do not
18 mean that you must accept all the evidence as true or
19 accurate. You should decide whether you believe what each
20 witness had to say and how important their testimony was.
21 In making that decision you may believe or disbelieve any
22 witness in whole or in part. The number of witnesses
23 testifying about something doesn't necessarily matter. In
24 deciding whether to believe a witness I suggest you ask a
25 few questions to yourself. Did they impress you as one

1 who is telling the truth; did the witness have any
2 particular reason to not tell the truth; did the witness
3 have a personal interest in the outcome of the case; did
4 they seem to have a good memory. Did the witness have the
5 opportunity and ability to accurately observe the things
6 they are testifying about. Did they appear to understand
7 the question clearly and answer it directly. Did the
8 witness' testimony differ from other evidence. But please
9 keep in mind that a simple mistake by the witness doesn't
10 mean they weren't telling the truth as they remember it.
11 People naturally tend to forget some things or remember
12 them inaccurately. So if a witness misstated something
13 you must decide whether that was because of an innocent
14 mistake or lapse in memory or an intentional deception.
15 The significance of your decision may depend on whether
16 the misstatement was an important fact or an unimportant
17 detail.

18 Medical malpractice. In this case the Plaintiff
19 claims that the Defendant committed medical malpractice.
20 Medical malpractice is a form of carelessness or
21 negligence. In order to recover the Plaintiff must
22 establish by a preponderance of the evidence four things.
23 One, the standard of care; two, a breach of that standard
24 of care; three, proximate cause; and four, damages. I
25 will explain each of these elements fully later in my

1 instructions.

2 Standard of care. The Plaintiff must prove the
3 standard of care the Defendant owed in treating the
4 Plaintiff. When a doctor treats a patient the law does
5 not require perfection or infallibility. The law does
6 require the doctor use the degree of knowledge, care and
7 skill ordinarily possessed and used by doctors in good
8 standing in that field of medicine under the same or
9 similar circumstances. The law requires that the doctor
10 follow the generally accepted practices and procedures in
11 their profession and not cause unnecessary harm. A doctor
12 who holds themselves out as a specialist in a particular
13 field is required to use the degree of learning and skill
14 ordinarily possessed by a specialist of good standing in
15 that field.

16 Breach of the standard of care. The Plaintiff must
17 prove the Defendant negligently departed from the standard
18 of care in treating the Plaintiff. Negligence is the
19 failure to do what an ordinarily careful and prudent
20 doctor in the doctor's field of medicine would have done
21 under the same or similar circumstances; or doing
22 something that an ordinary, careful and prudent doctor in
23 that field would not have done in the same or similar
24 circumstances. The mere fact that a treatment does not
25 benefit the patient or even harms the patient is not in

1 and of itself negligence. A bad result, injury, death, a
2 failure to cure or an incorrect diagnosis is not enough
3 alone to show the Defendant was negligent. Further, the
4 fact that another medical professional would have used a
5 different treatment course does not amount to malpractice.
6 In considering whether the Defendant made a reasonable
7 decision you must consider the decision in relation to the
8 facts as they existed at the time and in not in light of
9 what hindsight may reveal. Finally, the doctor's, a
10 doctor's breach of the standard of care must be
11 established by expert testimony unless the situation is
12 one in which common knowledge is enough to infer
13 negligence from those facts.

14 Ladies and gentlemen, I know it is tough to listen to
15 these readings, but we are half way there so stick with
16 me, we are half way there. And, again, you don't have to
17 memorize this, you will have a written copy.

18 Proximate cause. The Defendant's negligence must
19 have proximately caused the Plaintiff's injuries for the
20 Plaintiff to recover. The law defines proximate cause of
21 injury to be something that produces a natural chain of
22 events which in the end brings about the injury. In other
23 words, a proximate cause is a direct cause without which
24 the injury would not have happened. To prove the
25 Defendant's negligence proximately caused the Plaintiff's

1 injury in the law the Plaintiff must first prove causation
2 and fact. This is shown by proving the injuries would not
3 have occurred except for the Defendant's negligence. The
4 Plaintiff must also prove legal cause. Legal cause is
5 proven by showing the injuries were foreseeable. This
6 means the injuries occurred as a natural and probable
7 consequence of the Defendant's negligence. The Plaintiff
8 must prove that some injury from the negligence was
9 foreseeable but they do not have to prove this particular
10 injury was foreseeable. However, the Defendant cannot be
11 held responsible for things which could not have been
12 expected to happen. Proximate cause does not mean the
13 only cause. Where several causes have combined to produce
14 an injury, the Defendant is not relieved from liability
15 because the Defendant is responsible for only one of the
16 causes. Where a Plaintiff is injured by the wrongful act
17 of two or more people he has the option to sue each one
18 separately or sue them as parties in the same action. The
19 Plaintiff has the choice of designating the party he
20 claims committed the wrongful act. Simply put, the
21 Defendant's acts can be the proximate cause of the
22 Plaintiff's injuries if there are at least one of the
23 direct causes, incurring causes. An intervening force may
24 be a superceding cause that relieves an actor from
25 liability. However, in order to get relief from liability

1 the intervening cause must be one that could not have been
2 foreseen or anticipated. In other words, the intervening
3 negligence of a third party will not excuse the first
4 wrongdoer if that intervention ought to have been foreseen
5 in the exercise of due care. The negligence of a later
6 treating doctor is foreseeable. Further, even if an
7 intervening act is not foreseeable the first wrongdoer is
8 liable if the intervening act is a natural and probable
9 consequence of the actor's conduct. You may not award any
10 damages for an injury or condition from which the
11 Plaintiff may have suffered or may now be suffering unless
12 it has been established by the greater weight of the
13 evidence that that injury or condition was proximately
14 caused by the accident or incident in question. When the
15 opinions of medical experts are relied upon to establish
16 casual connection, that expert must, with a reasonable
17 certainty, state in their professional opinion the
18 injuries complained of most probably resulted from the
19 negligence of the Defendant.

20 Damages. Actual damages. The Plaintiff must prove
21 the expenses she claims she incurred as a result of the
22 injuries were necessary and reasonable. Actual damages,
23 also called compensatory damages, are designed to make the
24 injured party whole. This means the damages are an
25 attempt to put the injured party in the same position they

1 were in prior to the accident to the extent that is
2 possible with money. Actual damages include compensation
3 for all the injuries that are the proximate result of the
4 wrongful conduct. The existence causation or amount of
5 damages cannot be left to conjecture, guesswork or
6 speculation. However, the law does not require proof of
7 loss to an absolute or mathematical certainty. It is
8 sufficient that their damages be proved to a reasonable
9 degree of certainty. The evidence by, presented by the
10 Plaintiff must enable you, the jury, to determine what
11 amount is fair, just and reasonable. The Plaintiff bears
12 the burden of proving by the preponderance of the evidence
13 that she is entitled to compensatory damages.

14 Elements of actual damages. In determining the
15 amount of compensation for injuries suffered by the
16 Plaintiff as a result of the Defendant's actions it is
17 proper for you to consider an award, past and present
18 damages for out-of-pocket expenses; medical expenses
19 including physician, hospital, medical, physical therapy,
20 rehabilitation and transportation expenses connected with
21 medical treatment; psychological trauma; mental anguish,
22 psychological injury; depression; pain and suffering and
23 loss of enjoyment of life. The Plaintiff bears the burden
24 of proving these elements by a preponderance of the
25 evidence.

1 Medical bills. In medical malpractice cases the
2 general rule is the Plaintiff may recover for the
3 necessary and reasonable expenses caused by the injury
4 such as the amount necessarily incurred from medicines,
5 medical services, surgeries, hospital care and nursing. A
6 person who suffers personal injuries from the negligence
7 of another person is entitled to recover at the reasonable
8 value of the medical care and expenses incurred for the
9 treatment of the injuries. Accordingly, the Plaintiff may
10 recover amounts incurred for past, medical and other
11 out-of-pocket anticipated expenses such as vocational,
12 physical and other rehabilitation efforts. Recovery for
13 medical expenses is controlled by what the services were
14 reasonably worth and not by what was actually paid or
15 contracted to be paid. If you determine from the evidence
16 under the law as I instructed you that the Plaintiff is
17 entitled to recover damages including medical or health
18 care cost, then the Plaintiff can only recover the amounts
19 as you determine from the evidence to be reasonable and
20 necessary. While the amount actually charged may be
21 considered by you you are not bound by that amount. You
22 should find only that total that is reasonable and
23 necessary.

24 Future damages. A Plaintiff is never entitled to
25 recover conjectural or speculative damages. However, if

1 you find the Plaintiff is entitled to a verdict for actual
2 damages your verdict should include an amount to cover any
3 past, present and future damages which were proximately
4 caused by the Defendant. Any future damages must be
5 reasonably certain to occur in the future as a result of
6 the Defendant's acts. Future damages need not be proven
7 to a mathematical certainty or be based on evidence of the
8 precise amount of damages to be, the Plaintiff has
9 suffered. Instead, the evidence must allow you to
10 determine the amount which is fair, just and reasonable.

11 Pain and suffering. Pain and suffering is a material
12 element of damages upon which recovery may be based. The
13 Plaintiff is entitled to compensation for her pain and
14 suffering which she proves directly results from the
15 wrongful acts of the Defendant. An award for pain and
16 suffering compensates the injured person for the physical
17 discomfort of the emotional response and the sensation of
18 pain caused by the injury. In making an estimate of the
19 damages is to award for pain and suffering you should
20 consider how bad the injuries were, whether they caused
21 the Plaintiff to suffer; how long the pain and suffering
22 lasted; or is expected to last. You should also consider
23 the Plaintiff's age, health, habits and condition before
24 the injury compared to what the condition after. Pain and
25 suffering has no market price. Pain and suffering is not

1 capable of exact measurement nor is there a fixed rule or
2 standard by which it can be measured. The amount of
3 damages to be awarded for pain and suffering, if any, must
4 be left to the judgment of you, the jury. You should use
5 a calm and reasonable judgment to ensure the damages are
6 just and fair and reasonable in light of the testimony and
7 evidence presented.

8 Loss of enjoyment of life. Loss of the capacity to
9 enjoy life resulting from a personal injury is a proper
10 element of damages. Damages for loss of enjoyment of life
11 compensate for the limitations resulting from the
12 Defendant's negligence on the injured person's ability to
13 participate in and derive pleasure from the normal
14 activities of life or for their inability to pursue their
15 talents, recreational interest and hobbies.

16 Mental suffering. Mental suffering, apprehension,
17 shock, fright, emotional upset, humiliation and anxiety
18 present or expected in the future can properly be
19 considered as damages. The amount of damages for mental
20 suffering cannot be exactly measured. If you find the
21 Plaintiff was permanently injured as a result of the
22 Defendant's actions then you must decide how, if at all,
23 the injury will affect the rest of the Plaintiff's life.
24 A person's life expectancy is determined by a life
25 expectancy table which is part of the laws of our State.

1 The life expectancy is only an estimate of the probable
2 average remaining length of the life of all the people in
3 our State of a certain age. I charge you that the
4 Plaintiff was born with this injury and has a total life
5 expectancy of 80.84 years. This fact is to be considered
6 by you along with any other facts and evidence bearing the
7 Plaintiff's life expectancy including her occupation,
8 habits, health, health at the time of injury in deciding
9 the amount of damages to be awarded, if any.

10 Fair and impartial trial. Ladies and gentlemen of
11 the jury, I wish to express the hope that each of you will
12 be mindful of the importance of your responsibility. You
13 are not called upon to serve as jurors very often and the
14 proper performance of this duty requires each of you to
15 reach the height of freeing your mind of all improper
16 influences. As the presiding officer of this court I am
17 vitally concerned that whatever verdict you find will be
18 the result of your going in the jury room and limiting
19 your consideration to the evidence and the law you heard
20 and weighing it fairly and impartially as I have every
21 confidence that you will do. Your verdict in this case
22 cannot be based on sympathy or compassion or prejudice or
23 emotion or some other consideration not found in evidence.
24 Remember, your verdict must be unanimous. Ladies and
25 gentlemen, this is the verdict form and what will happen

1 after I finish these instructions is the attorneys will
2 make their closing arguments. The Plaintiff has the
3 burden of proof so they get a reply argument and then we
4 will send you back to the jury room. Please don't start
5 deliberating. The last step is, the attorneys have to
6 look at all the evidence, make sure nothing is missing,
7 everything is in order and then the Bailiff will bring you
8 the evidence in the case, the documents and bring you a
9 copy of the verdict form. When the Bailiff brings you the
10 evidence and the verdict form that is your signal to begin
11 deliberations. The verdict form has three questions. The
12 first question says, did the Defendant breach the standard
13 of care and proximately cause the injury. That is a yes
14 or no question. You write yes or no. And if the answer
15 is no you stop there. If the answer is yes, there are two
16 more questions. The first question is, if the answer to
17 question one was yes, what is the amount of economic
18 damages you award. And economic damages are medical
19 bills, future medical bills, things like that that are
20 quantifiable with a number. And then the third question
21 is, if the answer to question one was yes, what amount of
22 non-economic damages do you award. And that would be pain
23 and suffering and things like that, mental anguish. Then
24 at the bottom there is a space to date it and for the
25 Foreperson to sign it. Any questions about the verdict

1 form, ladies and gentlemen. All right. Ladies and
2 gentlemen, I remind you that the verdict must be
3 unanimous. You should only fill out the verdict form once
4 all jurors are in agreement. And then when that has been
5 done and the jury agrees the Foreperson will fill out the
6 verdict form and knock on the door and notify the Bailiff
7 that you have a verdict. At that time we will receive you
8 back in the courtroom. Ladies and gentlemen, that is the
9 end of my legal instructions and now it is time for the
10 attorneys closing arguments. I ask that you give the
11 attorneys your attention, please. Mr. Graham.

12 MR. GRAHAM: Your Honor, you indicated earlier that
13 we could have a technology --

14 THE COURT: I apologize. Yes, sir. Ladies and
15 gentlemen, I am going to give you a quick break. The
16 attorneys ask for a short break to set up their computers
17 and electronics before closing. This will be a very quick
18 five minute break. Thank you.

19 (Whereupon, the jury was excused from open court for
20 a break.)

21 THE COURT: First thing, from the Plaintiff, other
22 than the charges you ask me to do earlier, Mr. Graham, any
23 objections to the charge I gave the jury?

24 MR. GRAHAM: No, sir.

25 THE COURT: From the Defense, other than what you

1 presented earlier?

2 MR. DAVIS: No, sir.

3 THE COURT: And last thing, Counsel, if y'all want to
4 look around and make sure all family members that are on
5 your side are here. Once the closing starts the Bailiff
6 won't let anyone in. Okay. Everybody here that ought to
7 be here?

8 MR. DAVIS: It appears from my side, yes.

9 THE COURT: Mr. Jordan?

10 MR. JORDAN: Yes, sir.

11 THE COURT: Let's bring them in.

12 (Whereupon, the jury came into open court at
13 approximately 11:15 a.m.)

14 THE COURT: Mr. Graham, closing argument.

15 MR. GRAHAM: May it please the Court.

16 THE COURT: Yes, sir.

17 MR. GRAHAM: It has been a long couple of weeks. You
18 will be retiring soon to the jury room to begin your
19 deliberations. When you get there you are going to have
20 three jobs to do. One of your jobs will be to answer His
21 Honor's question on the verdict form that we will discuss
22 in just a moment. The second job you have will be to
23 express to your fellow jurors why you feel the way you do
24 about those questions and about the issues in the case.
25 Thirdly, you have the right and the obligation to make

1 sure that everyone in the jury room follows His Honor's
2 instructions because that does not always happen. You
3 have the responsibility individually to let your Foreman
4 know if that is happening and ask your Foreman to knock on
5 the door and tell the Bailiff what the problem is. And if
6 the Foreman, no offense to the Foreman, but if the Foreman
7 or Foreperson I should say, if the Foreperson declines for
8 any reason to make that knock on the door then it becomes
9 your job individually, even if you are not the Foreperson,
10 to make that knock on the door. It is a necessary part of
11 seeing that justice is done in this case. Why is Alexia
12 suing. The first reason is because when Dr. Miller had
13 done his 180 degree rotation, he's got the mom in the
14 McRoberts position with the legs pushed way back; he has
15 got a nurse bending over to push down on the shoulder
16 bone; and those are traction related maneuvers. The baby
17 doesn't just pop out with those two maneuvers. The Doctor
18 has to pull and he is suppose to pull gently, like he did
19 when he diagnosed shoulder dystocia. You pull gently and
20 you feel for whether there is resistance. If there is
21 resistance, you stop. The safety rules require you to
22 stop, go to another maneuver. If you have done the
23 standard maneuvers then what you need to do is repeat
24 those maneuvers. Repeat them and just double check every
25 aspect of those maneuvers to make sure they are being done

1 the right way. Sometimes, you know, maybe the Doctor, get
2 to do a posterior arm method, then after the rotation he
3 can go back and try the posterior arm method again. Maybe
4 he sees that a nurse is pushing down in the wrong place.
5 Maybe he sees, you know, that he's rotated one way and
6 maybe it makes sense to try rotating the other way. If
7 you are going from one stuck shoulder to the other stuck
8 shoulder why not try to stop in between where there is no
9 shoulders and see if the baby will come out that way.
10 These maneuvers are there for a reason, they are for
11 patient's safety. The first reason we are suing is
12 because he didn't follow that patient safety rule which
13 leads me to the second reason we are suing. He chose to
14 forcefully pull on that head and bend that neck, wrench
15 that neck, torque that head quickly. And as Dr.
16 Gurewitsch said, the way the injuries look he probably
17 twisted that head as he was torquing and bending on the
18 head and neck. That is the second reason we are suing.
19 There is a third reason we are suing and that is because,
20 since 2007 no one has stepped up to do voluntary justice
21 in this case. So we are here today asking you to empower
22 justice, it is your decision. You have the power. Why
23 are those two, why are violating those two safety rules
24 wrong. Well, it is foreseeable that the, well it is
25 important that brachial plexus nerve damage be avoided

1 because it takes priority in the first two or three
2 minutes. There has been a lot of talk from the Defense
3 about the importance of protecting the brain. Hugely
4 important, we all want to keep our brains. But the brains
5 are not a problem in the first two or three minutes. You
6 heard Dr. Gurewitsch who is, you can tell from her resume
7 she is one of the real leaders, she is at John's Hopkins,
8 CDC picked her to try to figure out how to prevent these
9 injuries. The shoulder is the priority in the first two
10 or three minutes. If you can't, excuse me, protecting
11 against brachial plexus injury is the priority during
12 those first two or three minutes. And for heaven's sake,
13 they are the only priority in the first 45 seconds. We
14 have talked earlier in, last time I had a chance to talk
15 to you, we talked about some safety rules. It is
16 important that doctors, like the rest of us, take the time
17 to do the job right. If you have got three or four
18 minutes before there is a serious concern about putting
19 nerve safety aside and focusing on brain safety, that does
20 become important, four, five, six minutes. But before
21 then it sounds like a short time, you know, two, three,
22 four minutes sounds short. But it is not to a
23 professional. They think about the things you do well,
24 think about the things you are an expert at. How long
25 does it take you to do those things compared to somebody

1 like me. We must all take the time to do the job right.
2 Safety rule number two, from day one of obstetric
3 residency, if you get a shoulder dystocia stay calm.
4 Don't panic, you have been trained for this, use your
5 training. I am sure we will hear, in a few minutes, what
6 a terrible emergency this was. As long as you follow your
7 training you are in a situation where there is an
8 emergency that could be about to happen in a serious way
9 or five minutes from now. But in the beginning you have
10 got plenty of time to follow your training, stay calm,
11 don't panic. And the third safety rule is, instead of
12 using force, repeat those maneuvers, make sure and the
13 nurses are doing everything correctly, get them to, get
14 yourself or anyone else to improve what you are doing to
15 make sure those maneuvers are being carried out properly.
16 Forceful pulling and bending of the neck should never be
17 performed in the first 45 seconds. In the beginning of
18 the trial you saw us put up a note from the nurse on the
19 fetal heart monitor strip where she said 45 seconds. We
20 weren't sure what the Doctor was going to say. He said,
21 45 seconds. When his expert Doctor, Chauhan and the other
22 experts know that 45 seconds is a crazy short time to do
23 this many maneuvers. You got to be moving fast, you got
24 to be moving quickly and roughly, not smoothly and gently;
25 you are suppose to use finesse, not force. And 45 seconds

1 you don't allow yourself time for finesse, it is all about
2 force. It is foreseeable that that strong pulling on the
3 head and neck will injure the brachial plexus nerves if
4 you pull too hard, if you bend too far. That happens, it
5 is foreseeable which is why you need not to do that in the
6 first four, five minutes. It is foreseeable that forceful
7 bending and wrenching of the neck will injure those
8 nerves, so don't do it. What caused Alexia's nerve
9 damage. The only witness, expert witness in this case who
10 has training and knowledge about mechanical forces in the
11 engineering principles involved in a baby being delivered
12 is Dr. Gurewitsch, she has been trained, not only in
13 medicine at John's Hopkins, she has been published in
14 Engineering Journals, she has written; somebody made a
15 comment about Dr. Alan now being her husband. May they
16 have a happy future together, Robert Alan is known as the
17 leading biomechanical engineer on these issues. She has
18 published, she has coauthored many, many articles with
19 him, those have appeared in obstetrics journal, obstetrics
20 journals as well as, as well as engineering journals and
21 biomechanic journals. What does Dr. Gurewitsch say. You
22 can't get this kind of horrific injury, pulling two or
23 three nerve roots out of the spinal cord and rupturing the
24 other two without massive force, at least 50 pounds of
25 pulling force, at least 60, excuse me, at least 60 degrees

1 of bending force. She also suggested that there was
2 probably some twisting instead of pure rotation, some
3 twisting on the head which, you know, that gives you a
4 bigger stretch. Anyway, the quickness and the twisting
5 and the bending and the pulling is what caused her
6 injuries. The first expert witness that we put on the
7 stand is an obstetrician, Dr. Fred Duboe, from Chicago.
8 He is not one of the Ivory Tower guys like you heard from,
9 from the Defense, Dr. Chauhan and Dr. Ernest. He is in
10 the trenches delivering babies every day. And you heard
11 him talk about, you don't get this kind of harm to a baby
12 without the same kind of strong forces that Dr. Gurewitsch
13 was talking about. He talked also, he was like a week ago
14 so I am not sure how much of this you remember but
15 together you probably remember a lot more than I do. I do
16 remember that Dr. Duboe was talking about this Defense
17 theory, that we knew they were coming up with, that
18 somehow the baby comes sliding through the birth canal and
19 the shoulder gets stuck on a kind of bump covered with
20 soft tissue and somehow, somehow bends the neck so much
21 that caused that kind of nerve damage. It makes no sense.
22 If this was a tiny baby flying through the birth canal
23 then maybe you can imagine that, maybe a tiny enough baby
24 would have room to bend the head. This baby is microsomic
25 which means in the top percentile of big babies. This

1 baby took forever to get through the birth canal, Dr.
2 Miller gave medicine; Cytotec, Pitocin, I don't know if
3 anybody has had those but the point of giving those is to
4 strengthen contractions, make them be more frequent and
5 push the baby down faster. Now, here we have got a
6 situation where he kept trying, push, push, push harder,
7 push harder. Got the nurses, got to that, push harder,
8 push, push. And they kept yelling push because the babies
9 head was in there tight enough that it was a slow decent.
10 These guys want you to believe that that shoulder came
11 down in a birth canal that the baby was squeezing all
12 sides of. Being down, hit a little bump, covered with
13 soft tissue and somehow had room to bend his neck, even
14 though he starts off flat against the birth canal. So we
15 have Dr. Duboe talking about standards of care and how Dr.
16 Miller violated that. Dr. Gurewitsch, she is the one from
17 John's Hopkins, leading maternal fetal expert in this
18 country especially on the issues we have been talking
19 about today. I know it seems like a medical maze, all the
20 expert witnesses. I will explain later why you don't need
21 to be confused about that. I get confused and I have done
22 these cases a lot. I can only imagine they may be
23 confusing for some of you as well. But we will talk about
24 that medical maze in a minute. Dr. Gurewitsch, at least
25 50 pounds, at least 60 degrees of bending, severe injury,

1 extreme forceful manipulation of the head. You heard from
2 Dr. Resnick, until very recently, Chief of the Pediatric
3 Neurology Department at the University of Miami now called
4 Nicholas because guess who got his friends to donate a
5 bunch of money, Jack Nichols. But anyway, Dr. Resnick
6 came in here, he showed you the diagram, normal anatomy,
7 Alexia's anatomy, after those nerve roots got ripped out
8 and the other damage was done. And he explained, if you
9 remember, he didn't take time to go through all the
10 muscles, thank goodness, but he had the diagram color
11 coated to show, this nerve, C5 goes with those muscles.
12 C6 goes with those muscles, et cetera; et cetera. Then
13 when Alexia came out for him to do an examine, I don't
14 know what y'all saw but it looked to me like a perfect
15 match with that he had just explained, should be the case
16 with those kind of, with that kind of nerve damage. Dr.
17 Armenta, at the Texas Brachial Plexus Children's Center,
18 on board to do the next three surgeries. They tried to
19 improve the nerves, she got this but they are trying to
20 improve her shoulder so she might be able to brace
21 herself, if she ever gets the ability to fall off, to ride
22 a bicycle and is not afraid of falling off and hitting her
23 head. Then if they can get her some shoulder motion, she
24 can brace herself when she falls off of the bicycle which
25 gives her a chance, a fair chance to learn how to ride a

1 bicycle, to be with other kids. To have some kind of
2 social life, not to be a shut in at age 14. I remember
3 growing up in church, around Christmas time the youth
4 group would always get together and do, after candle light
5 service in church we would carry candlelights out into the
6 community and sing Christmas Carols for the shut in's. I
7 don't know if that is a well known phrase or not but that
8 is what we called them. And I always thought what a
9 horrible concept, shut in. I mean it is like being in
10 prison, it sounds like. But if this girl doesn't get the
11 ability to have some kind of recreational outlet that she
12 can use to spend time with her peers in laughing, joking,
13 fun way, you know, while staying in shape with the
14 exercise of it, she is a shut in at 14 years old. Dr.
15 Armenta can help with that. And notice, in case anybody
16 was wondering about how much can these surgeries help, the
17 less you have the more benefit you get from even a tiny
18 improvement. She can move her shoulder just a little bit,
19 if she can bend her elbow at least a little bit; if she
20 can learn to lift her wrist instead of, she can learn to
21 lift her wrist a little bit and then move her fingers a
22 little bit, she might be able to use a keyboard, she might
23 be able to use a TV remote control. I mean, that may seem
24 like small things to us but if this is all you got the
25 rest is a lot. Dr. Maureen Nelson, she is a pediatric

1 physiatrist in San Antonio, Texas. I used to get confused
2 when I first met her and saw the name, physiatrist. I
3 thought she was a psychiatrist. But physiatrist means
4 somebody who specializes in physical medicine and
5 rehabilitation. So the physiatrist part comes from
6 physical medicine, doing Botox injections to try to
7 weakened, try to weaken certain muscles so the other ones
8 might be able to get stronger; doing all kinds of bracing
9 that might be able to help get better movement, just by
10 starting off with a cast here, wait a month, move the hand
11 up and do a cask here, do a cast here in hopes that over
12 time with enough therapy she would be able to do this.
13 Now, Dr. Armenta, I am sure y'all noticed, Dr. Armenta
14 said that he was kind of disappointed that the family
15 hadn't gotten the therapy that he wanted them to have.
16 And some of you may have thought, that is a criticism of
17 Alexia for not going or her parents for not taking her.
18 That is not what is going on. What is going on is, I love
19 South Carolina, I love Charlotte, Charlotte is a big city
20 but Charlotte is not one of the cities that has
21 specialized therapist that know what you are suppose to do
22 for brachial plexus injuries. They do the normal
23 occupations therapy that they would do for somebody who
24 gets injured at work or somebody who is in a wreck. Dr.
25 Armenta was upset that they hadn't she hadn't gone and

1 gotten the serial casting. Well, guess what, they don't
2 do that here. She is trying to find somebody that will
3 help her do the things Dr. Armenta recommends before he
4 does that surgery. But it takes money to go find a place
5 to do that kind of therapy and either go back and forth or
6 find a place where you can stay for an extended time to
7 get that done. These are not easy steps for the family to
8 take, given the resources here that are limited in that
9 one aspect. I mean, there are so many ways that Charlotte
10 is a hub of medical excellence. But just like other
11 hospitals around the County, they brag, we got rated
12 number one; dermatology, we got rated number one on emergency
13 medicine. You know, you might even see billboards around
14 town bragging about one or two things they got awards for.
15 It is tough to find a hospital that is good at all of
16 these medical disciplines. You know, where do you go for
17 that, Hopkins, Mayo Clinic. Dr. Grossman, until he
18 retired a few years ago had done as many of these nerves
19 resection surgeries as anybody in the world. He is
20 retired now, he was not retired when he first started
21 working on this case and gave his deposition. But he is
22 now. So the child went down there for a second opinion.
23 I mean, she has got Dr. Armenta's opinion when he came to
24 Charlotte but she wanted to get another opinion, going to
25 Texas for surgery, does that make sense. And then she

1 found out, the only place that makes sense to get a second
2 opinion is Miami. So not exactly saving time and money
3 and distance, but there are not that many surgeons who
4 specialize in this kind of surgery. So anyway, you have
5 got his testimony about a few important things, second
6 opinion on the surgery; the recognition that even with all
7 of these surgeries she is still going to be severely
8 impaired. But she will have more than she has now. But
9 perhaps the most important part of his testimony was about
10 causation. He says, I see these kids, I see what happens
11 to those nerves when they get ripped out. And
12 obstetricians gang up and come up with some book that
13 says, oh, the birth canal did it; oh, the uterus did it;
14 he calls that for what it is. It is junk science, it is
15 the Defense maze of medical nonsense that they use as a
16 tactic in every one of these cases to get you confused and
17 try to protect their doctors who do this to people all
18 over the Country. At the beginning of the trial, I told
19 you, this is not an unusual case. It is a very special
20 case to my, to Alexia and her lawyers but it is not an
21 unusual case. Cases like this take place over the County
22 every week, probably more than one every week, probably
23 multiple every week. These same experts fly around the
24 Country, defending these doctors. I thought it was
25 interesting when Dr. Chauhan, who is really one of the

1 biggest traveling experts, I thought it was very
2 interesting when I asked him, are there any States you
3 haven't testified in. And he said, oh, yeah, he got
4 really excited. There is, there is five, maybe ten States
5 I haven't testified in. You know, like that made him some
6 kind of a small town witness. He goes all over the place
7 and does this for doctors like Dr. Miller. And there is
8 some interesting things about Dr. Chauhan we will come
9 back to. So we have got the injury, on the left upper
10 side of the screen we have got normal anatomy; on the
11 bottom right we have got the horrific damage to Alexia,
12 those bottom nerves pulled out from the spinal cord. You
13 heard Dr. Gurewitsch, to do that it takes the force of
14 pulling a carrot out of the hard ground by the root, not
15 pulling the top off of the green parts, the leaves and not
16 doing that but pulling hard enough on that root to pull it
17 out of the ground in one quick strong move. That is not
18 gentle force. That is not guidance. Here carrot, I am
19 going to guide you out of the ground. I mean, there is a
20 lot on the screen. On the right we have got some
21 highlighted parts of the operate note, we have talked
22 about that in testimony, I don't want to rehash that. On
23 top we have got some information that I really can't read
24 because I have got such bad vision. Then we have got the
25 surgery that was done down at MUSC. MUSC is a part of

1 this State, there are many wonderful doctors there,
2 tremendous number of wonderful nurses and other
3 professionals. But they are not one of these brachial
4 plexus centers and unfortunately all they could do
5 resecting those nerves. This was all they could
6 accomplish and that was only with lots of therapy after
7 the surgery. Dr. Margaret Greer-Simmons, now she is what
8 is called a pediatric neuropsychologist which basically
9 means she is one of the psychologist that not only does the
10 anxiety and depression kind of work but she also gives
11 tests, like IQ test and special perception tests and all
12 kinds of other things you heard her talk about. To me the
13 most important part of her testimony was her diagnosis
14 that what is going on with Alexia is, starts with anxiety.
15 If you just, I am uncomfortable talking about this in
16 front of Alexia but, you know, sometimes you will see a
17 youngster with a face that just looks very depressed and
18 not engaged in the world around her. So someone like me
19 thought she was depressed, she has some emotional
20 problems. Dr. Greer-Simmons is smart enough and tough
21 enough, she taught at the Citadel. She's able to make the
22 connection that this starts with anxiety, social anxiety
23 about going outside and being teased or bullied or made
24 fun of, even her sister laughed at her because she
25 couldn't put her hair in a ponytail like her younger

1 sister. So who knows what happens around other school
2 children at that age. When you are young like we saw in
3 some of the happy pictures, at that age, none of this
4 matters, nobody notices, nobody makes fun of you very
5 much, if they do you kind of let it roll off your back.
6 Once you get to those adolescent years, the early teen
7 years, I mean I don't know about you guys but I can
8 remember 7th grade, 8th grade, in that general timeframe.
9 A lot of people had it tough. I got a taste of that
10 myself but some people really had it tough. But anxiety
11 triggers the depression which is important to think about
12 when you try to project what her future situation will be
13 in terms of her forever. What difference would it have
14 made if he had done his job right. We wouldn't have \$221,
15 \$221 thousand dollars in past medical expenses. We
16 wouldn't have the reduced earning capacity, the reduction
17 in job opportunities, career opportunities and the future
18 lifecare expenses. The projection that Darlene Carruthers
19 made about that. So we are looking at a whole lot of
20 money. So if you total it up, the future economic loss
21 are over \$1.2 million. Now, it sounds like a lot to me.
22 I suppose it sounds like a lot to many of you. Two of the
23 Defense experts spoke the truth on this subject. If that
24 was my daughter, that is what she would get. There is
25 nothing about those numbers that is not medically

1 necessary and reasonable. Two Defense experts vouched for
2 that, she needs the three surgeries, a little help is a
3 lot of help for somebody who only has this. This is a
4 photo her mom took of her holding an apple. If it is a
5 big apple she can't hold it in one hand. So it speaks for
6 itself. The Defense uses excuses. Angela's birth canal,
7 uterus did it; Alexia was too big; the animation proves
8 what happened. The Defense and their buddies wrote some
9 medical articles to dress up their excuses. They claim to
10 be heroes for getting Alexia out to prevent brain damage.
11 Now, brain damage should be avoided at all cost,
12 absolutely. None of us, none of us would want to deal
13 with any, any mild brain damage for anyone, any loved one.
14 But these guys are pro's, they know that for the first few
15 minutes you are suppose to focus on protecting the arm and
16 the brachial plexus nerves. There is plenty of time, if
17 you stay calm and using your training and then you can
18 take care of the brain, pull as hard as it takes to get
19 that baby out. If your training has let you down for some
20 reason and you haven't gotten the baby delivered in the
21 normal time then yank the, pull the head as hard as you
22 want to to spare the brain. But that is after, you heard,
23 I think it was one of my expert's mention a four minute
24 rule. It really takes longer before your brain is at
25 risk, use a four minute rule for a cushion. Because none

1 of them want to get close to a risk of brain damage. So
2 if you can't get your baby delivered, if that shoulder
3 dystocia released within that three to four minute
4 timeframe, then do what it takes to protect the brain.
5 But that is no excuse to rip nerve roots out of a baby's
6 left spinal cord, 45 seconds after you realize there is a
7 problem. Oh, I like this one, we will come back to this
8 later. But Alexia crashed into her mother's pubic bone.
9 You know, when you have a bad wreck and you see those cars
10 all crumpled up and trucks and trains all mashed up and
11 totaled, that kind of a crash can cause all kinds of
12 horrible, horrible problems. So they suggest there is a
13 crash of Alexia's left shoulder into the tiny bump covered
14 with soft tissue. We will talk about that speed of a
15 crash in a moment. And these things just happen. Why do
16 you expect us to deal with resolving a shoulder dystocia
17 even though we are professionals, we are trained how to do
18 it, it should come second nature to us. But if we botch
19 it, these things just happen. See these dressed excuses
20 for what they are. Although they say the uterus pushed
21 too hard and created too much compression, he ordered
22 Cytotec and Pitocin. Now, I don't know how many ladies or
23 husband's spouses have ever been induced with these drugs
24 or sometimes they call it augmented where they, you start
25 on your own and then they make it more powerful with these

1 drugs. But the whole point of those drugs is to make your
2 contractions faster and stronger. And then they come into
3 this courtroom and say, Angela, why did you let your
4 uterus push so hard. They say, oh, even though most of
5 these happen when the injured side is under the suprapubic
6 bone, this was a mysterious case where it was actually,
7 the left shoulder when it was on the bottom going past the
8 tiny little sacral promontory bump. And, of course, we
9 mentioned this. You know, saying it was a big baby, that
10 is what caused the problem. I mean, maybe it increases
11 the risk of the shoulder getting stuck but it certainly
12 doesn't increase the risk of a baby's neck turning like
13 this going down a birth canal that is holding it and
14 keeping it from going down quickly. You heard Dr.
15 Grossman, this is junk science, it is a medical maze meant
16 to confuse. Sadly it works, in some States in this
17 Country it works. And in some States people like you stop
18 it. Junk science is not going to prevent accountability
19 or medical negligence in our community. We will not
20 accept junk science as their excuse for negligence. They
21 try to support their crackpot theories with a article
22 about nerve damage to hind legs of baboons, if you put a
23 tourniquet on their legs, tight enough and long enough.
24 That is proof positive, proof positive that the uterus
25 presses those nerves and damages them during the hours of

1 long labor and delivery process. Dr. Chauhan was honest
2 about this. He was embarrassed it looked like to me.
3 Before I even pointed him to the footnote, he knew where,
4 he knew what was there. Oh, oh, this has nothing to do
5 with anything, this is a 50-year old article, it is about
6 baboons. And it has nothing to do with this case. True
7 but it has everything to do with the quality of their junk
8 science. Angela, did you put a tourniquet on that
9 baboon's leg. Alexia is a human baby, now a human
10 14-year-old. At the time of these events she was a human
11 baby, a human baby. Any human baby picked out randomly in
12 every community in this Country, her mama's birth canal is
13 not a tourniquet, her uterus is not a pressure device that
14 tightens and tightens and tightens like a tourniquet. A
15 brain is virtually important, we talked about this. The
16 arm takes priority those first few minutes. I was
17 supposed, it was going to be interesting to me to see what
18 Dr. Miller would say about how long, some of the experts
19 have said, maybe up two minutes. We knew one of the
20 nurses had said 45 seconds and we thought that he would
21 come up with some flimsy excuse why that was. But he
22 admitted that, he couldn't come up, apparently he couldn't
23 come up with any excuse of why the nurse was wrong, 45
24 seconds. That is a confession. Dr. Chauhan, you remember
25 that. Dr. Chauhan didn't know that question was coming,

1 about how long does it take you to do these maneuvers.

2 Oh, three minutes, two minutes. When Dr. Ernest came in,
3 I didn't bother asking him those questions. Why was that.

4 He went second, he got educated. Let's talk about

5 crashing into her mom's bones. All right. You probably
6 are wondering, what on earth is Graham doing to Dr.

7 Ernest, to do that drawing about the stations and the head
8 and the inches. But so we have got, he drew, I mean the

9 baby's length and the record is 21 and a half inches. She

10 says, no, the baby will be more in a fetal position so it
11 is less than 21 and a half inches. And then there is one

12 and a half inches from zero station to the head being out.

13 And so, you know, so in his handwriting, his calculations,
14 this baby went less than 23 inches in 39 minutes. So how

15 fast was this, how fast was this baby hurtling own that
16 birth canal, crashing into that bump, way less than one

17 mile an hour, way less than one percent of one mile an

18 hour, way, way way less. Oh, what a crash it was. Can

19 you believe the Defense team. The fact on which an expert
20 witness, are not to be unreliable, that itself is equally

21 unreliable.

22 (Whereupon, Mr. Graham played an excerpt of testimony
23 from Dr. Chauhan.)

24 MR. GRAHAM: The facts be damned. Well, what do I
25 need facts for, I am doing my job for these guys. I don't

1 need no facts. Did this guy come anywhere close to
2 hitting the bull's eye. No. Did he get lucky? Yes. He
3 is so lucky, he gets paid, after he gives his testimony
4 and refuses over and over and over and over again all
5 across the Country and all the five or ten States that he
6 will not let anybody know how much money these guys are
7 paying him. I wish I had some of his luck. Alexia was
8 not so lucky. Mission improbable. Dr. Chauhan says it is
9 highly improbable that he used 50 pounds of pulling and 60
10 degrees of bending. But did he say, did he even say the
11 guy didn't do it. Mission improbable. (Mr. Graham moves
12 away from microphone.) If Dr. Miller and his lawyers make
13 a good enough animation to get their experts to change
14 their minds maybe they can sell it to you as well. You
15 heard Dr. Ernest. Well, sure, I said both shoulders got
16 stuck at the deposition but I haven't seen the animation
17 yet. Of course, it also has to do with my knowledge and
18 experience. But the first thing he said was, I haven't
19 seen the animation yet. I was frankly stunned for them to
20 make us all aware, we all have personal knowledge that
21 they came up with their final animation. And then they
22 thought, maybe we could do better so they do everything a
23 different way. You are not often going to catch a Defense
24 making different versions of evidence they are trying to
25 use to get their experts to change their mind so they can

1 get you to fall for it. Was it two versions, was it two
2 versions. We saw two versions yesterday. Final one and
3 final two. They were exposed. It looks like there might
4 have been more than two. I am not sure if you were here
5 yesterday when there was a discussion about animations
6 being emailed to my office but emails have some
7 interesting features. Sometimes you can look around the
8 edges of emails and learn some things. So let's look at
9 this. Look at that left arrow what does it point to.
10 Points to V4, V5. And the other one to the right says B5.
11 What do you make of that. That is a, could it possibly be
12 version four and version 5. Never in my, how many years,
13 never in my career have I heard anything like I heard from
14 Dr. Miller when they were trying to make hay with these
15 various animations. I had never heard a Defendant doctor
16 in a medical malpractice case say, none of that matters,
17 it is Bugs Bunny. It is Bugs Bunny. This is Bugs Bunny.
18 I guess this does have something to do with Bugs Bunny,
19 just like they keep changing the signs, these guys kept
20 changing the animations. Let's talk about the law. His
21 Honor has already told you the law. That is Judge
22 McKinnon's department but I am allowed to talk about how
23 it relates to this case. The burden of proof,
24 preponderance of the evidence, crystal clear.
25 Preponderance of the evidence means that you outscore the

1 other team. You can have a fifty, you can have an even
2 balance, which is more likely, right or wrong; our side or
3 their side. If you believe there is even a feather on our
4 side to break that balance the scale goes down, that is
5 all we have to prove. But this is not a case about
6 feathers. Sometimes jurors, former jurors have told me
7 that they thought that you had to prove more than that.
8 We hear a lot about proof beyond a reasonable doubt in
9 some famous criminal trials lately, proof beyond a
10 reasonable doubt. That is kind of like scoring in a
11 football game from the one inch line to the other end of
12 the field. It is like in baseball, being down 12 runs and
13 hitting five grand slams in a row. I mean, beyond the
14 burden of proof is a really, really high standard to me.
15 Which is more likely right or wrong. If anybody tells you
16 in the jury room that they are not convinced that this,
17 they are not one-hundred percent convinced that this
18 happened you have got a job to do. You got to tell your
19 Foreperson to let the Bailiff know to let His Honor know.
20 And if the Foreman won't do it knock on the door yourself
21 and tell the Bailiff what is going on. More likely than
22 not. Evidence, evidence consist of testimony, it consist
23 of the medical records, the other various documents that
24 have been introduced. Base your decision on the evidence,
25 not on personal experiences. Your personal experiences

1 are very important but don't decide that one side or the
2 other should win because you had a cousin that did this or
3 that or filed suit or didn't file suit. This happened to
4 somebody else and they didn't get any compensation for it,
5 justice wasn't done in their case, why should it be done
6 in this case. You can't do any of that. If anybody is
7 talking about any kind of wrong way to deliberate on this
8 case you have got to, you know what you got to do. Direct
9 and circumstantial evidence. Direct evidence is pretty
10 much, what does a bill say. Kind of hard to argue over
11 what a bill says. Direct evidence is the testimony that
12 you hear up there. Direct evidence is what you see in
13 terms of what Alexia can and can't do. Direct evidence is
14 proper evidence for you to take into account, headline
15 news, right. But the point I am about to make is that
16 circumstantial evidence is just as valuable, it is just as
17 worthy of your attention. Let me give you an example. I
18 had a whole lot of time to keep up with the weather
19 reports this week but I have been told that snow is
20 predicted and then predicted later on. The last I heard,
21 I may not be up to date, but the last I heard is due on
22 Sunday. Let's say you go to sleep before the snow starts,
23 you never see any snow coming down. You wake up in the
24 morning and see snow on the ground. Does that mean it
25 snowed last night. That is called circumstantial

1 evidence, it is worthy, it is valuable, it is important.
2 It doesn't come from the witness stand per se, but it
3 comes from understanding what the facts are and connecting
4 the dots. So if these guys come up and tell you, what do
5 you mean, it snowed last night. I hired some people to go
6 up to Sugar Mountain, they have got some of those
7 artificial snow blowers, they came back here and they blew
8 snow all around your home. If you buy that you buy that.
9 Expert witnesses. We have talked about this a good bit.
10 In a case like this there are always experts, we have to
11 pay ours, they have to pay theirs, all except one of them
12 in the Country that I know of forthrightly tells what kind
13 of money they got, all except one. Experts in this case
14 like this never agree, so don't think that because the
15 experts didn't agree that that means we didn't meet our
16 burden of proof. They never agree. They don't agree on
17 what the standard of care is, they don't agree on whether
18 or not the Defendant violated the standard of care. They
19 don't agree on whether the violation of the standard of
20 care caused problems. They don't agree, usually, how bad
21 the problems were that they caused. They disagree on
22 virtually everything and it is your job to sort it all
23 out. They want it to be hard for you to sort it all out
24 because this medical maze, all of this journal articles,
25 all of this high flatulent talk. I told you earlier in

1 the case I was going to try, try, try to keep it down to
2 language we could understand but when you get these guys
3 here, you know, it is hard to do that. And so I hope that
4 medical maze tactic doesn't fool anybody. And if you are
5 worried about, how do we do this, being jurors is an
6 important job. How on earth are we suppose to sort this
7 out. Well, i have two ideas for sorting it out. First of
8 all, pay attention who seems believable. Witnesses like
9 Dr. Chauhan who won't tell you or anybody else how much
10 money they pay him; Dr. Ernest who told you that he
11 totally changed his opinion about this case once he saw
12 the, one of the animations that he Defendant and his
13 lawyer created either two or five different times. Dr.
14 Miller, what about his credibility. First, back at the
15 deposition, I don't remember if the Dad is there. Angela
16 said he was, I have no reason to doubt her. She is
17 telling the truth, I don't remember him being there. Oh,
18 see this picture, we have got this big drape, we forced
19 him to stand behind the drape so he couldn't see anything
20 and couldn't testify to what he saw. At his deposition
21 Dr. Miller says, oh, well, the reason you come to
22 episiotomy is to give the baby more room to come out. An
23 episiotomy cuts soft tissue, shoulder dystocia is when the
24 shoulder gets stuck because it is behind the bone.
25 Episiotomy is not to let the baby come out which is what

1 he said in his deposition. Cutting an episiotomy is to
2 give the Doctor room to stick his hand in, to do the
3 maneuvers, the safety maneuvers to get the baby out. Of
4 course, when he got to trial he was educated and knew that
5 that is what an episiotomy are for. And there is some
6 other contradictions but it is your, it is up to you to
7 judge the credibility of the experts. So that is one
8 answer to how do you figure it all out. There is another
9 answer on how you figure it all out. You have heard from
10 number of expert witnesses paid by both sides. Which is
11 the most important expert, you guys are. You are the
12 experts on common sense, you are the experts on life
13 experiences in terms of what makes sense and what sounds
14 like a fairy tale. You have the power, there may have
15 been times in your life like they have been mine where you
16 just feel like you are in a box where people tell you what
17 to do, they tell you what not to do. You have leaders
18 that you despise, you are forced to live with other
19 people's decisions. Maybe those decisions make good
20 sense, maybe they are absurd. But sometimes you feel
21 yourself in that box where you have no say, no power.
22 This is not one of those days. The jury box is not a box
23 that confines you. The jury box is a box that empowers
24 you. This case is not just about Alexia. Our system of
25 justice in this Country is not just to compensate one

1 person but it is to protect the safety of others. These
2 injuries are random. They could happen to anybody's
3 child, they could happen to anybody's grandchild, the
4 shoulder dystocia. And if the shoulder dystocia is not
5 handled in accordance with the safety rules this can
6 happen to anybody's baby, anybody's grandbaby, I am not
7 going to say great-grandbaby because everyone here is
8 younger than me. We have talked a bit about -- the other
9 one is credibility, there is several charges about that.
10 You can read these examples. There weren't many doctors
11 in this case who would have actually treated Alexia. Dr.
12 Nelson and Dr. Armenta have. You think they hesitated to
13 tell the truth about what was going on here. Dr. Grossman
14 examined her, Dr. Nelson examined her. Did anybody on the
15 Defense examine her. Examine her would require them to
16 care about the facts. Okay. I tell you what, the
17 photographs, then to see a Doctor who has been found out
18 and others are seeking to hold him accountable. The
19 testimony, prior testimony, current testimony, where does
20 the credibility lie. Dr. Ernest, gotten ahead of myself,
21 we talked about him. Okay. This was another one of my
22 enjoyable parts of the case. Okay. You have got Dr.
23 Chauhan, takes a while to try to get the facts out of them
24 but there is proof, they have to stick to it now. One,
25 severe brachial plexus injury, one permanent brachial

1 plexus injury in his career. What was it caused by. We
2 didn't fill this in because we knew what you know what the
3 answer was. Every time these experts have had a severe
4 permanent brachial plexus injury on their watch, either
5 they are on hands or they are under links, it was caused
6 by severe powerful pulling on the head, bending of the
7 neck. So much so that Dr. Ernest had a chat with his
8 Junior Resident about what she had done. He thought that
9 was the appropriate discipline. Don't do this to any
10 other kids. Is she a Board Certified Obstetrician now,
11 getting defended when she botches a delivery by these same
12 guys that keep flying around the Country. Why should he
13 keep up with that. The animations are a flip flop, there
14 are other flip flops. Medical malpractice. You see the
15 words there, you heard them from His Honor. What we are
16 talking about here is just like any other personal injury
17 case where somebody is driving down the road and, maybe
18 they are driving on a beautiful highway and the mountains
19 come into their peripheral vision and they slide over the
20 lane and wind up in a head-on collision. Horrible
21 outcome, who should be held responsible for that, society
22 as a whole or the guy who broke the rules of the road.
23 Doctors have their own rules of the road. We have talked
24 about some of those, safety rules. When doctors violate
25 safety rules just like a careless driver, just like a

1 careless shopkeeper who doesn't clean up messes, just like
2 a careless airplane mechanic who doesn't take the time to
3 do the job right. Horrible things happen when people
4 break safety rules. So for that reason doctors are held
5 to the rules of the road which you can read here in legal
6 lingo, that means failing to do what a reasonably prudent
7 physician under the same or similar circumstances or doing
8 that which a reasonably prudent physician would not do.
9 And, of course, we don't have the case unless that
10 negligence causes the damage and we have talked some about
11 that. But medical malpractice is really not that hard to
12 understand when you realize it is a negligence case, this
13 is not a criminal case. Dr. Miller is not going to jail,
14 this is not anything that is going to affect his license
15 to practice medicine. And in a civil claim like this it
16 is just about 12 fair-minded strangers coming together
17 from different walks of life with the collective wisdom of
18 all of you to speak the truth. The standard of care is
19 very much like, I mean it is part of the medical
20 malpractice law that you saw up there and we have talked
21 about this before, the rules of the road, standard of
22 care. Actual damages. You see the charge there. Some of
23 these are real easy. What is the past medical bills, look
24 on the piece of paper and you will see, \$221,000.00
25 dollars. What is the future economic damage, look there

1 and you will see, \$1.2 something million. And you have
2 got the lifecare plan in front of you, you have heard the
3 Defendant and one of his expert's say that it shouldn't be
4 changed, it is all medically necessary. But if anybody
5 here doesn't like part of it, that is fine. If in your
6 collective wisdom you think there is some part on there
7 that you think is just too much or sounds a little nutty
8 to you or whatever. Oliver Wood, the economist told you
9 how to do that, I hope you remember how to do that. But
10 for heaven's sake, don't just say, this plan needs a
11 haircut, let's knock some percentage off of this. That is
12 not how the way it works, that is not evidence. Your
13 decision should be based on the evidence. So if you take
14 anything off of the lifecare plan, if you take anything
15 off the lifecare plan do it based on evidence, do it based
16 on collective decision making. The rest of the actual
17 damages that you will be asked to consider are not, the
18 rest of the damages are not economic damages. By economic
19 damages we are talking about specific dollar figures that
20 you can add up, easy enough. The other part of the
21 damages has a name that the law uses which I think is one
22 of the worse names that I have heard of, non-economic
23 damages. What on earth does that mean. What that means
24 is it is human losses, human damages. What does it feel
25 like to not be able to ride a bike for fear that you are

1 going to crack your skull. What does it feel like to not
2 want to make friends at school because you are afraid they
3 might laugh at you behind your back or bully you. And
4 what about all the things you can't do, some things you
5 can do, you can hold a large apple. If one hand is not
6 good enough for it, you can lean over and push it against
7 your hand like that. How you eat it, I don't know. But
8 there are certain things that Alexia can do and certain
9 things she can't do. That apple is too big for one hand,
10 she can't eat it unless her mama cuts it up for her,
11 unless she has one of those rocker knives that we saw. I
12 don't know if it works for apples, it works for peeling
13 potatoes. So what is, what are these damages, these human
14 harms and losses and damages worth. How do you put a
15 number on anything like that, you can't, you can't. But
16 it is your job to do so. And I am going to give you some
17 ideas about how to do that. Just think about how severe
18 the harm is, just think about how many years she is going
19 to live, this is forever. Every day of every week of
20 every month of every year. You heard the charge on life
21 expectancy. what does life expectancy mean. It means that
22 if you round up everybody in a certain age group at a
23 certain year in time, you gather information and come up
24 with a figure of what is the average amount of time that
25 we might live to be. And if that is 80 something or 60

1 something, the truth is half of the people are going to
2 live longer than that, half of those people will live
3 shorter than that. With the care Alexia deserves, if she
4 gets that there is a good chance she will live longer than
5 that, I hope and pray she does, I hope and pray she does
6 with the tools that she needs to be a full person to the
7 best of her ability, to the best of society's ability.
8 Who should take the risk, if the money, if the appraisal
9 is based on what half the people her age lives to be, then
10 that means she runs out of money when she reaches that
11 average age. What does she do then, does she, should the
12 man that caused this problem take that risk. Should she
13 take the risk of her running out of money or should he
14 take the risk of her running out of money. Mental
15 anguish, emotional harm, I mean you have seen glimpses of
16 it, physical pain, emotional pain, loss of enjoyment of
17 life. When I first became a lawyer I was wondering what
18 on earth is that. In the Bible, one of my favorite books,
19 Song of Solomon, Solomon enjoys his life and loss of
20 enjoyment of life means different things to us than it
21 did, Solomon but we live for the weekends, we live for
22 retirement, we live for the evening after we get off of
23 work. Whatever we do then to gain joy out of our lives is
24 one of the main things we are talking about here for these
25 human losses. If your daddy, at his age, still holds

1 sprint records at his high school what does it mean to his
2 daughter that she can't jog or run with him or make him
3 proud by competing in tournaments. If she wants to be an
4 obstetrician, and can she deliver a baby one-handed. What
5 is it like when she is ready to have a man in her life. I
6 remember when I was a youngster we used to have pickup
7 game. There were some good athletes who would be the team
8 leaders or the first chosen and then there would be a few
9 people in the back. Please don't call me last, please
10 don't call me last. What if you do everything you can
11 with your devoted therapist and your personal drive to
12 learn how to put that hand and this hand and learn how to
13 use your right arm strength, hit a volley ball. Just such
14 an incredible effort on her part but how is she going to
15 make a team when she can't spike the ball or serve the
16 ball. I mean how is she suppose to serve the ball. You
17 know, I mean, basketball, I mean, you can say you play
18 basketball but sitting on the sideline watching other kids
19 play basketball was not my idea of playing basketball.
20 You know more than I do all the things it takes two hands
21 to do. If she is someday able to be a proud homeowner, I
22 mean, even if she has the finest riding lawnmower how is
23 she suppose to get her arm up there to operate it, what is
24 she going to do. And gardening, even carrying a lunch
25 plate from the school cafeteria. I mean, we could go on

1 and on, you in your collective wisdom can think of all of
2 these things. Let me just go forward in time. Assuming
3 that there is a loving man in her life some day and
4 assuming they have children, one of the joys of parenthood
5 is the human touch, the human interaction. Right now she
6 had got great parents who do everything they can for her.
7 What is she going to do when they are gone. And before
8 they are gone is she going to keep living with them, will
9 she be able to have her own place and her own
10 independence. I have always heard that when we are young
11 our parents are our parents. And when our parents get old
12 we become their parents. She will never be a, the kind of
13 parent to her parents that the rest of us would have the
14 physical capacity to do. When she's at retirement age, in
15 that general timeframe, 50, 60 years old or older and
16 wiser, who is going to help her, how are you suppose to
17 take care of a home and herself. Will she go in some kind
18 of nursing home or something, heaven forbid. So I am not
19 going to go through the rest of these items on here, you
20 can read them, you can use your collective wisdom to try
21 to figure out, you know, money, it does not -- good way to
22 balance what happened to change one's life, that is all we
23 have got. Later on you are going to hear about, well,
24 compensation comes from a (inaudible), compensation
25 requires you to appraise what her damages are worth

1 including those human damages. Most people think of that
2 as pain and suffering and that is part of it. To me it is
3 no where near other human losses, loss of enjoyment of
4 life, loss of activity. Trying to find new and creative
5 ways to tie your shoes, then they come untied and other
6 people pretend they haven't come untied so they don't feel
7 bad. There are a couple of more things I want to say.
8 Part of the charge, usually when jurors or anybody else in
9 a case like this hears about sympathy they think the Judge
10 is telling them, don't run up the compensation dollars
11 because you have sympathy for Alexia. That is not what
12 that means. The last thing Alexia needs is sympathy, she
13 has had 14 years of sympathy. Don't take sympathy for
14 Alexia into account. She is here for justice, she is here
15 for a true and accurate appraisal of what her human harms,
16 losses and damages add up to as best you can do that in
17 dollar terms. What we are worried is about, if anybody
18 here is thinking they need a Doctor, (inaudible), it is
19 embarrassing to his professional status, his work or
20 earning, it is highly unlikely. Also on those lines are
21 improper, that is not what your verdict should be based
22 on. So if anybody back there is worried about what this
23 might do to the Doctor, you know what to do. Proximate
24 cause, proximate is basically, there is a legal definition
25 for it but the root word is, close, nearby, foreseeable.

1 If you do, if you do this and this and cause damage then
2 that is a proximate cause. If you, if you, say you are
3 playing pool, hit one cue ball, hits another ball and
4 another ball, that is still proximate cause because it is
5 close in time and place. But if you have got some crazy
6 connection, like somebody trips and falls over and they
7 hit a toy and the toy runs that way and then the toy trips
8 over a pedestrian. Do you blame it on this guy, it is
9 just a simple concept. And another thing that is
10 important to know is that it doesn't have to be the only
11 cause, a cause is all you need, a significant factor in
12 causing the injury. So even if you believe any of the
13 stuff you have heard from the Defense team, even if you
14 believe that, you still return a verdict for the
15 Plaintiff, for Alexia, if the negligence was a
16 contributing cause, a substantial factor among other
17 causes. We believe that it's just a negligence but you
18 don't have to believe that to render a verdict. So we
19 have got the harm suffered by Alexia, we have got all of
20 these elements of damages we have been discussing, medical
21 bills are easy, the future damage, certainly the economic
22 part of that is easy; the non-economic part of that we
23 talked about, the human losses carry on. Mental
24 suffering, we have talked so much about this. Okay, life
25 expectancy we have talked about. Fair and impartial

1 trial; jury verdict. Well, before we get to the jury
2 verdict, has anybody figured out why Dr. Lupo was called
3 in by the Defense? Doesn't remember this delivery, she
4 doesn't remember the child, mom and dad. She doesn't play
5 a role in vaginal deliveries, she does play a role in
6 C-sections and they were her, all I can figure is that she
7 was their star witness on drapes, drapes, is a huge part
8 of the Defense. Interesting, interesting to me, it is
9 telling to me that a big part of the Defense in this case
10 is how could this man, Antwan, had seen anything, how
11 could he have talked to this doctor and call the doctor on
12 what he was doing to his baby's head. How could he do
13 that if he was hiding behind or reasonably restricted
14 behind that drape. You know, daddy's aren't allowed to
15 watch their children be born. Daddy's aren't allowed,
16 they have to stay behind the drape. Alexia has two
17 futures. One, with your support where she will get the
18 care that she needs and deserves, the aids, the
19 assistants, the professional help, the tools. Handyman
20 stuff around her home, all of the things she needs, people
21 to help her with toiletries and hair, all of those things.
22 Or future number two, living in a box. One of the thing
23 about this case, not only are there two futures but there
24 are two standards of care. Our standard of care through
25 our expert witnesses emphasis the word, care, care,

1 carefulness, following your training, take the time to do
2 your job, don't cut corners on patient safety, that is our
3 standard of care. Their standard of care is, if you botch
4 a delivery and cause life changing harm to a baby, if you
5 call the right Defense team we have got your back, we have
6 got your back. In the communities that go with, we have
7 got your back, that communicates with the obstetrical
8 community in that, with the obstetrical section of that
9 community. Then when a random baby comes along and gets a
10 shoulder stuck, safety rules don't do you any good. No
11 rule is worth anything if it doesn't get enforced. We got
12 your back is not a good way to enforce and inspire and
13 encourage patient safety. There is another standard of
14 care that emphasis care where doctors follow their
15 training, where doctors take the time to do their job,
16 where doctors don't take shortcuts on patient safety. If
17 you are lucky enough to live in a community like that you
18 have a healthier community. Random events won't cause
19 harm to as many. We have talked about this before, the
20 knock, knock, knock. This is what it is all about. What
21 is more likely to, the preponderance of the evidence, more
22 likely true or not true. Did we prove by that standard
23 that Dr. Miller was negligent, failed to meet that
24 standard of care and that his negligence caused the damage
25 to Alexia. The answer is yes, I hope and pray. I believe

1 it should be, I don't believe it is close. After
2 answering yes to that question then you go down to number
3 two and number three. And this is where you get back to
4 the economic damages which makes sense, past medicals,
5 future, reduced earning capacity and future medical
6 expenses. And then the third item down there will be, on
7 the verdict form it is probably called non-economic
8 damages but that sounds so cold, it is not. That is the
9 human damages, that is what happens, that is what real
10 people care about. Does collecting bills out of your
11 mailbox and either having an automatic pay system on your
12 bank account or having to write a check the old fashion
13 way, is that the joy of anyone's life, those are the
14 economic damages. Everything else is human damages, that
15 is what the case is about. Those are the economic
16 damages. It is not to me to tell you what figure would
17 balance, that is up to your collective wisdom. There is
18 no mathematical certainty about this. To me this is what
19 America is about. What other Country in the world allows
20 12 people to come together and how to determine a dispute
21 of a 14-year-old girl like Alexia and a powerful man like
22 Dr. Miller. You have the power, you have the power to do
23 justice as you have seen, to give a true and accurate
24 appraisal of these harms, losses and damages as you see
25 it. When I am in front of a jury, you know, it is one of

1 my favorite things. I might stumble and bumble in the
2 early parts of the case but this is what the trial is all
3 about. This is the American way. I know there are people
4 that don't watch football anymore because they don't like
5 certain things. Here we all come together, we all salute
6 the flag, we all pledge allegiance, we see a man in a
7 military uniform or a veteran and we say thank you for
8 your service, thank you so much. These are human values,
9 these are human values, when a professional does wrong,
10 commits negligence, you should compensate, you should be
11 held accountable. Accountability is one of the few things
12 I know that, we ask for accountability, we ask for
13 justice, we ask your verdict to speak the truth.

14 THE COURT: Counsel, y'all approach, please.

15 (Whereupon, a bench conference was held in the
16 presence of the jury but out of the hearing of the
17 jury.)

18 THE COURT: Ladies and gentlemen, I am about to let
19 you go for your lunch break. I am sorry it is a little
20 later today. I ask you to be back at 2:45. You have
21 heard one of the closings from one of the attorneys, the
22 other side hasn't had their closing yet so remember you
23 cannot discuss the case with each other, not until you
24 have heard from both sides and got all the evidence. back
25 there. Have a good lunch, see you back at 2:45.

1 (Whereupon, the jury was excused for a lunch break.)

2 THE COURT: Counsel, anything we need to take up from
3 the Plaintiff?

4 MR. GRAHAM: No, Your Honor.

5 THE COURT: From the Defense?

6 MR. DAVIS: No, sir.

7 THE COURT: Thank you, Counsel, see you back at 2:45.

8 (Whereupon, a lunch break was taken.)

9 THE COURT: Let's bring them in.

10 (Whereupon, the jury came into open court at
11 approximately 2:48 p.m.)

12 THE COURT: Mr. Davis, closing.

13 MR. DAVIS: May it please the Court.

14 THE COURT: Yes, sir.

15 MR. DAVIS: Ladies and gentlemen, I can't begin to
16 thank you enough for the patience, the endurance and the
17 attention you have given to this case to this point. I
18 beg you for just a few more minutes. And on behalf of Dr.
19 Miller, I want to try to point you to what we think is the
20 evidence in the case that will help you make your decision
21 as you do your deliberations and arrive at a unanimous
22 decision at the end of those deliberations, to decide
23 whether or not Dr. Miller was negligent or whether he was
24 not negligent in this case. The Plaintiff, as the Judge
25 told you, has what we call in the law the burden of proof.

1 He has got to prove by his experts or his evidence that my
2 client was negligent. So what is the standard of care, we
3 want to talk about the standard of care because that is
4 really what we are here about, that is what this case is
5 about, it is about the standard of care. Did Dr. Miller
6 meet the standard of care or did he fall below it. The
7 standard of care, as the Judge told you, and has charged
8 to you on the law a little while ago, is that which the
9 reasonably prudent, in this case, OBGYN would do or would
10 not do in the same or similar circumstances. That is it,
11 it is not complicated but it is very important and we want
12 to talk about it. So how does the Plaintiff in this case,
13 how did they attempt to prove and persuade and convince
14 you that he was negligent, that he did something he wasn't
15 suppose to do or where is there proof, how did they
16 attempt to do that in this case. Well, let's look at
17 their experts. Dr. Duboe, he was the first expert they
18 called and ladies and gentlemen, you heard everything I
19 heard when he testified, both on direct and
20 cross-examination then redirect, back and forth. You
21 heard everything I heard. There is 12 of you, there is
22 one of me, you are going to most likely remember things
23 much better than I will. So use your collective memory as
24 you think about, well, what did Dr. Duboe say. I want to
25 point to you some things that I recall him saying and ask

1 you to consider these things as you consider his opinions
2 that Dr. Miller was negligent. in the last 15 years he has
3 reviewed an average of one or two cases, medical
4 malpractice cases as an expert a month. He has given a
5 couple of hundred depositions, reviewed several hundred
6 cases. He has testified in about 60 medical malpractice
7 cases as an expert who charges \$450.00 dollars an hour to
8 review a case; \$550.00 dollars an hour to give a
9 deposition; and \$5,000.00 dollars a day for his appearance
10 here last week. I did the math, I think he said he did
11 about 28 hours of review, that is about \$20,000.00 dollars
12 just off this case. He has testified in 60 of these
13 cases. He told you that in his opinion there is no
14 evidence in his opinion that Dr. Miller was not adequately
15 trained to handle a shoulder dystocia. In his opinion it
16 seemed to him like the shoulder dystocia ranged anywhere
17 to 60 seconds until it resolved at 120 seconds. That was
18 his take. He agreed that OBGYN's are taught to apply
19 gentle downward traction and as a prudent obstetrician
20 develops the feel, the experience the doctor develops the
21 feel for, what that traction is. That was his testimony.
22 That feel he said and explained to you comes with
23 experience. It comes with knowing what to do. He told
24 you Dr. Miller had no deficiency in his training. He
25 didn't tell you he didn't know what to do. After

1 successful woodscrew maneuver because we talked about that
2 and I asked him about it, he said, well, when a successful
3 woodscrew maneuver is performed, as it was in this case,
4 once the obstetrician is sure that the anterior up right
5 shoulder that was stuck becomes dislodged then he can
6 place his hands on the baby's head and he can use gentle
7 downward traction if necessary, he said, to then effect
8 the delivery. Dr. Duboe also said that he agrees that Dr.
9 Miller, in his note that has necessarily been made much
10 of, we are going to make much of it. Dr. Miller never
11 wrote the word, traction, anywhere in this delivery note
12 less than an hour after he was finished taking care of
13 Angela Patton and got to the place where he could document
14 what had happened. He agreed that Dr. Miller, as you can
15 see from the evidence and this is evidence that you will
16 have with you in the jury room, he said that Dr. Miller
17 never documented or wrote on his note anything about a
18 second anterior left shoulder stuck behind the pubic bone.
19 You got to ask yourself the question, why didn't he write
20 that down there, he wrote everything else down. If that
21 happened don't you know he would have written it down
22 there, it is not on here. This is evidence an hour after
23 the delivery, consider that. And you see the word,
24 effort, Dr. Duboe and you see traction. Well that is
25 fine, what do you see, ladies and gentlemen. What do you

1 see. A part of the basis of that opinion he told you that
2 he sees traction when he reads effort is based in large
3 part on the injury in this case. This is their expert,
4 not mine. When I asked him, he said I have no opinion on
5 how many pounds of pressure Dr. Miller actually used
6 during this delivery, I don't have an opinion about that,
7 I don't know. He is not aware of any way, he is not aware
8 of any way to measure the delivering obstetrician's,
9 including his, I would assume and certainly Dr. Miller, he
10 has no way of objectively measuring the force that an
11 OBGYN uses when he is doing a delivery. He is not
12 claiming in this case that a shoulder dystocia is either
13 predictable or foreseeable. But he does agree that an
14 obstetrician, when confronted with a shoulder dystocia
15 that is unpredictable and unforeseeable seen during a
16 delivery, it is an obstetrical emergency. And then he
17 said this. Dr. Duboe, when I asked him, do you agree, you
18 have read Dr. Miller's deposition, it was taken in 2011,
19 over six hour video deposition. You have read that. Yes
20 sir, I have. And you read where he clearly talked about
21 what he meant by moderate, whether meant by effort. Yes
22 sir, I have read that. And he told you, ladies and
23 gentlemen, that Dr. Duboe, their expert said, if Dr.
24 Miller never used anything other than gentle downward
25 traction in this delivery along with the other maneuvers

1 that he documents here, that he met the standard of care
2 in spite of the injuries to this child. That was Dr.
3 Duboe's sworn opinion. What other expert did they present
4 by way of testimony on the standard of care. It was Dr.
5 Edith Gurewitsch. In a deposition I took of her, those
6 are mostly all my questions in 2013, in Baltimore,
7 Maryland when I flew up there and took her deposition
8 because she had been identified as an expert on the
9 standard of care. I wanted to know what she had to say,
10 what her opinions were, what the basis of her opinions
11 were. I had no idea that was eventually going to be all
12 the trial testimony anybody was ever going to hear from
13 Dr. Gurewitsch but that is their choice, not mine, that's
14 fine. So we listened and we listened and we listened to
15 145 pages of a read deposition taken in 2013, this
16 expert's opinions are frozen in time. In 2014 is when the
17 monograph, I think is what Dr. Chauhan and Dr. Ernest
18 called it from ACOG, the American College of Obstetrics
19 and Gynecology produced a 100 plus page monograph about
20 brachial plexus injuries. Dr. Gurewitsch was not one of
21 those folks working on that work. Her testimony was in
22 2013. Look, Dr. Gurewitsch, let's remember some of the
23 things that she said. Trust me, I am not going to go over
24 145 pages of her opinions or testimony. I don't have the
25 time and I don't have the heart. Mr. Graham sent her

1 about 13 cases as of June 2013 to review as an expert.
2 She earns about fifty percent of her income as an expert
3 in medical malpractice work. If she makes \$100,000.00
4 dollars a year, \$50,000.00 of that is from doing this
5 work. She admitted that there was at least, as of 2103,
6 at least one year she made as much as \$100,000.00 dollars
7 doing work like this. You will see in her list of all the
8 cases that she gave us back in 2013, look for the word on
9 the far right side, Plaintiff or Defense. It is almost
10 all Plaintiff. I ask her in her deposition at one point
11 about how many deliveries are there in a year in the
12 United States. Her testimony was about four million. So
13 she said that anywhere to 12,000 to 20,000 births a year
14 would result in permanent brachial plexus injury,
15 according to her percentages that she gave us. I did the
16 math, if I missed on the math please correct me. She said
17 only five percent of that number would be deliveries like
18 this one in a case out of four million births. What does
19 that translate out to be if you do the math on that. That
20 means that in 2007 when Alexia was born in April, with
21 four million births, according to Dr. Gurewitsch, if her
22 math is correct, anywhere from 600 to a thousand severe
23 permanent brachial plexus injuries like Alexia's occurred
24 in that year. Those are her statistics, not mine. When I
25 took her deposition back in 2013, which you heard in this

1 trial, she said that she does not feel like or have an
2 opinion that when she encountered a permanent brachial
3 plexus injury, I guess we maybe should have put her on the
4 chart with Dr. Chauhan and Dr. Ernest, but we didn't and
5 that is okay. And she said, as of 2013, I had a serious
6 injury, permanent brachial plexus injury and I was the
7 delivering physician. Well, Doctor, you feel like you did
8 anything wrong? No. Do you feel like you fell below the
9 standard of care, pulled too hard, did anything? No.
10 Were there any extenuating circumstances? No. Okay.
11 That is fair. I am not criticizing her for that
12 complication from that delivery. It happens to the best.
13 I ask her if she discounted Dr. Miller's ability to recall
14 this delivery. I don't discount it, I remember mine.
15 People remember these things, I don't discount his ability
16 to recall. And has agreed, as did Dr. Duboe and Dr.
17 Chauhan and Dr. Ernest and Dr. Miller and every OBGYN that
18 testified before you under oath in this case on either
19 side, when a shoulder dystocia happens it is an
20 obstetrical emergency. It is, it is not even close. Dr.
21 Duboe tried to kind of, well, you know, you have a couple
22 of minutes. And I looked at Dr. Chauhan's explanation.
23 That is like if the house is on fire and it is just a
24 little fire you have got a couple of minutes, don't worry
25 about it, don't do anything fireman, you got time. You

1 don't know when that fire is going to take over the whole
2 house. It is an emergency and everybody agreed to that,
3 even Dr. Duboe, even Dr. Gurewitsch. It is an emergency,
4 Dr. Gurewitsch told you, as I recall her testimony, but
5 because by the time the head is delivered the umbilical
6 cord is under some stretch and a part of the body is in
7 the birth canal and this, without question, was a large
8 baby. Not as big as the one previous but it was a big
9 baby. She told you that the cord, the umbilical cord,
10 that is the baby's lifeline. You squeeze that at any
11 point in time, in any mechanism, however you want to do
12 it, whether it is pinched, whether it is compressed. When
13 that umbilical cord is not open that is how the baby
14 breathes, that is how the baby gets oxygen and blood and
15 life. That is the baby's literal lifeline. And when you
16 put a squeeze on that thing that baby is going to be in
17 trouble if it goes long enough and nobody has questioned
18 that in this case. She said that when the umbilical cord
19 is under some stretch and a part of the body is in the
20 birth canal pressing against that, that umbilical cord,
21 that baby is in trouble in a shoulder dystocia and that is
22 why it is an emergency, she said. The cord, which is the
23 blood supply to the baby is more vulnerable she says and
24 variably compressed in that situation in a shoulder
25 dystocia situation. Dr. Gurewitsch also told you that she

1 greed that one cannot really know to what degree that that
2 umbilical cord is being compressed during a C-section.
3 You can't know that. You have got two minutes, you got
4 seconds, you better be doing what you are trained to do
5 and do it right, it is an immediate emergency. If the
6 shoulder dystocia cannot be resolved within four to five
7 minutes, that increases the risk of permanent brain damage
8 to the baby from a lack of oxygen. That does not say that
9 there is no risk from moment one. She told you that if
10 shoulder dystocia occurs and cannot be resolved timely,
11 her words, that can result in significant permanent brain
12 damage, it is called cerebral palsy, that is a medical
13 term for when a child lacks oxygen long enough for
14 whatever reason in birth and the brain tissue begins to
15 die for lack of oxygen and it is a permanent terrible
16 condition. That is what she explained. And everything
17 flows from that bad situation. She told you that a
18 shoulder dystocia situation, if it cannot be resolved
19 timely, can result in death. She told you that a shoulder
20 dystocia situation is most often unpredictable. And it is
21 often unpreventable. She said that a contracting uterus
22 during labor exerts a force on the baby during labor and
23 delivery. When the uterus is contracting there is a force
24 pushing that baby, she agreed with that. When I asked
25 her, I said, how many pounds of pressure. She said, well,

1 approximately 30 pounds of force just from the contracting
2 uterus. Now, remember, her threshold is 50 pounds. So
3 now we have 30 that is already cooked into it. Well, Dr.
4 Gurewitsch, how about mom pushing, does that add some more
5 to it. Oh, yes, that definitely does. Five pounds, ten
6 pounds. We are up to 35, 40 pounds. Now that is without
7 the Doctor putting his hands on that baby's head.
8 Remember her number is 50. We start out with 35 or 40
9 before the Doctor puts his hands on the baby's head. We
10 have got 10, 15 left. That is it according to Dr.
11 Gurewitsch. She agreed that there is no indication in
12 this case with Dr. Miller to have avoided a trial of labor
13 and vaginal delivery. And she does not criticize Dr.
14 Miller for doing and calling for this emergency C-section
15 and then when the heart rate returned to normal, to
16 proceed with a vaginal delivery. She didn't criticize
17 them for that at all. Nobody did. She said you do what
18 you are trained to do. She said that when the woodscrew
19 maneuver is done, that usually causes the posterior
20 shoulder or in this case, it would be the left shoulder
21 that was, the left shoulder was down originally. And then
22 when it was rotated it became the up shoulder, anterior
23 shoulder as the baby was rotating. She explained that
24 when that is done, the woodscrew, usually causes a
25 posterior down, in this case, left shoulder to arrive in

1 front of the pubic bone and not behind it. That is what
2 she said. She agrees that one the delivering physician
3 dislodges the shoulder that is stuck, that is the up right
4 shoulder before the woodscrew. It is fairly simple in
5 terms of delivery. Because at that point the Doctor
6 doesn't even need to use any downward traction. The baby
7 just comes out and you catch it, those are her words. She
8 agrees with that, is what she told you. Dr. Gurewitsch
9 said that usually with a woodscrew, that is usually how it
10 happens. And if it happens that way, the Doctor, she
11 said, if he needs to, can apply gentle downward traction
12 with both hands on the baby as the baby is coming out.
13 And that would be appropriate if that were done, is what
14 she said. She agrees that after the baby is rotated 180
15 degrees in a woodscrew maneuver, it is rare that she would
16 have to use traction because usually the baby just rolls
17 out, it rolls as in a screw. It is a winding fashion,
18 these are her words. It is winding or unwinding down and
19 out. Her opinion was that he used 50 pounds of traction
20 and her opinion was that Dr. Miller used excessive
21 traction based largely on the nature and degree of this
22 injury. Those were her words. She agreed that the more
23 experience an OBGYN has, the more experience he has in
24 delivering babies, typically the better he will do in an
25 obstetric emergency like a shoulder dystocia. She told

1 you in attempting to resolve a shoulder dystocia, in her
2 opinion it is within the standard of care for the
3 delivering physician to us up to, catch this, two times
4 his normal pulling effort to resolve the shoulder dystocia
5 in addition to other attempts and maneuvers. But she told
6 you, I cannot know Dr. Miller's normal force when doing
7 gentle downward traction. I have never met him, I have
8 never talked to anybody who knows him, I don't know. She
9 wouldn't know what Dr. Miller's baseline force is. In
10 real time she agreed that the amount of downward traction
11 required, excuse me, downward traction employed by a
12 delivering physician to effect vaginal delivery, she said
13 is very difficult, in her words, if not impossible to
14 quantify. And she agreed that is more of a feel by the
15 delivering physician as to the amount of downward traction
16 that he or she would normally use. She allowed an
17 quantified and put a number and you will remember better
18 than me, I thought it was 20 pounds. She said if his
19 normal pulling is 10, which is average, Dr. Gurewitsch
20 will allow him 20. We start out with 35 from the
21 contractions of the uterus and mom's pushing and we are up
22 to 35 or 40, let's add 10, let's add 15 to that. Are we
23 over 50? But then she says, no, no, he pulled 50 pounds.
24 That is her opinion. But she did tell you that, she
25 agreed to resolve a shoulder dystocia and effectively

1 deliver the baby between 45 second and 120 seconds is
2 doing the resolution of the shoulder dystocia in an
3 appropriate and reasonable amount of time. She told you
4 there are, in her opinion, she is the expert, there are no
5 objective measurements of whatever force Dr. Miller used
6 at any point in time during this delivery, none. I don't
7 know where she was on April 5, 2007 when this 45 seconds
8 to two minutes of shoulder dystocia was being resolved.
9 My guess is she wasn't in South Carolina and she certainly
10 wasn't in that operating room. What else did she say. I
11 read this, I don't want to misquote her. Page 129, line
12 12. I asked her. Question, if Dr. Miller never used more
13 than gentle downward traction would he have met the
14 standard of care. Her answer without any explanation,
15 yes. That is the Plaintiff's case on the standard of
16 care. They did present Dr. Grossman, he is a
17 neurosurgeon. I don't hold it against him that he is
18 retired, that is not important. I have no qualms or
19 dispute with Dr. Grossman about his skills as a
20 neurosurgeon and what he has done and when he was in
21 practice. But what he told you is, look, I don't know
22 anything about shoulder dystocia, I am not an OBGYN, I am
23 not here to testify about the standard of care. And, oh,
24 by the way, all OBGYN literature on this is junk science.
25 This 2014 work by ACOG over 18 to 24 months, or however

1 long it took them to do all of the research and put that
2 together, that is junk science. But I am not an OBGYN, I
3 will differ to OB's on the standard of care. That was Dr.
4 Grossman. Ladies and gentlemen, no expert in this case on
5 either side has ever claimed, number one, that the vacuum
6 attempt caused any harm at all to this child or to Angela.
7 There has been no expert testimony in this case that
8 Pitocin or Cytotec or Methergine or any other medications
9 that Angela was appropriately given during her labor and
10 delivery and post-delivery, caused any harm to this child
11 or caused shoulder dystocia or caused a brachial plexus
12 injury, no testimony on that at all. Let's talk about the
13 animation, I am going to show it to you in a little bit,
14 not quite yet. When we hire companies to create an
15 animation to help you, the jury, try to understand what we
16 think happened, we want to get it as right as we possibly
17 can. They do an initial, how do you like this, version
18 one. Well, this needs to be changed, that needs to be
19 changed, version two. How about this. No, we got it,
20 that is not quite right. I am not an animator, I mean, we
21 hire these people to do this and that is fine, it is for
22 your benefit, not mine. So they do several versions, that
23 should not surprise you. One version, for example in this
24 case, they sent it back to us. I said, that looks pretty
25 good except they had the little labels, you know, they had

1 the label right shoulder pointing to the left shoulder and
2 the label on the right shoulder to the left shoulder. I
3 said, y'all have got to change that, that's not going to
4 help the jury, that is kind of confusing. So they had to
5 change that, another version. Yes, there were multiple
6 versions. It is my responsibility to be sure that we play
7 the final, final version. That is on me, don't hold that
8 against Dr. Miller. But we got the right one finally and
9 showed it to you and we showed it to Dr. Miller and he was
10 cross-examined as thoroughly as Mr. Graham wanted to
11 cross-examine him on that final, final, if I can call it
12 that. Make of that what you will. Let's talk a little
13 bit about the law and then I am going to talk about what
14 evidence did we put up. We don't have the burden of
15 proof. But I thought it would be helpful if we brought
16 experts and we brought Dr. Miller as an expert and the
17 eyewitness to this whole event. Let's talk about the law,
18 I am not going to dwell on this, I promise. Just a few
19 things that I want to highlight that Judge McKinnon
20 earlier shared with you and you have got this, you will
21 have it just like I do. The burden of proof, the
22 Plaintiff has the responsibility to prove every essential
23 part of his claims by a preponderance or greater weight of
24 the evidence. Evidence, direct evidence. Mr. Graham
25 mentioned this as well. So I want to talk just a second

1 about direct evidence. The Judge, I believe, told you
2 that direct evidence is the testimony of a person who
3 claims to have actual knowledge of a fact such as an
4 eyewitness. It is evidence which immediately establishes
5 the main fact to be proved. When I was a Deputy Solicitor
6 in Greenville County many years ago, I was a Prosecuting
7 Attorney, it was my duty and responsibility in a criminal
8 case to prove the accused guilty by evidence beyond a
9 reasonable doubt. That is really a heavy burden. Every
10 criminal case I prosecuted I had that same heavy burden.
11 Did I, did circumstantial evidence result in convictions
12 from time to time, sure it did. And that is up to the
13 jury, it is going to be up to you. But I am here to tell
14 you, as a prosecuting attorney, if I have got an
15 eyewitness, I saw him, I was standing right there and I
16 saw him pull the gun, I saw him pull the trigger and kill
17 the guy, shoot him, shot him right in the heart. When I
18 got that witness I have a pretty good chance of getting a
19 conviction, if the jury believes him. They may not,
20 eyewitness is powerful testimony. It is direct testimony.
21 It is evidence which immediately establishes the main fact
22 to be proved. Did Dr. Miller use excessive force in
23 pulling on that baby's head at any point in time. Now,
24 their case is very narrow, they claim that he did that
25 only after he did all the rotational maneuvers. That is

1 what their claim is. We are down to a few seconds, that
2 is our case. We will get back to direct evidence in a
3 little bit. Conflict and testimony of expert witness, I
4 agree with Mr. Graham and every one of these cases we ever
5 tried, the experts look at the same evidence and come to
6 different conclusions. Y'all need to sort that out, how
7 do you do that, who do we go with -- if we have got, and
8 you have got to because they have got, they have got the
9 burden to prove the case to you through their experts.
10 How do you resolve it. And the Judge told you you should
11 consider the relative credibility and knowledge of the
12 experts and you should find in favor of the expert's
13 testimony which, in your opinion, you are the experts on
14 credibility, not us, not anybody else. You should find in
15 favor of the expert testimony which, in your opinion, is
16 entitled to the greater weight. When he talked to you
17 about the breach of the standard of care, he emphasized,
18 well, he didn't emphasize it, I am going to emphasize it,
19 excuse me. He charged you that the mere fact that a
20 treatment does not benefit the patient or that it even
21 results in harm to the patient is not in and of itself
22 negligence. A bad result injury is not enough alone to
23 show that the Defendant was negligent. How many times did
24 you hear the Defense experts, Dr. Duboe and Dr. Gurewitsch
25 say, well, the injury, the injury, the injury, had to be

1 excessive force. That is the kind of testimony the law
2 says you shouldn't consider, that is your call. On
3 proximate cause, the Judge told you that the Defendant
4 cannot be held responsible for things which could not have
5 been expected to happen. Is a shoulder dystocia
6 predictable, Dr. Duboe, Dr. Gurewitsch, no, it is not.
7 Let's talk about briefly some of the Defense witnesses
8 that we brought to you, you judge their credibility, you
9 judge their reliability, you judge their opinions, their
10 testimony as you will. We brought Dr. Lupo, Dr. Lupo is a
11 medical doctor, she is an anesthesiologist, she was there
12 in the operating room, she doesn't remember that but we
13 have got her record. So we said, read your record and
14 tell us what was going on as far as your records are
15 concerned. I classified, I think she said, ASA, American
16 Society of Anesthesia, ASA rating, they rate the
17 anesthesia at 2E. And I said what does the E stand for.
18 Emergency. This is an anesthesiologist who is doing the
19 preanesthesia check list on a lady that is being wheeled
20 down the hall by her doctor to the operating room to do an
21 emergency cesarean section. And Dr. Lupo told you,
22 according to her records, well, it was due to a decrease
23 or low heart rate of the baby. That is her record. And I
24 did ask her, well, Dr. Lupo, are there drapes. Oh, yes,
25 there are drapes for me, I can't see down there, I am

1 behind and there are drapes across. There is a sterile
2 field in the operating room, nobody can just sort of
3 wonder into a sterile field. Dr. Lupo, have you ever seen
4 a nurse get up on the table and straddle a patient as they
5 are doing suprapubic pressure. She said, I have never
6 seen that happen. And her comment was, I think that would
7 be really hard to do. We called Dr. Chauhan. He,
8 himself, has written 50 articles, peer reviewed, published
9 articles on the issue of shoulder dystocia and brachial
10 plexus injury. He has been qualified as an expert witness
11 in these kind of cases in almost every State in the Union.
12 And his opinion, oh, and he reviews cases for Plaintiffs
13 and Defendants. And he told you, look, if this was a
14 situation I would be here testifying against Dr. Miller,
15 not for him. He told you that most likely, as he looked
16 at this case and looked at the records and looked at the
17 note, most likely this was a posterior left arm injury,
18 posterior arm shoulder dystocia. If that happened then
19 the injury occurred before Dr. Miller even saw the fetal
20 head emerge and deliver or that he knew there was any
21 shoulder dystocia. Before he put his hands on her, Dr.
22 Chauhan says that he thinks is what happened. He said,
23 unequivocally, in my opinion, not only did Dr. Miller not
24 fall below the standard of care, he met the standard of
25 care in several places, in his opinion, he exceeded the

1 standard of care. He said that there was a significant
2 concern for lower heart rate. Dr. Miller, an hour after
3 the delivery, documents the heart rate went down from 60
4 to 90, that means four, about eight to ten minutes.
5 Normal heart rate is 120, 130. And that would get an
6 OBGYN's attention and it should have and it did, thank
7 goodness it did. Dr. Chauhan said that is a very
8 worrisome situation and that is what led to wheeling her
9 quickly down to the operating room for emergency cesarean
10 section. He said it was appropriate for the Doctor, in
11 that situation to go ahead and try a vacuum just to maybe
12 get the baby a little bit down. The vacuum didn't attach,
13 it didn't work, it didn't cause any harm, he abandoned it,
14 he moved on, did the next thing. He said it was
15 appropriate to encourage the delivering mom, you have got
16 to push, we got to get this baby, I am concerned about the
17 heart rate. It has been down, it has come back up but it
18 has been down, I am concerned about the baby, please push,
19 please push, we got to push. And I don't have, there is
20 no evidence that Angela Patton didn't push as hard as she
21 could. The poor effort, that is not criticizing her, it
22 is just like, she's doing the best she can, it just wasn't
23 moving the baby. That is when he said, we have got to go.
24 I have got to tell you quickly as I can, the risk of a
25 cesarean section because I need to consent to it but I am

1 concerned about your baby's heart rate and we need to do.
2 And she said I will sign it and appropriately so, what
3 mother wouldn't. He said that shoulder dystocia is not a
4 foreseeable situation, it is unpredictable, unpreventable.
5 But he told you in his opinion that it is an obstetric
6 emergency, you can't know, he said, how long that shoulder
7 dystocia is going to last. You can't know how long it is
8 going to take you to resolve it. Is it 45 seconds, is it
9 60 seconds, is it two minutes, is it three minutes, is it
10 four minutes. You don't know, you cannot know that on the
11 front end. We called Dr. Ernest. I heard earlier today
12 that Dr. Ernest changed his opinion. He didn't totally
13 change his opinion on the standard of care ever, when he
14 was deposed in 2018 by Dr. Graham. He was crystal clear,
15 that based on his review of the records, including this
16 note, that that was enough information for him to make a
17 decision that Dr. Miller met the standard of care. He
18 didn't change his opinion about that ever. What changed
19 his opinion was him telling me, Dr. Ernest, I want you to
20 assume because you couldn't be here in the courtroom when
21 Dr. Miller testified at trial, you read his deposition.
22 But he testified at trial and said some things. Let me
23 ask you to assume these things that he said. That there
24 was never a second shoulder dystocia. I want you to
25 assume that is what Dr. Miller testified to under oath in

1 front of this jury in this trial because he hadn't heard
2 that before. Why. Because Dr. Miller was never asked in
3 over six hours of his deposition that was taken in 2011,
4 Mr. Graham never asked him, hey, when you rotated that
5 baby 180 degrees did you cause that left shoulder to then
6 get stuck behind the pubic bone. He never asked that. It
7 didn't come up until after Dr. Gurewitsch's deposition in
8 2013 about this steering wheel, this second shoulder
9 dystocia theory. It is just made up out of whole cloth.
10 Dr. Chauhan, you have been involved with 10,000
11 deliveries. Yes, sir. Have you ever seen or heard in a
12 rotational maneuver of 180 degrees where the bottom
13 shoulder becomes stuck on the top. Have you ever seen
14 that. No sir, I haven't. Well, you have done a lot of
15 reading, have you ever read about that happening. Has
16 that ever been reported? No, sir. Ever seen it, ever
17 read it, ever heard about it. No, sir. Dr. Ernest, he
18 was the Chair at Wake Forest, Bomagrade, (ph), School of
19 Medicine before coming to Carolina's Medical Center where
20 he was the Chief of eternal fetal medicine. Just up the
21 road right before he retired. Yes, he has published, he
22 has done things. Here is the part about Dr. Ernest
23 credentials that I would want you to carefully consider.
24 When Dr. Miller or Duboe or Dr. Chauhan or Dr. Ernest
25 himself wants to become Board Certified as an OBGYN, they

1 have got to take a written Board and then a couple of
2 years later they post their cases and say, here is what I
3 have done in a couple of years, I am qualified to take my
4 oral Boards. And I can't become Board Certified until I
5 pass the oral Boards. Dr. Ernest was one of those guys
6 that does the oral examination. You think he knows a
7 thing or two about the standard of care in OBGYN.
8 Consider that as you consider his opinions, consider his
9 demeanor, consider how he testified, what he told you,
10 how he told you. He reviews for Plaintiffs, he reviews
11 for Defendants. He is not one-dimensional. In his
12 opinion he said that Dr. Miller did not fall below the
13 standard of care. He said in my opinion, most likely this
14 was a posterior shoulder dystocia when the baby's left
15 down shoulder was coming through, got stuck on the sacral
16 promontory. That can happen, he thinks that is what
17 happened in this case and that resulted in a stretching of
18 that brachial plexus before the head ever delivered,
19 before Dr. Miller could ever put his hands anywhere on
20 that baby. The thing he spoke about and he said a lot of
21 things, that almost gave me chills. I don't know how it
22 hit you. When he looked at that lab that was taken of her
23 coregas, it was taken right after Alexia was born and he
24 talked about the base excess of minus 13. I have no idea
25 what that means. Dr. Ernest explained to us, that didn't

1 happen in 45 seconds. That happened over a period of
2 time, probably when she had this low heart rate for eight
3 to ten minutes. And her reserves, as a baby, getting
4 ready to be delivered were being depleted. And that base
5 excess is a blood measurement that tells him as a Board
6 Certified, National Board Examiner, Chair, Chair, Chair,
7 of maternal fetal medicines, that condition existed for
8 many more than two minutes before delivery. I don't want
9 to misquote him, what I recall him saying was, based on
10 that value alone, in my opinion, Alexia was very near
11 death from metabolic acidosis. He said that is the worse
12 kind of acidosis you can have. He said Dr. Miller's
13 actions to resolve the shoulder dystocia, in the amount of
14 time he did, was not only timely, in retrospect we didn't
15 know the base excess until after the baby was delivered.
16 Looking back at that he is telling you, in my opinion, if
17 had of delayed much more for whatever reason, if he had
18 taken the two minutes Dr. Duboe would have you, have him
19 take, maybe we would be here for a different reason. And
20 we are thankful that Alexia is with us today. Where is
21 Antwan, where was Antwan. I will just point to her, to
22 his wife, her testimony, Angela Patton's testimony. What
23 Angela told you under oath clearly was, Antwan, everybody
24 knows where she was. This is the head of a patient in an
25 operating room having a delivery. These are the, you saw

1 pictures of them. You heard Dr. Lupo talk about them.
2 Drapes are here as well. Angela said, these are, this is
3 her testimony. Antwan was to my left, behind one of the
4 nurses. And, ladies and gentlemen, yes, he was behind the
5 drapes as well. We brought another expert, their expert,
6 Dr. Greg Miller. Let's show the animation, please, Drew.
7 Thank you. Whenever Dr. Chauhan, may have been Dr.
8 Ernest, said those arrows, one arrow going straight to the
9 middle. That's a posterior shoulder dystocia on the
10 sacral promontory that causes a stretch to the brachial
11 plexus nerves resulting in injury to those nerves before
12 the head delivers. This is what the experts and Dr.
13 Miller talk about. Nobody criticized Dr. Miller for any
14 of the maneuvers that he performed. McRoberts,
15 suprapubic, episiotomy. Nobody criticized Dr. Miller for
16 attempting the posterior shoulder or posterior arm
17 delivery. There is no criticism to this point of anything
18 he did. That didn't work, the posterior arm delivery. So
19 what he does, got to do something else. What is my
20 protocol, what is the next thing, the woodscrew maneuver.
21 And, Drew, stop here. Where is the left shoulder, it is
22 not stuck behind that pubic bone. How do we know that,
23 because the animation says so, no. Because the eye
24 witness expert, Dr. Miller said, where is the right
25 shoulder, you can't even see it, you can't see the top of

1 the right shoulder, you can't see the left shoulder. We
2 can see it because this is a cutaway, it is an
3 illustration. In real life no one including the
4 delivering physician can see the top of the right
5 shoulder. Go ahead. And here is where they, stop. This
6 is where they say the negligence happened, this is where
7 they say he used excessive force but they have got to move
8 the shoulder behind the pubic bone to make that fit.
9 Ladies and gentlemen, according to the only eyewitness
10 expert, it doesn't fit. Neither Dr. Chauhan nor Dr.
11 Ernest, not, I will repeat this one more time, have ever
12 read, heard or seen that shoulder dystocia happens when
13 you turn the woodscrew and stick like they alleged that
14 happened, never seen it, never read about it, never heard
15 about it. Dr. Chauhan has read a lot of medical
16 literature, never seen it documented ever; neither has Dr.
17 Ernest, a National OBGYN Board Examiner. Ladies and
18 gentlemen, Dr. Miller is appropriately trained, was
19 appropriately trained, was appropriately experienced and
20 he testifies as an eyewitness. You judge his credibility,
21 what he said and how he said it, as you will. We will
22 submit to you he is the only expert, he is the only
23 eyewitness who was in a position to know what happened.
24 He made a note an hour after the delivery and explained,
25 as best he could, in his handwriting, you will see the

1 handwriting. There it is. Ladies and gentlemen, if you
2 write a letter to me, I am not suggesting you should, if
3 you write a letter to a friend, I will put it that way;
4 and you are describing something or you are making a
5 comment and your friend reads it and says, what does it
6 mean, what does he mean by that. Who do you think the
7 best person is to explain what this meant, the person
8 reading the letter or the person that wrote it. That is
9 what we have got here. We brought you the witness who
10 wrote the note and he explained, not just today but back
11 in 2011, he told you what moderate effort meant. It meant
12 some total of everything I did, every one of their experts
13 agreed. That is true, he didn't violate the standard of
14 care. That is where we are in this case. You must
15 determine, it is down to this. You must determine if you
16 find that Dr. Miller was being truthful, not just in 2011
17 in the courtroom, several days that he was on the witness
18 stand, he is well trained, he is experienced, this is in
19 2007, not now, forget now. Dial it back to 2007, there
20 was no panic, there was no rush. He did what he was
21 trained to do and he was crystal clear, not only in his
22 deposition, but before you and this trial on direct and
23 cross-examination, he at no time ever used excessive
24 traction on the head of this baby, never. He performed
25 his duty to both of his patients, he had a mama patient

1 and a baby patient at the same time, he is responsible for
2 both of them. He performed his duty well within the
3 standard of care and he was crystal clear that he never
4 used anything other than gentle downward traction at any
5 time. I don't know how many deliveries he had under his
6 belt in 2007 but he is up to about 9,000 now and he's
7 never had a permanent brachial plexus injury other than
8 this case. Ladies and gentlemen, no one is here, we are
9 not here to deny the injury to this young lady. We are
10 not here to deny the hardship it has and will impose on
11 her and her family. That is not what we are here to do.
12 I am not going to tell you or suggest to you in any way
13 that you shouldn't have compassion, that you shouldn't
14 have sympathy, you shouldn't have as a fellow human being,
15 your heart should go out to her, that is absolutely
16 appropriate. Not to do so would be strange. What we are
17 asking you to do is decide the case on the standard of
18 care based on the experts testimony and Dr. Miller,
19 whether or not he met the standard of care or whether he
20 was negligent. That is what the law asked of you and I
21 would suggest that is what the law requires of you. I
22 don't suggest that that is easy but that is what you are
23 sworn to do. Decide the case on the evidence or the lack
24 of evidence regarding whether Dr. Miller pulled too hard
25 at any point in time and used excessive traction or

1 lateral traction, whatever they allege at any point in
2 time in this delivery. Ladies and gentlemen, as I finish
3 and I appreciate so much your patience, I am about done.
4 When I get finished Mr. Graham has a right because he has
5 the burden of proof to address you again, I am sure that
6 he will. I would if I were him. Don't hold that against
7 him, he has a right to do that and he should. We are at a
8 point where, if you can imagine, you may have seen
9 pictures or maybe statue of our Lady of Justice and she
10 stands there tall and eloquent. She has got a long robe
11 on and in one hand she holds a set of scales. In another
12 hand she holds a sword and that is the execution of
13 justice. But in the scales before she executes justice
14 with her sword she is weighing, she has got these scales
15 in her hand. And what you are asked to do in this case as
16 you deliberate and consider the evidence or lack of
17 evidence, is you are sort of weighing the evidence. What
18 was the Plaintiff's case, it might have tipped over so
19 slightly in their favor. But then if you weigh all of the
20 evidence, did it tip ever so slightly in Dr. Miller's
21 favor. Or there is another option. As you weigh back and
22 forth, taking whatever time you, ladies and gentlemen,
23 need to take to deliberate and decide this case
24 unanimously. In that middle process of deliberating and
25 weighing that evidence on those imagine a set of scales,

1 there is a third option. They are dead even. Just like
2 when you started. If you find that they are even at the
3 end of your deliberations then the law would indicate that
4 the Plaintiff has not proven their case beyond, excuse me,
5 with a greater weight or preponderance of evidence and
6 your decision should be for the Defendant, Dr. Miller. If
7 they tip ever so slightly in Dr. Miller's favor, if they
8 do then that should also be a verdict for the Defendant.
9 If they tip ever so slightly in favor of the Plaintiff you
10 should find for the Plaintiff and award whatever damages
11 you deem appropriate in this case. There is another thing
12 about our Lady of Justice that I want to talk about, she
13 has got the sword, she has got the scales. If you notice,
14 she has got a blindfold on. Why is that. It is so she
15 doesn't see the parties. She doesn't see if it is a
16 Angela Patton or Alexia Lumpkin or Dr. Miller. She is
17 blinded to that. She is just going to weigh the evidence
18 and she will make her decision blindfolded based on that,
19 on those scales. And then she will take that sword and
20 execute justice. That is what you are asked to do. A
21 verdict comes from a Latin word, veredicto, two words.
22 What that means in Latin is to speak the truth. Ladies
23 and gentlemen, I ask you to consider, based on the
24 evidence or the lack of evidence as you weigh the scales.
25 I ask you to consider returning a verdict in favor of the

1 Defendant, Dr. Miller. I ask you to consider that your
2 verdict speaks the truth. And whoever is the Foreman or
3 Foreperson on the jury, what you must do is when you get
4 to question one, did the Defendant, that is Dr. Miller,
5 breach the standard. You can draw a line there if you
6 want to. Yes or no. Reading the whole sentence. Did the
7 Defendant, Dr. Miller, breach the standard of care and
8 proximately caused the injury. There is a blank line.
9 You put in, you write in yes or no. If you write no, you
10 sign and knock on the door. I ask you to consider that
11 based on the evidence or lack of evidence in this case,
12 that has been presented in this trial, if that be your
13 verdict. Thank you.

14 THE COURT: Thank you, Mr. Davis. Ladies and
15 gentlemen, the final person you will hear from is Mr.
16 Graham again. As was said, the Plaintiff has the burden
17 of proof in the case so they do get a reply argument. Mr.
18 Graham.

19 MR. GRAHAM: May it please the Court.

20 THE COURT: Yes, sir.

21 MR. GRAHAM: Thank you, Your Honor. Back again. We
22 have been hearing about how wonderful Dr. Miller's
23 delivery was and what an excellent note he wrote telling
24 the truth about all things that happened at the delivery.
25 I am still trying to figure out, where does he acknowledge

1 that this baby had her nerves ripped out of her spinal
2 cord. For such an excellent note written an hour after he
3 knew this baby had a dramatic drastic injury to her arm,
4 he chose not to mention that in this note. And look at
5 this sentence here. He goes through this long
6 description, head delivered, LOP, right shoulder would not
7 deliver, McRoberts, suprapubic, third degree episiotomy
8 without success, could not deliver the posterior shoulder
9 and therefore woodscrew maneuver performed; and rotation
10 of 180 degrees, occurred to ROA, anterior left shoulder
11 delivered using McRoberts suprapubic pressure and moderate
12 effort. McRoberts suprapubic pressure and moderate
13 effort. Who, among you, believes that moderate effort
14 means, oh, I am repeating all of this. I delivered the
15 baby with McRoberts suprapubic pressure and moderate
16 effort. Now, usually doctors will just check a blank for
17 general traction. So and sometimes they use a lot more
18 than general traction but they write general traction.
19 For a doctor to write moderate traction suggest to me it
20 is quite a bit larger than general traction or moderate
21 traction. But for them to say that this moderate effort
22 is a repeat of all of this instead of being in the natural
23 flow of the English language sentence, I delivered the
24 head with McRoberts, suprapubic and moderate effort. Does
25 it make sense that moderate effort is a repeat of

1 everything. Makes no sense to me. And as was pointed
2 out, maybe last week, traction is defined as pulling or
3 effort. So I leave you with that. Another thing, I find
4 it curious that Mr. Davis said something who writes a
5 letter like this knows far more about it than someone who
6 reads the letter like this. What kind of letter is this.
7 Dear Angela. This is no letter. To me this seems more
8 like what happens after, what happens after an airplane
9 crash. The pilot survives, passengers don't, the
10 investigator says, hey, Mr. Pilot, we want you to write a
11 report about what happened. Fill in the blanks. This was
12 definitely a mechanical failure, there was no possibility
13 of pilot error. And if you have any doubts about that I
14 will hire some people to say there was no pilot error.
15 And you should believe me because I am the one that wrote
16 it. I think one who reads it and thinks about it knows a
17 lot more about really, what really happened than what the
18 author of this report claims to have happened. Just a
19 couple of things to hit on. There was so much talk about
20 Dr. Gurewitsch who is a giant, if I may say that without
21 sounding disrespectful, Mr. Davis was talking about me
22 hiring her 13 items. Not so. I asked her and paid her to
23 review cases of mine, to see if she thought they had
24 merit. So I would know whether or not to file suit or
25 not. Six or seven times, I don't remember which, six or

1 seven times she said no, I will not support this case. So
2 the idea that somehow that makes Dr. Gurewitsch some kind
3 of a prostitute witness, if you will, is just beyond
4 disrespectful. And he also said that she does almost all
5 Plaintiffs work. If you look, he put some records in
6 evidence about, first she list all of the cases she had
7 testified in the last few years before whatever date of
8 her deposition. Nobody else did that. She talked about
9 how much money she got. She even presented a chart that
10 is in evidence that says, over the past few years this is
11 how many cases I was asked to review on behalf of the
12 Plaintiff, on behalf of the Defendant. These are the ones
13 who actually followed up and sent me records to review and
14 paid a retainer to review it. These are the ones I
15 rejected, these are the ones I accepted. If you go
16 through there you will see that, yes indeed, there were
17 more Plaintiffs cases submitted to her but the percentage
18 of cases that she accepted were much higher on the Defense
19 side than on the Plaintiffs side, is what she has done in
20 response to my inquires, turning down roughly half of
21 them. She has not turned down anywhere near half of the
22 Defense cases she has been asked to review. And there was
23 all this business about Dr. Gurewitsch had some kind of
24 horrible brachial plexus injury that she said was not her
25 fault. What she said was, this was a mild injury. She

1 never said I didn't pull too hard. She said she didn't
2 think she was negligent. So this is the chart that she
3 analyzed, what type of force can lead to what type of
4 injury, and there are overlapping categories. But if you
5 go up here, we have got routine delivery, in other words,
6 no shoulder dystocia. A shoulder dystocia, I am sorry,
7 difficult delivery and a shoulder dystocia. She allows
8 more traction for difficult deliveries of shoulder
9 dystocia. And then here she has got temporary injury, no
10 injury, and then down here she talks about the nerve
11 stretching and then getting injured, kind of like a rubber
12 band, pull it and it doesn't break when you let go, it is
13 kind of sagging as elastic. That is what that is. But
14 the injury, up here she has the code for that. Here is
15 the, so if you have got 25 pounds of pressure, you may get
16 a stretch, you are not going to get an injury. If you
17 have got 30 pounds of pulling force then you are to get an
18 injury, it may be a mild injury or actually will be a mild
19 injury. It is only when you get down to, say about, 30
20 pounds, 34, 35 pounds that you get to the bottom and then
21 it takes more to get to severe. Then she puts permanent
22 injuries versus temporary injuries. So look at this
23 category, this one is, as severe as you can get. It
24 brings you down here to the extreme of force. The amount
25 of force is certainly not the only thing she looks at, she

1 can look at the injury and learn a lot. Just like looking
2 at skid marks on the roadway. I mean, you learn a lot.
3 You don't have to see the speedometer on a car to know how
4 fast it, if you have the length of the skid marks and
5 other information about the weight of the car and all of
6 that stuff. This is like, just basic evidence collection
7 and then analyze it and see what it adds up to, kind of
8 like a CSI on TV or something. But, anyways, she, so the
9 injury proves force, it proves excessive, well, it proves
10 60, 50, at least 50 pounds of force and at least 60
11 degrees of bending. But that doesn't mean she thinks the
12 Doctor is negligent. First, she wants to look at how long
13 it has been since the head came out, what do the fetal
14 heart monitor strips look like and various other
15 considerations to figure out was he heroic to save the
16 baby and the baby's brain by doing that. But he did botch
17 this delivery by yanking the baby's nerves out of the
18 spinal cord after 45 seconds. So for Mr. Davis to say,
19 all she looks at is the injury is just not correct. Oh,
20 another thing I found interesting was Mr. Davis' statement
21 about, if you got a fire starting to burn you better drop
22 everything and get that fire put out. I don't know about
23 Mr. Davis and Dr. Miller, but the way I was raised we take
24 care of rescuing our children. And in my case, my dog,
25 before we put the fire out. I want to make sure the loved

1 ones I care about are safe before I worry about a fire
2 that is in the very early stages. I have got two minutes
3 to rescue my family and put out the fire. There is all
4 this business we keep hearing about, about the uterus
5 pushing 30 pounds and then you add the Doctor's pounds to
6 get that so this 60 pounds business must really be 30
7 pounds; 30 plus 30 equals 60. That is not how it works.

8 (Inaudible, Mr. Graham moves away from microphone.)

9 Early, (inaudible), the uterus --

10 THE COURT: Mr. Graham, if you don't mind, grab the
11 microphone.

12 MR. GRAHAM: Thank you.

13 THE COURT: Yes, sir.

14 MR. GRAHAM: The uterus pushing from behind, the baby
15 goes through with the head and neck bones parallel or a
16 continuation of the axis of the spine. 30 pounds in that
17 direction is quite different from 30 pounds in that
18 direction or 50 pounds in that direction, 60 degrees. You
19 don't just add one and the other, there are two totally
20 different forces. And, remember, they show the arrows
21 coming not just from behind from each side on their
22 animation. Well, those things are from the side, you know
23 what they are suppose to be, of course, they are trying to
24 show you that this is compression, we are pushing that
25 baby 30, with 30 pounds of force and we are compressing

1 the baby from the sides, compressing the baby from the
2 sides is baboon logic. They have got eyewitness testimony
3 and we don't. Okay. They have got the Doctor who wrote a
4 letter, he is their eyewitness. Very truly yours, Dr.
5 Miller. We don't have an eyewitness. These guys at
6 Piedmont, Antwan, stay behind the drape. No, you can't
7 see your baby. No, you can't see your baby being born.
8 Does that resinate with anybody. I want to take just the
9 last few minutes of my time to just sort of speak from my
10 heart. We have got what could easily be a cog in the
11 wheel, cog in the wheel of industrial medicine, who gets
12 ground up, tossed aside and forgotten about. I resent
13 that and I resent the way they go around the Country
14 trying to cover, CYA, with all of these highly paid
15 experts and animations. They show you an animation again
16 after they have been exposed. Veredicto, look at their
17 animation, it speaks the truth. It speaks the truth so
18 well it got our experts to change their mind one-hundred
19 percent. Obviously, I don't know how you guys are viewing
20 this case, you have every right to view it as you see it,
21 based on what you have heard from the evidence, based on
22 your life experiences, as long as your life experiences
23 don't stand in the way of following the evidence. But for
24 those of you who see the evidence the way that we see the
25 evidence, I just want to point out, if anybody says to

1 you, Dr. Miller saved this baby's life or brain, remind
2 them, he ripped nerve roots out of her spine in the first
3 45 seconds. If anybody in the jury deliberation room
4 says, I don't know, I don't know, it seems like, it seems
5 like, it is hard to know who to believe. With all the
6 medical maze they create, it is so easy to get wrapped up
7 in that to think, you know, I can't decide whose got the
8 heavy end of the balance scale. I am so freaking confused
9 I better say the Plaintiff didn't meet the burden of
10 proof. Notice, we didn't hear anything about the
11 Defendant proved their case. It is either they proved it
12 by a tiny bit or it was a tie. Well, when you decide, you
13 know, the truth, which is more likely to be the truth,
14 just remember we believe there is a dramatic difference in
15 weight. There may be one or two things that you are
16 worried about or think, you know, I am just not certain
17 about this, somebody said something, the mom said
18 something that didn't sound quite right. Part of
19 Gurewitsch's deposition was so long winded, I got tired of
20 listening to it. There might be all kinds of reactions
21 that you have. I submit to you that human beings are
22 capable of, (inaudible), this young lady right here, when
23 she came out of the birth canal she had no idea, no idea.
24 Her spinal cord nerves had no idea. So if you are having
25 trouble, to believe, if you have trouble figuring out that

1 those experts were believable versus these experts, Dr.
2 Miller is believable than the parents; if you have any
3 doubts about any of that put them aside. There is always
4 a chance that something, (inaudible), unless they have
5 just been born. These are the skid marks on the highway,
6 somebody trained in obstetrics, biomechanical science; in
7 looking at the skid marks on the road and figure out how
8 fast this guy --

9 (Inaudible, Mr. Graham moved away from microphone.)

10 -- in terms of the amount of your verdict, you have seen
11 the figure that we put up there. In my heart I personally
12 believe that is an appropriate number, I recommend it to
13 you. You may think that is a high number, you may think
14 that is a low number, it is your decision to make
15 collectively. I just don't want to see this happen to
16 anybody else's child.

17 THE COURT: Ladies and gentlemen, that concludes the
18 evidence and the argument in this case, what remains is
19 jury deliberations. I am not going to ask you to start
20 deliberating tonight. And the reason for that, you might
21 can deliberate for half an hour or whatever, the reason I
22 am not asking you to do that is, if I ask you to start
23 deliberating I have to release the alternates. And then
24 when you come back tomorrow morning, if someone's husband
25 or wife or child had COVID or something, our alternates

1 are all gone and we have got a big problem. I know you
2 have worked really hard and you probably would like to get
3 started deliberating tonight. But, instead, I remind you,
4 please don't discuss this case with anyone over night,
5 don't do any research. Report back at 9:30 tomorrow
6 morning to begin deliberation.

7 (Whereupon, the jury was excused from open court for
8 the day.)

9 THE COURT: Counsel, anything from the Plaintiff's
10 perspective that we need to take up?

11 MR. DAVIS: No, Your Honor.

12 THE COURT: From the Defense?

13 MR. GRAHAM: No, sir.

14 THE COURT: Thank you for a well tried case over two
15 weeks, has been a long two weeks everybody. See you back
16 at 9:30 tomorrow.

17 MR. DAVIS: I want to thank the Court with your
18 patience with all of us. Thank you.

19 THE COURT: Now might be a good time to go through
20 the exhibits. That way when we come in tomorrow we can
21 just give it right to the jury.

22 MR. GRAHAM: Thank you, Your Honor.

23 (Whereupon, the trial will resume the next morning at
24 9:30 a.m.)

25 January 14, 2022

1 THE COURT: By my list the three alternates are
2 Juror, Rosiak, number 60; Juror Rowe, 235; Juror Holland,
3 122. Is that what you have, Ms. Foster?

4 MS. FOSTER: Yes, sir.

5 THE COURT: Let's bring them in.

6 (Whereupon, the jury came into open court at
7 approximately 9:36 a.m.)

8 THE COURT: Ladies and gentlemen, thank y'all for
9 being so prompt. I am going to send you right back in, we
10 just got to get a couple of things out of the way. Has
11 everyone been able to follow the rules that I have given
12 you.

13 I really appreciate that. It is now time to release
14 the three alternates. So when I send everyone back I need
15 these three jurors to stay here in the courtroom with me.
16 Juror, Rosiak, number 60; Juror Rowe, 235; Juror Holland,
17 122. Those are our three alternates. They need to stay
18 in the courtroom. And, ladies and gentlemen, I understand
19 that Juror Holland was your Foreperson. That is
20 completely acceptable, just reelect a new Foreperson when
21 you get back in the room to deliberate. And then one
22 other thing, the Clerk of Court wanted to do something
23 nice for y'all so they are going to order from a
24 restaurant for lunch today. The Bailiff will give you
25 menus in the jury room. You can order anything on the

1 menu, the only thing they crossed out was large pizzas.
2 Anything else is fine, circle what you want and write your
3 name on the top. The Bailiff will bring those back with
4 the evidence. Do that first, give them to the Bailiff so
5 they can get the food ordered. Other than that, ladies
6 and gentlemen, I am going to send you back and a minute or
7 so later the Bailiffs will come in with the evidence and
8 everything else. Those three jurors, please stay.

9 Let's get them the menus and verdict form and
10 evidence.

11 Counsel, I know y'all went through the exhibits
12 yesterday and everything is in order.

13 MR. DAVIS: Yes, sir.

14 MR. GRAHAM: Yes, sir.

15 THE COURT: Thank you, Counsel.

16 (Whereupon, the jury starts deliberations at
17 approximately 9:40 a.m.)

18 (Whereupon, the three alternates were excused from
19 the trial of the case.)

20 MS. FOSTER: We have a question.

21 THE COURT: It is a new Foreperson, we don't have a
22 new question yet. The Jurors indicates that Juror Pinto,
23 Juror 219 is their Foreperson, John Pinto.

24 (Whereupon, a break was taken awaiting the verdict.)

25 THE COURT: We have a note. Mr. Jordan, any word on

1 Mr. Graham?

2 MR. JORDAN: The word is, he is on his way to court.

3 THE COURT: Okay. The note, they are tearing a
4 little tiny paper. This is the note. The note says, we
5 would like the transcript of Dr. Grossman's testimony. I
6 don't think we can give them the transcript. I think we
7 can tell them that the Court Monitor can replay portions
8 of Dr. Grossman's testimony. Mr. Jordan, is that your
9 understanding of what is permitted?

10 MR. JORDAN: Yes, Your Honor.

11 THE COURT: Mr. Davis?

12 MR. DAVIS: Yes, sir.

13 THE COURT: Madam Court Monitor, is it possible for
14 you to replay out loud the recording of Dr. Grossman's
15 testimony.

16 COURT MONITOR: Yes, sir.

17 THE COURT: Okay. That was by video, correct. By
18 Webex. Dr. Grossman testified by Webex. Dr. Grossman,
19 there is no transcript. We can tell the jury we can play
20 back. Can we test it out real quick to see what it, how
21 long was his entire testimony on Webex.

22 (Whereupon, a short break was taken while Court
23 Monitor locates testimony of Dr. Grossman.)

24 THE COURT: Okay, let's bring the jury in.

25 (Whereupon, the jury came into open court at

1 approximately 10:53 a.m.)

2 THE COURT: Ladies and gentlemen, I have a note that
3 says we would like the transcript of Dr. Grossman's
4 testimony. A transcript has not been prepared yet but we
5 can replay for you all or part of Dr. Grossman's
6 testimony. Would you like for us to do that?

7 Is there a particular or should we just start playing
8 it and you can let us know if you have heard enough. Is
9 that the best way, is there a particular portion you would
10 like to hear?

11 I will send you back to the jury room while our Court
12 Reporter tries to locate that discussion in the recording,
13 okay.

14 (Whereupon, the jury was excused from open court.)

15 (Whereupon, the jury came into the courtroom. The
16 Court Monitor played Dr. Grossman's testimony for the
17 jury.)

18 THE COURT: For the record, earlier this afternoon
19 the jury sent a note requesting testimony be played back
20 and the Court Reporter kindly did that but obviously we
21 had to go off the record for the Court Reporter to use her
22 system to play back the testimony. For the record, we
23 played for the jury Thursday of last week which was the
24 6th, we played three minutes, three hours, 23 minutes and
25 17 seconds to three hours, 32 minutes and five seconds.

1 And then skipped ahead to 3 hours, 33 minutes and 33
2 seconds and then played until 3 hours, 45 minutes and 9
3 seconds. All right. Thank you.

4 Let's go back on the record. And also during that
5 period the jurors had asked for a list of the expert
6 witnesses and their fields of expertise. We did not
7 provide a list but with consent of both parties, the Court
8 read the names of the experts and the fields of their
9 expertise. And further, while we are on the record, the
10 Court has granted both parties 14 days for any post-trial
11 motions.

12 I understand the jury has a verdict. Let's bring
13 them in.

14 (Whereupon, the jury came into open court at
15 approximately 4:48 p.m.)

16 THE COURT: Mr. Foreman, has the jury reached a
17 verdict?

18 MR. FOREMAN: Yes, sir.

19 THE COURT: If you will hand it to the Bailiff,
20 please.

21 Madam Clerk, publish the verdict, please.

22 CLERK OF COURT: The State of South Carolina, County
23 of York, in the Court of Common Pleas. Case number
24 2009-CP-46-0195, (05195).

25 Did the Defendant breach the standard of care and

1 proximately cause the injury. Yes.

2 If answered yes to the question, if question one was
3 yes, what amount of economic damages. The amount of
4 one-million, five-hundred thousand. \$1.5 million, I
5 apologize.

6 Number three. If the answer to question one is yes,
7 what amount of non-economic damages resulted, in the
8 amount of one-million.

9 Ladies and gentlemen, signed by Foreperson, John
10 Pinto on January 12th, 2022.

11 THE COURT: 14th. Madam Clerk, I think it is the
12 14th.

13 CLERK OF COURT: 14th, I apologize. January 14th of
14 2022. Ladies and gentlemen, if this is your verdict
15 please indicate by raising your right hand.

16 Let the record reflect that all jurors affirmed the
17 verdict.

18 THE COURT: Mr. Davis, would you like the jury
19 individually polled?

20 MR. DAVIS: Yes, sir.

21 THE COURT: Madam Clerk.

22 CLERK OF COURT: If you will please stand when your
23 name is read.

24 Kristina M. Breece. Is that your verdict?

25 JUROR: Yes.

1 CLERK OF COURT: Is it still your verdict?

2 JUROR: Yes.

3 CLERK OF COURT: Sheryl Johnston. Is that your
4 verdict?

5 JUROR: Yes.

6 CLERK OF COURT: Is it still your verdict?

7 JUROR: Yes.

8 CLERK OF COURT: Dara DeMauro. Is that your verdict?

9 JUROR: Yes.

10 CLERK OF COURT: Is it still your verdict?

11 JUROR: Yes.

12 CLERK OF COURT: Matthew Anderson. Is that your
13 verdict?

14 JUROR: Yes.

15 CLERK OF COURT: Is it still your verdict?

16 JUROR: Yes.

17 CLERK OF COURT: Leighann Watkins Calvert. Is that
18 your verdict?

19 JUROR: Yes.

20 CLERK OF COURT: Is it still your verdict?

21 JUROR: Yes.

22 CLERK OF COURT: Scott Kodell, is that your verdict?

23 JUROR: Yes.

24 CLERK OF COURT: Is it still your verdict?

25 JUROR: Yes.

1 CLERK OF COURT: Daniel Fulk. Is that your verdict?

2 JUROR: Yes.

3 CLERK OF COURT: Is this still your verdict?

4 JUROR: Yes.

5 CLERK OF COURT: Steven Pesa. Is that your verdict?

6 JUROR: Yes.

7 CLERK OF COURT: Is it still your verdict?

8 JUROR: Yes.

9 CLERK OF COURT: Celeste McCaiin. Is that your
10 verdict?

11 JUROR: Yes.

12 CLERK OF COURT: And is it still your verdict?

13 JUROR: Yes.

14 CLERK OF COURT: John Pinto. Is that your verdict?

15 JUROR: Yes.

16 CLERK OF COURT: Is this still your verdict?

17 JUROR: Yes.

18 CLERK OF COURT: Debora Fritts. Is that your
19 verdict?

20 JUROR: Yes.

21 CLERK OF COURT: Is this still your verdict?

22 JUROR: Yes.

23 CLERK OF COURT: Chadwick Blackmon. Is that your
24 verdict?

25 JUROR: Yes.

1 CLERK OF COURT: Is it still your verdict?

2 JUROR: Yes.

3 CLERK OF COURT: Let the record reflect all jurors
4 were polled and affirmed the verdict.

5 THE COURT: Anything further from the Plaintiff
6 before I release the jury?

7 MR. GRAHAM: No, Your Honor.

8 THE COURT: From the Defense?

9 MR. DAVIS: I think there are some things we need to
10 take up. I don't know if the jury needs to be here to
11 talk about it.

12 THE COURT: Yes, sir.

13 MR. DAVIS: We can talk about it now.

14 THE COURT: You want to approach the bench?

15 MR. DAVIS: Sure.

16 (Whereupon, a bench conference was held in the
17 presence of the jury but out of the hearing of the
18 jury.)

19 THE COURT: Ladies and gentlemen, that completes your
20 service. I am not going to make a big speech. I know
21 y'all are ready to get out of here but I just want to
22 thank you very much. I can tell y'all paid close
23 attention, this was a long two weeks with highly technical
24 medical testimony. And y'all spent time to deliberate
25 today even though it was Friday. So I just want to

1 commend you for your service and your hard work in this
2 case and on behalf of the State of South Carolina and York
3 County, thank you very much. You are now released from
4 all restrictions. If you choose to talk about the case
5 with anyone you certainly can. You can talk with family
6 or friends. The lawyers may contact you, you are under no
7 obligation to speak with them if you don't want to. But
8 lawyers want to get better at their jobs like other people
9 so they may call you. If you feel like giving them
10 feedback about what they did good or bad you are welcome
11 to do that. And you are released from all restrictions
12 about discussing the case with anybody you would like.
13 Thank you and have a great weekend.

14 (Whereupon, the jury is excused from the trial of
15 this case at 4:55 p.m.)

16 THE COURT: Anything from the Plaintiff?

17 MR. GRAHAM: Yes, Your Honor. I just want to clarify
18 that, the verdict is against both Dr. Miller and against
19 the other Defendant, the Practice Group.

20 THE COURT: The question was Defendants. That is
21 correct.

22 MR. GRAHAM: And I don't know if it is appropriate to
23 bring this up at this time, Your Honor, but I would note
24 that we made an offer of judgment a very, very long time
25 ago which, in the amount of one-million dollars which

1 would lead to eight percent --

2 THE COURT: I appreciate that, I think that is an
3 issue for post-trial motions. But I don't think we need
4 to get into that today. Let me take a look at the verdict
5 form. Okay. The verdict form actually says the
6 Defendant, singular. But my understanding that both
7 parties agreed that the respondeat superior replied and
8 the verdict would be against both entities.

9 MR. GRAHAM: Yes, sir.

10 THE COURT: Mr. Davis, I think most everything you
11 mentioned can be handled in post-trial motions. If you
12 think there is anything we need to do today I will be
13 happy to listen.

14 MR. DAVIS: And I appreciate you giving me that
15 opportunity. Just to put on the record, I had asked you
16 about offset for the settlement by the hospital. I don't
17 know what that amount is. And also limitation on caps, on
18 the non-economic damages since there were no punitive
19 damages.

20 THE COURT: Yes, sir.

21 MR. DAVIS: So I am happy to address those in the
22 next --

23 THE COURT: Perfect. Just for my own curiosity, for
24 the offset purposes. Do you mind telling me, Mr. Graham,
25 what the settlement was.

1 MR. GRAHAM: Your Honor, for judgment --

2 THE COURT: Settlement from the hospital.

3 MR. GRAHAM: Oh, I am sorry. I think it was fifty
4 thousand but I would like to verify that before I
5 represent to the Court.

6 THE COURT: That's okay. That was purely for my own
7 curiosity. And I know y'all will file motions. So,
8 again, January 28th, motion deadline. I know this was a
9 long two-week trial. If you need more time let me know.
10 I had to dig out today two weeks worth of stuff in my
11 chambers. I am sure when y'all get back to the office you
12 will have plenty of stuff to look at as well. Well tried
13 case on both sides. It is great to have great lawyers in
14 my courtroom so thank you very much.

15 MR. GRAHAM: Thank you, Your Honor, it is great to
16 have a great Judge in the courtroom in which I appeared.

17 THE COURT: I appreciate that. Gentlemen, y'all have
18 safe travels.

19 MR. GRAHAM: Thank you.

20 MR. DAVIS: Thank you.

21 *** END OF REQUESTED TRANSCRIPT OF RECORD ***
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25

1 CERTIFICATE OF REPORTER

2 Case Name/Number: Angela Patton vs. Gregory A. Miller

3 2009-CP-46-05195

4 Date of Hearing: January 4 through 14, 2022

5 Court Reporter/Monitor: DCRP/Joy E. Holston Transcribed

6 State of South Carolina)

7)

8 County of Newberry)

10
11
12 I, Joy E. Holston, Official Court Reporter, do hereby
13 certify that the foregoing is a true and correct record of
14 the recorded proceedings; that said proceedings were
15 transcribed to the best of my ability from the audio
16 recording and supporting information; and that I am
17 neither counsel for, related to, nor employed by any of
18 the parties to this case, and I have no interest,
19 financial or otherwise, in its outcome.

20
21 November 22, 202222
23 Joy E. Holston24 _____
25 Joy E. Holston, Court Reporter